At-A-Glance:

Affordable Care Act Requirements for Substance Use Disorder Services

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Michael Cunningham
Acting Director
Department of Alcohol and Drug Programs

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I. OVERVIEW

The Patient Protection and Affordable Care Act (ACA) reshapes the nation's health system to make it easier for millions of Americans to obtain, pay for, and keep health care coverage.[1] The ACA requires health plans and insurers to provide access to insurance to individuals, regardless of their health status, age or occupation and provide a standard set of essential services and improved health outcomes. In return, individuals will be required to purchase and maintain insurance coverage for themselves and their families.

While federal guidance will play a large role, much of the responsibility to implement the ACA depends on action by state governments. Full implementation of the ACA will be phased in over the next decade with key elements going into effect in 2014. By 2014, California will need to expand Medi-Cal and reconfigure eligibility standards, create a health benefit insurance exchange where individuals and small businesses can use federal tax credits to purchase private health plans, and implement a wide range of reforms to private markets, as mandated by the new law.

II. ACA REQUIREMENTS FOR SUBSTANCE USE DISORDER SERVICES

As perhaps the most significant legislation affecting the substance use disorder (SUD) field, the ACA's public and private insurance expansion presents several opportunities to serve new clients with untreated SUDs, increase prevention efforts, improve service quality and health outcomes, and reduce overall health care costs. These goals support the Center for Medicaid and Medicare Services' (CMS) "triple aim" approach for improving health care.[2] The California Department of Alcohol and Drug Programs (ADP) anticipates a substantial increase in demand for SUD services resulting from ACA implementation.

Provisions of the ACA that will benefit those with substance use problems include:

1. No Denial of Coverage for Pre-Existing Conditions (September 2010 for children; 2014 for adults)

Insurers will no longer be able to deny coverage based on pre-existing medical conditions, including SUDs.

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[1] On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148). The following week, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152), which amended numerous health care and revenue provisions in PPACA. The two bills are commonly referred to as the Affordable Care Act or "the ACA."

[2] "Triple Aim" of delivery system reform as characterized by Don Berwick, Administrator of the federal Centers for Medicare and Medicaid Services (CMS).

2. Extended Coverage under Parents' Health Plans (September 2010)
Young people up to age 26—a population with a significant incidence of SUDs—, who do not have their own health insurance can obtain coverage under their parents' plans. Previously, health insurance for dependents in many states ended at age 19 or upon graduation from college.

3. Coverage of Evidence-based Preventive Health Services (September 2010)
The ACA requires coverage of evidence-based preventive health services at no-cost sharing that have received an "A" or "B" grade recommendation by the United States Preventive Health Services Task Force (USPSTF).

- Screening and brief intervention for alcohol misuse is a 'B' preventive list recommendation. The USPSTF recommends screening and counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
- Tobacco cessation is an 'A' preventive list recommendation. The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. The USPSTF also strongly recommends that clinicians screen all pregnant women for tobacco use and provide augmented pregnancy-tailored counseling to smokers.

The coverage of preventive health services requirement applies to Medicaid benchmark plans for the newly-eligible population, Medicare, qualified health plans in the newly-created state health insurance exchanges, and new individual and small group plans. If California chooses to cover these preventive health services for traditional Medi-Cal recipients (children, parents, aged, blind or disabled), there is a state option to receive a one percent increase in the federal medical assistance percentage (FMAP) rate.

4. Prevention and Public Health Fund
The ACA creates a new Prevention and Public Health Fund designed to expand and sustain the necessary infrastructure to prevent disease, detect it early, and manage conditions before they become severe. This new initiative will increase the national investment in prevention and public health, improve health, and enhance health care quality. Initial investment will be $500 million in fiscal year 2010 and increasing to $2 billion per year beginning in fiscal year 2015.

5. Community Transformation Grants
Awarded by the Centers for Disease Control and Prevention, these are competitive grants to State and local governmental agencies and community-based organizations for evidence-based, community preventive activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.

