

Aligning SSA and Providers with Health Care Reform



Health Policy Student Forum
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AGENDA



- Massachusetts landscape pre/post HCR
- Impact of HCR on providers
- Importance of data
- Changing role for the SSA



Overview of Uninsured in Massachusetts (2004)



- 7.4% uninsured adults (460,000)
- 25.4% (highest rate) 19-24 year olds similar to national data
- 51.3% below 300% FPL
- Overall higher rates of uninsured among
 - blacks, Hispanics
 - part-time workers of small employers



Health Care Reform in Massachusetts



- 439,000 newly insured since 2006
- 98.1% of adults insured as of Spring 2013
 - 99.8% of children are insured
 - 99.6% of individuals 65+ are insured
- Of the uninsured, 90% are below 500% FPL



Commonwealth Care SUD Coverage

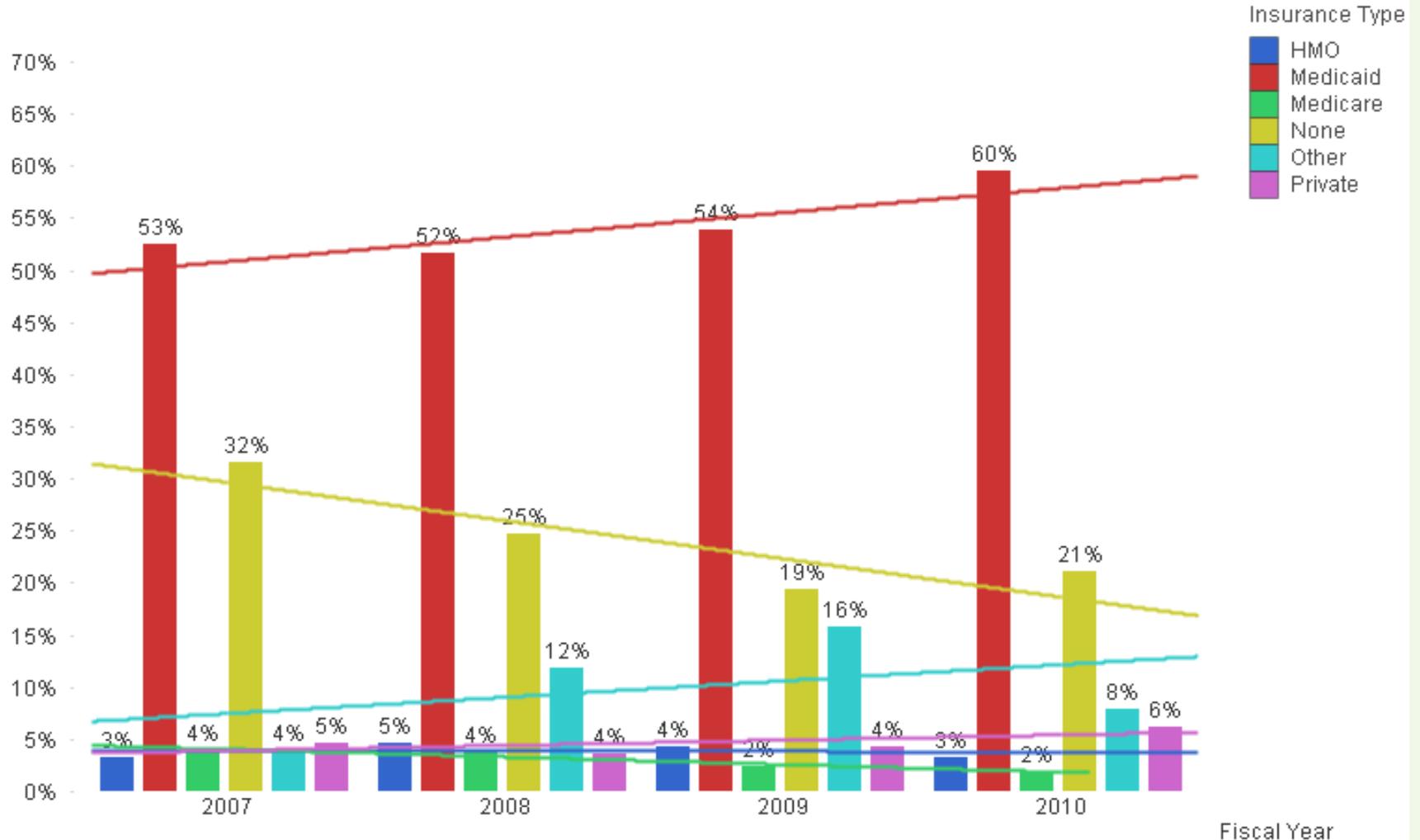


- Advocacy by SUD/MH community led to improved SUD/MH benefits
- Varying premiums, co-pays by plan and service
- Some plans require prior authorization for some SUD services
- All plans cover:
 - inpatient and outpatient SUD services
 - smoking cessation (150,000 have stopped smoking)
 - methadone maintenance, buprenorphine, Vivitrol
 - no co-payments for methadone maintenance