6. SUD services as an Essential Health Benefit (January 2014)
The ACA will require health plans to meet a minimum benefit level that contains essential health benefits. Essential health benefits include a general category for mental health and SUD services, including behavioral health treatment.

The essential health benefits requirement applies to qualified health plans offered in state health benefit insurance exchanges, all new individual and small group health plans, and benchmark or benchmark-equivalent benefit packages for the newly-eligible Medi-Cal population. The essential health benefits requirement does not apply to employer-based coverage obtained in the large-group market. Individual and small group health plans issued before the passage of ACA are exempt from the essential health benefits requirement provided they meet federal requirements concerning grandfathered status.

7. Parity Coverage of SUD services (July 2010)
The 2008 federal Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act (MHPAEA) ensures more fair and equal access to SUD treatment services by requiring group health plans that provide SUD treatment benefits to do so at the same level they provide for medical/surgical conditions. MHPAEA requirements also apply to Medicaid Managed Care plans that provide SUD treatment benefits.

The ACA builds upon the principles of the MHPAEA by *requiring* that health plans provide essential health benefits for SUD at parity within benchmark plans for the newly-eligible Medicaid population, qualified health plans participating in the state health benefit insurance exchanges, and all new individual and small group plans.

For Medi-Cal beneficiaries, it is important to distinguish that only the newly-eligible Medi-Cal population will receive parity coverage of SUD services. Within the traditional Medi-Cal population enrolled in Medi-Cal managed care plans, SUD benefits are not provided. Rather, plans refer to county provided SUD services.

The MHPAEA and the ACA will create additional opportunities for SUD providers to bill private insurance for SUD services. SUD providers may need to meet additional requirements to qualify as a health plan provider. California insurers may need to increase the number of SUD treatment providers to comply with the MHPAEA and its implementing regulations that require six classifications of benefits: (a) Inpatient, in-network; (b) Inpatient, out-of-network; (c) Outpatient, in-network; (d) Outpatient, out-of-network; (e) Emergency care and (f) Prescription drugs.

California's existing SUD service system faces challenges. Some existing and new SUD service providers will succeed in meeting these requirements while others may be excluded because they lack adequate qualifications. Undoubtedly, more rigorous standards are favorable in the long-term for delivering SUD services; however, this may be problematic for some providers and individuals seeking SUD treatment in the short-term.

III. PUBLIC PROGRAM EXPANSION

1. Expansion of Medi-Cal to 133 percent of the federal poverty level

Effective January 1, 2014, the ACA will expand eligibility for Medicaid to individuals under age 65 who earn less than 133 percent of the federal poverty level (approximately $14,000 for an individual and $29,000 for a family of four) based on modified adjusted gross income. People with incomes above 133 percent of the federal poverty level who lack access to employer-sponsored insurance will obtain coverage through the newly created state health insurance exchanges.

Annual Income		**Coverage Options**	**Cost**
Individual	*Family*		
Up to $14,400	Up to $29,327	**Eligible for Medi-Cal.** Low-income Californians who are U.S. citizens, as well as most legal immigrants, can enroll in Medi-Cal.	Copayments of $1 to $5 for selected services. A provider may not refuse care if a patient cannot pay for the cost of a visit.
Up to $43,320	Up to $88,000	**Eligible to buy subsidized private coverage through a new health insurance exchange market.** Participating insurers must offer a package of "essential" benefits that covers at least 60% of health care expenses.	Buyer's share of premium many not exceed 2% of annual income at the low end of the earning scale to 9.5% at the top. Yearly limits on out-of-pocket costs also apply.

2. Benchmark Benefits for the newly-eligible Medi-Cal population

During 2014-16, the federal government will provide 100 percent of the funding required for states to cover the newly-eligible Medi-Cal population. The existing Medi-Cal enrollees will be reimbursed by the federal government at the pre-American Reinvestment and Recovery Act (ARRA) level. By 2020, federal financing will taper to 90 percent for newly-eligible Medi-Cal enrollees. However, to receive this increased federal financing, the Medi-Cal expansion population must be provided "benchmark or benchmark equivalent" coverage. Because the Medi-Cal program has moved towards managed care, as indicated by the Section 1115 Waiver's mandatory enrollment of seniors and persons with disabilities into managed care, it is expected that benchmark coverage will be provided through a Medi-Cal Managed Care plan. The newly-eligible Medi-Cal population will be comprised largely of single childless adults and will receive a reduced set of benefits from the full-scope Medi-Cal benefits offered to the traditional Medi-Cal population (children, pregnant women, low-income parents, aged, blind or disabled).

The newly eligible Medi-Cal population's benefit packages, however, must meet at least "benchmark" standards, which are still relatively comprehensive. Benchmark coverage is defined in Section 1937(b) of the Social Security Act as coverage equivalent to the Federal Employees Health Benefit Plan, state employee coverage, coverage offered by the largest non-Medicaid commercial health organization in the state, or "Secretary-approved coverage." Current benchmark package requirements include inpatient and outpatient hospital services, physician services, lab and x-ray services, prescription drugs, mental health services, well-baby and well-child care, and other appropriate preventive services as designated by the federal Health and Human Services Secretary.

Beginning in 2014, the ACA requires benchmark coverage must include at least "essential health benefits," as defined in the ACA, as well as, parity coverage of mental health conditions and SUDs. This will require benchmark coverage to further include SUD services and to provide them at parity. Since the statutory language describing benchmark coverage is relatively general, CMS is expected to provide further guidance to states on the type and level of coverage that will be required.

3. Potential Impacts of the ACA on Publicly-Funded SUD Services in California

Drug Medi-Cal (DMC) is a SUD treatment program for those qualifying for Medi-Cal. DMC is administered by ADP under the terms of a memorandum of understanding with the Department of Health Care Services (DHCS), the state agency that oversees the Medicaid program. Like Medi-Cal, DMC provides a one dollar federal match for every one dollar spent by the state. DMC is currently the largest source of state-funding for SUD treatment funding in California.

The DMC program provides five different statutorily defined treatment modalities for SUD. They are: (1) narcotic treatment; (2) Naltrexone for opioid dependence only; (3) outpatient drug free counseling (group or individual); (4) day care rehabilitative (more frequent, longer duration counseling), and; (5) perinatal residential services. These services are provided in an outpatient rather than a hospital inpatient setting. DMC services are reimbursed based on either the maximum "negotiated rate" set by the state for each service delivered by the provider or the provider's usual and customary charge, whichever is lower.

DMC services are not delivered in a "capitated" or managed care setting. Rather, treatment services are "carved out" from the regular Medi-Cal Program as county services. Thus, they are delivered by a specialized system of providers certified by the state rather than through participating physicians or health plans. A provider must be state-certified to participate in DMC. Counties are not required to participate in DMC, and in fact, only 43 counties do so, and not all DMC counties provide all five treatment modalities.

Currently, the DMC delivery system is governed by the federal government and the California State Legislature. In order for ADP to make any changes to the existing DMC program, California must first gain the Legislature's approval through legislation, including an appropriation if changes are anticipated to be more costly. Once the

Legislature approves changes, federal approval must be attained through a document know as a State Plan Amendment (SPA). Once the federal government approves the SPA, California is able to make its approved modifications. Under the ACA, the way DMC operates and the mechanism for modifications is expected to change. However, at present, SUD services for the existing Medi-Cal population will be DMC services delivered by certified DMC providers.

It is currently unknown how Medi-Cal benchmark coverage will interface with DMC. Until further federal guidance on essential health benefits for SUD will look like in Medicaid benchmark coverage, the DMC program will continue to operate as it exists.