Insurance Status of Clients Entering Detox

Trend in Insurance Type by Fiscal Year





BSAS Enrollments by Insurance Status FY 2013



	Uninsured	Insured
ATS Enrollments	16.4% (7,658)	83.6% (39,042)
All Enrollments	18.3% (19,058)	81.7% (85,235)

Prepared 7 June 2013 by the Office of Data Analytics and Decision Support, Bureau of Substance Abuse Services, Massachusetts Department of Public Health. Data Refreshed May 14, 2013 * Excludes enrollments with missing data for insurance status. ** For purposes of this analysis, a client is considered uninsured during a fiscal year if the client reports being uninsured for any enrollment episode during that year.



FY 2013 Clients Served by Insurance Status and Demographic Characteristics



Characteristic		Uninsured	Insured
Age	18-20	4.6%	4.6 %
	21-29	37.2%	30.0%
	30-39	28.3%	25.0%
	40-49	18.5%	22.0%
	50-59	9.2%	12.8%
	Greater than 59	1.7%	3.1%
Sex	Male	78.6%	63.6%
	Female	21.4%	36.4%
Race-Ethnicity	White, Non-Hispanic	73.4%	77.1%
	Black, Non-Hispanic	7.7%	6.3%
	Hispanic	13.7%	12.3%
	Other	5.2%	4.3%
Total Clients Served		19,614	66,427

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FY 2012 Uninsured Clients Served by Level of Care



Characteristic	Uninsured
Criminal Justice Programs	32%
Detoxification	18%
Residential Treatment	13%
Supportive Case Management	10%
Medication Assisted Treatment	9%
Youth Programs	1%

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Cost of MA HCR



Independent studies of MA HCR show

- FY 2011 state budget spend on health care was 1.4% greater than pre-HCR
- Insurance premiums increased an average of 2.3% vs 5.8% nationally
- MA Medical Loss Ratio requires 90% of premiums be spent on medical care, greater than ACA requirement of 80-85%



The Changing Health Care Reform Landscape in MA

Chapter 224



- Signed in August 2012 -- “An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation.”
- Seeks to reduce the growth of health care costs and improve quality by making a number of changes including, furthering behavioral health and substance abuse treatment integration and facilitating administrative simplification.
- Going forward system will focus on the person in a holistic way and strive to integrate all needs – medical, behavioral health, and psycho-social



Delivery & Payment System Reform



Integrated Care Models

- Fully integrated PC, MH and SUD
- Co-located PC, MH, SUD
- Separate by coordinated PC, MH and SUD

Payment Models

- Shared risk
- Global payment (move away from FFS models)
- Bundled payment



What System Change May Mean



- Expanded coverage will include more individuals in need of addiction services
- Because ACO and PCMH are responsible for whole person, increased integration and coordination of addiction services potentially key to achieving quality and cost growth goals
- Focus on outcomes as a payment driver



What System Change May Mean for Addiction Treatment Providers



- Reformed delivery systems may result in:
 - Changed provider responsibilities (greater coordination with PCMH)
 - Increased provider-operated, broad networks such as Accountable Care Organizations, with responsibility and incentive to manage care for whole person (including substance abuse treatment)
 - Potential for shared savings and alternative payment methodologies across providers
- Important for addiction providers to be pro-active in accurately representing benefit of services to the whole care of the patient, and their role within the system, including through ensuring accurate and robust data



Importance of Data in the Context of Reformed Delivery System



- Comprehensive data is essential for:
 - appropriate case mix and risk adjustment
 - understanding capacity requirements
 - performance measurement and evaluation
 - payment for addiction services
 - addiction provider inclusion in integration efforts



Provider Performance Measurement



- Provider quality measures
 - Retention
 - Engagement
 - Transition to next level of care
 - Recidivism
 - OTP and OBOT (elimination of drug use)
 - Residential treatment outcomes



Observations



- Significant uninsured individuals still presenting for SUD treatment
- Considerable churning and dis-enrollment among plans
- Premiums, co-payments and deductibles can be a barrier to access
- SSA share of purchase of traditionally reimbursed services is shrinking



The Role of SSA's



Going forward, to continue to be relevant, SSA will need to:

- keep SUD at the forefront of Primary Care and Behavioral Health integration efforts;
- emphasize payment for and inclusion of community prevention, treatment and recovery support services;
- firmly establish a role as THE state authority for substance use policy;
- influence policy and service delivery across public and private payers and all types of providers
- think differently about blending of public money



REMEMBER



TREAT ADDICTION

SAVE LIVES