IV. HEALTH INSURANCE EXCHANGE

By January 1, 2014, the ACA requires states to establish a health insurance exchange—a marketplace for individuals and small businesses to purchase private health plans. On September 30, 2010, California became the first state in the nation to enact legislation to create an exchange after passage of the ACA. The legislation established the California Health Benefit Exchange (the Exchange) as an independent public entity governed by a five-member executive board. Further federal guidance is pending regarding Exchange operations.

The Exchange essentially picks up where Medi-Cal eligibility ends by providing premium subsidies to individuals and families with incomes between 133 percent and 400 percent of the FPL (up to $43,300/individual or $88,200/family of 4). The University of California, Berkeley's Center for Labor Research and Education estimated that 2.4 million Californians will be eligible for subsidies in the California Health Benefit Exchange, and another 2.2 million will be eligible to purchase coverage in the Exchange without subsidies.

Plans available in the Exchange must meet requirements for "essential health benefits." An essential health benefits package is defined as coverage that: 1) provides for essential health benefits as defined by HHS, which must include at least certain specified general categories; 2) limits cost-sharing and deductibles for such coverage; and 3) provides benefits that meet one of four defined categories of coverage. In determining the scope of essential health benefits coverage, the HHS Secretary must ensure that coverage is equal to the typical coverage provided by an employer. There are four categories for essential benefits packages—Bronze (minimum coverage), Silver, Gold, and Platinum—that cover the same set of services but range in the value of benefits provided.

While California has the flexibility to require its Exchange to offer benefits in addition to the essential health benefits, the ACA requires states to pay the entire cost of mandates that go above and beyond the definition of "essential benefits" for plans offered through Exchanges.

The ACA requires the Exchange's online enrollment portal to screen and enroll eligible individuals for the public programs of Medi-Cal and the Healthy Families Program (HFP) before enrollment into the Exchange. Because an individual's income may fluctuate, the ACA envisions continuous coverage through eligibility and enrollment coordination between the Exchange, Medi-Cal, and the Healthy Families Program (State Children's Health Insurance Program (SCHIP)).

V. DELIVERY AND PAYMENT REFORMS

1. Grants for Medical Homes for Medicaid Enrollees with Chronic Conditions

The ACA directs CMS to launch several efforts to strengthen primary care through patient-centered, coordinated "health home" and "medical home" concepts. The ACA defines patient-centered medical homes as a model of care that includes:

a) personal physicians;
b) whole person orientation;
c) coordinated and integrated care;
d) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;
e) expanded access to care; and
f) payments that recognize added value from additional components of patient-centered care.

Beginning January 1, 2011, states may opt to enroll Medicaid beneficiaries with chronic conditions into a medical home comprised of a team of health professionals that provide a comprehensive set of medical services including care coordination. Individuals must meet the following eligibility criteria: two or more chronic conditions; one chronic condition and at risk of developing a second chronic condition; or one serious and persistent mental health condition. Chronic conditions include: a mental health condition; a SUD; asthma; diabetes; heart disease; or being overweight, as evidenced by a Body Mass Index over 25.

States are encouraged to consult and coordinate with Substance Abuse and Mental Health Services Administration (SAMHSA) regarding the prevention and treatment of mental illness and SUDs among eligible individuals with chronic conditions.

It is important to note health home related services—not discrete medical services—would be reimbursed at an enhanced FMAP of 90 percent. Health home related services include: comprehensive care management, care coordination, health promotion and use of health information technology to link services.

2. Center for Medicare and Medicaid Innovation

The ACA creates within CMS a new center charged with exploring innovations in health care delivery and payment that will enhance the quality of care for Medicare and Medicaid beneficiaries, improve the health of the population, and lower costs through

improvement. The new Center for Medicare and Medicaid Innovation (CMI) has three areas of emphasis:

- **Better Care for Individuals:** Improving care for patients in formal care settings like hospitals, nursing homes, and doctors' offices, and developing innovations that make care safe, patient-centered, efficient, effective, timely, and more equitable. The Innovation Center will also promote the use of "bundled payments," a more efficient approach to paying for care where providers collaborate to manage multiple procedures as part of a single episode with a single payment, rather than the current fee-for-service method of submitting separate bills for each procedure, which leads to higher costs.

- **Coordinating Care to Improve Health Outcomes for Patients:** Developing new models that make it easier for doctors and clinicians in different settings to work together as a team towards caring for patients. Examples include identifying and widely deploying the best advanced primary care and health home models, and supporting innovations in accountable care organizations.

- **Community Care Models:** Exploring steps to improve public health and make communities healthier and stronger. The Innovation Center will work to identify and address major public health crises and the appropriate interventions for areas of great concern, such as obesity, smoking, and heart disease.

CMI will assess the progress of its programs and work with providers and other payers to replicate successful innovations in communities across the country. It will test models that include establishing "open innovation communities" that serve as information clearinghouses for best practices of health care delivery reform. These communities will act as testing grounds for new practices, yielding innovative ideas and lessons, and fostering ongoing exchange on shared challenges.

VI. SUBSTANCE USE DISORDER LISTED AS A NATIONAL PRIORITY

1. National Prevention Council

The ACA establishes a National Prevention Council, led by the U.S. Surgeon General, to develop a national prevention and health promotion strategy that is to be reported annually to Congress and the President. SUDs are listed as one of the national priorities to be included in the annual report. The Director of the Office of National Drug Control Policy will also serve as a member of the Council.

Specifically, the ACA requires that the Strategy contain “a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, SUD and domestic violence screenings) and the prevention measures for the 5 leading disease killers in the United States.

2. National Health Care Workforce Commission
The ACA establishes a National Health Care Workforce Commission that lists the mental health and behavioral health workforce, including SUD prevention and treatment providers, as a high priority. Workforce issues involve education and training capacity, projected demands, and integration with the health care delivery system. Other high priority workforce areas include: nursing, oral health, allied health and public health, and emergency medical services.

The Commission will also engage on the following topics:

- integrated health care workforce planning;
- the nature, scopes of practices, and demands for health care workers in the enhanced information technology and management workplace;
- how to align Medicare and Medicaid graduate medical education policies with national workforce goals; and
- the geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions.

Additionally, the ACA is complemented by the Obama Administration's Federal Year 2011 Budget, which increased funding by $7.2 million to train and engage primary healthcare providers to intervene in cases of substance use.

VII. WHAT IS CURRENTLY UNKNOWN?

Following will require federal and/or state guidance:

- HHS will issue definitions for essential health benefits, including the specific items and services for SUD.

- The Medicaid expansion population will receive a benchmark benefit plan that must include essential health benefits. Further guidance from CMS is needed on what this package will contain.

- The traditional Medi-Cal population receives SUD services in the carve-out DMC program. Will 2014 Medicaid benchmark plans (presumably under Medi-Cal managed care) utilize DMC for the provision of SUD services?

- Will SUD providers bill DMC or the broader Medi-Cal system in 2014?

- Will the state provide a different set of SUD services for the traditional and expansion populations in Medi-Cal as a result of the ACA? Or will the state take action to streamline SUD services, including parity coverage, for the traditional Medi-Cal population?

- The criteria for qualified health plans to participate in the Exchange is unknown.

- Will the state take advantage of a state option in the ACA to cover preventive health services for the traditional Medi-Cal population?

- How will the ACA change the relationship between primary care and specialty care?

VIII. CALIFORNIA'S EARLY IMPLEMENTATION OF THE ACA

Section 1115 Medi-Cal Demonstration Waiver: A Bridge to Reform

While many provisions of the ACA do not take effect until 2014, California is using its new Medi-Cal Section 1115 waiver to prepare for health care reform. DHCS has estimated that Medi-Cal will expand in 2014 to include more than 1.6 million new individuals, many of whom were previously not eligible for services.

Federal waivers granted under Section 1115(a) of the Social Security Act permits states to pursue a range of program changes in an effort to deliver health care more effectively and efficiently. They also allow states to direct the savings achieved to support service expansion and delivery system reinvestment. Approved in November 2010, California's new Section 1115 waiver covers a five-year period. The new waiver immediately expands coverage today for those who will become "newly-eligible" in 2014 under the ACA. It also implements models for comprehensive and coordinated care for some of California's most vulnerable residents. Finally, it will test various strategies designed to strengthen and transform the state's public hospital health care delivery system for the additional numbers of people who will access health care once the ACA is fully implemented.

The waiver is expected to increase and expand health care coverage to as many as 500,000 low-income uninsured residents by taking advantage of the Coverage Expansion and Enrollment Demonstration (CEED) offered in the ACA. The CEED projects builds upon the county-based health care coverage initiative (HCCI) formed in the previous 2005 hospital financing waiver. County-based low-income health programs (LIHP) will be provided to two groups: the Medicaid Coverage Expansion (MCE) population and the HCCI population. Eligible adults will be enrolled in a medical home and receive a core set of services, including inpatient and outpatient services, prescription drugs, mental health (MH), and other medically necessary services. The waiver immediately begins phasing in coverage for the MCE population, which comprises "newly eligible" adults from ages 19 to 64 with incomes up to 133 percent of the FPL, who are not otherwise eligible for Medicaid. The waiver also offers coverage for the HCCI population, which includes adults with incomes between 134 and 200 percent of the FPL. The State will build on its county-based HCCIs to offer benefits to this population, who beginning in 2014 will receive coverage through the Exchange. The new waiver does not specifically require SUD services in the county-based LIHPs. Counties can elect to provide SUD services in the benefit packages of LIHPs if counties provide the non-federal share of cost to receive the federal matching reimbursement.

In years two and three of the five-year waiver, there will be increased focus on the overall behavioral health delivery system that encompasses mental health and SUD

services and the development of a Medicaid benchmark benefits plan. Specifically, the waiver's Special Terms and Conditions require:

- **Design of Behavioral Health Needs Assessment -** Upon Demonstration approval, the State shall work with CMS, SAMHSA, the State Department of Mental Health and ADP to design an approach for a systems assessment to identify SUD and mental health services (including amount, duration, and scope) available throughout the State. This assessment design shall also include information on available service delivery infrastructure, information system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of behavioral health and physical health integration and other information necessary to determine the current state of behavioral service delivery in California.

- **Behavioral Health Services Assessment -** By March 1, 2012, the State will submit to CMS for approval an assessment that shall include information on available mental health and SUD service delivery infrastructure, information system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of behavioral health and physical health integration and other information necessary to determine the current state of behavioral service delivery in California.

- **Behavioral Health Services Plan -** By October 1, 2012, the State will submit to CMS for approval a detailed plan, including how the State will coordinate with the Department of Mental Health and ADP, outlining the steps and infrastructure necessary to meet requirements of a benchmark plan no later than 2014.

IX. CONCLUSION

Through federal guidance and financial assistance, California state leaders are currently examining how to best link California's existing public programs and services to the high performing health care systems envisioned by the ACA. Implementing the ACA requires advance planning, legislative authority, regulatory development, procurements, system building and testing. For the SUD field, the ACA has opened multiple policy windows. Specifically, the affirmative inclusion of SUD services as an essential health benefit testifies to the value of these services in achieving general health and wellness. In part, the work of implementing the ACA will include delivery system redesigns, new payment models and structures, and integration with primary care; and equally important, reaching far more individuals in need of SUD services, but currently lacking access. As ADP moves forward with implementing the Section 1115 demonstration waiver deliverables, it will do so with its stakeholders fully engaged in the process. As the ACA proceeds on a fast track to 2014, ADP looks forward to building collaborative partnerships across all sectors and systems to fully realize the promise and potential of health care reform.