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CAPITOL INSIGHT

Integrate This!

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Integrating health, mental health and substance use treatment.

The California Psychiatric Association (CPA) submitted comments to the California Department of Health Care Services (Department) as guidance for consideration in the Department's process of developing a new 1115 Medi-Cal Waiver on November 16, 2009. A "Waiver" is essentially a method of asking the Federal government - which has jurisdiction and oversight responsibility for Medicaid (in California the Medicaid program is called Medi-Cal) services to the low-income individuals - to formally agree to waive provisions in Federal Medicaid regulations governing how states must design program. Typical waiver duration is 5 years. There are various types of waivers and the current California 1115 waiver governs hospital financing and the delivery of care to the uninsured, and expires on August 31, 2010. This expiring waiver directs the delivery of health care and not mental health care. However, there is a significant opportunity in the waiver design process for the CPA to influence the development of integration of health, mental health and substance abuse care.

A bit of background: ABX4 6 was signed by the Governor as part of the budget deal struck with the Legislature in July, 2009. It directs the Department in specific ways to improve the health care of low-income Californians in the waiver renewal process. In particular, it requires the Department to: maximize Federal reimbursement dollars coming into California; maximize

opportunities to reduce the number of uninsured individuals; improve health care quality and outcomes; and promote home and community based care. To effectuate these aims the law requires the implementation of integrated care, medical home, and care and disease management models in a managed care environment. The specific target populations are seniors, the disabled and children with special health care needs as well as individuals with behavioral conditions.



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This may seem like pretty arcane stuff, and it is, but it is also an opportunity for CPA to use its expertise to assist in redesigning a care system that will provide better care to low-income Californians. The CPA sent a letter to the Department which pointed out essential ingredients for the redesign:

- 1) Sources for a variety of evidence-based integration of care models as catalogued by the Institute of Medicine and other sources;
- 2) Administrative structures that take advantage of physician leadership;
- 3) Timely access to services dependent on the availability of provider panels, and the importance of utilizing strategies such as effective reimbursements to ensure provider participation in panels;
- 4) Evidence-based services that address the needs of patients with co-occurring health, mental health and/or substance use conditions;

- 5) Training of primary care providers to appropriately screen, identify, treat and refer individuals with mental health and/or substance use disorders;
- 6) Availability of essential age-appropriate mental health services for all age groups, including children, transitional aged youth, adults, and older adults;
- 7) Continuous quality improvement based on the best evidence and outcome measurement;
- 8) Availability of an integrated electronic medical record (EMR) that, to the extent that is permitted by statute and regulation, needs to be developed to integrate general medical, substance use and specialty mental health records; and
- 9) Well-defined manner for addressing the unique service, documentation, and reimbursement requirements for those individuals who have dual eligibility for Medicare and Medi-Cal.

The full text of the CPA letter is available at www.calpsych.org. Deserving thanks are members of the CPA Public Psychiatry and Government Affairs Committees for their hard work identifying and refining the concepts and expression of the CPA position on the 1115 Waiver. The CPA expects to participate in a stakeholder process that ABX4 6 requires the Department to convene in order to receive input on the design of the mental health portion of the waiver. We will keep you apprised.

Mental Health Insurance Parity and Other Managed Care Issues

AB 244, authored by mental health champion Assemblyman Jim Beall (who received the prestigious Jacob Javits Award from the APA this May) would have required health plans in California to cover all DSM disorders, but was vetoed by the Governor on October 11, 2009. The Governor opined in his veto message: "I have vetoed similar measures twice before. The addition of a new mandate, especially one of this magnitude, will only serve to

significantly increase the overall cost of health care. This, like other mandates, also increases cost in an environment in which health coverage is increasingly expensive."

Mr. Beall has told the CPA that he will introduce a fourth parity bill in 2010.

The release of Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) regulations have been delayed from the statutory October 3, 2009 due date until early next year. The reason for the delay has been identified as an unanticipated deluge of input during the public comment time period – which takes time to process and respond to. Plans are required to be in compliance with MHPAEA on January 1, 2010. Without guidance to plans in the form of regulations it's difficult to say what changes in coverage standards, if any, will become mandatory.

In a related development, the CPA has discovered that Anthem Blue Cross (ABC) in California has informed psychiatrist providers there will be new coverage requirements in California - essentially changes in medical necessity criteria: 1) Outpatient psychotherapy must be authorized after the 12th visit (and presumably after every subsequent 12th visit); also, 2) Medications will be used for conditions where indicated as first line treatment in the "Psychiatric Outpatient Program."

The American Psychiatric Association has indicated that ABC has also instituted similar restrictions in other states, notably Florida and Illinois, and holds that these restrictions are inconsistent with the MHPAEA, and is negotiating with ABC to "mitigate these requirements."

CPA has also provided documentation of the change in ABC medical necessity criteria to the California Department of Managed Care and asked that it conduct an investigation. It seems like an unlikely coincidence that the date on the letter informing California psychiatrists of the changes predates the initial date of federal regulation promulgation, October 3, 2009, by a little over a week.

Prison Issues

The CPA has been invited by the Chief Deputy Director of Mental Health Programs to participate in the development of a strategic plan for the delivery of mental health services by the California Department of Corrections and Rehabilitation (CDCR). Stakeholder meetings are to begin in January, 2009, and the CPA will be joined by the National Alliance on Mental Illness, California.

A federal three-judge panel will rule shortly on a CDCR plan to reduce the population in prisons, having found earlier in the year that overcrowding was the proximate cause of constitutionally inadequate health and mental health care. The plan submitted on November 12, 2009, was the second plan, with the first plan being rejected in October by the three-judge panel. The state has indicated that it will most likely appeal whatever ruling the panel makes – in anticipation of yet another rejection by the panel. 2010 will mark the 20th anniversary of the filing of the Coleman lawsuit, alleging constitutionally inadequate mental health care in California prisons. While the quality of care delivered by CDCR has improved marginally over two decades according to some expert observers, it is still far from attaining the level of community standards, and the judges are expected to require aggressive remedial action by the release of 40,000 inmates. That cohort will likely include large numbers of people with mental illness and substance use disorders that will strain already overburdened community services – many of which have been slashed to the bone in the last several budget cycles. The CPA letter to the legislature on releases of inmates is available on the CPA website: www.calpsych.org.

Budgets, Budgets, Budgets

While economic indicators are strengthening somewhat, the California Legislative Analyst's Office (LAO), a bi-partisan fiscal and policy analysis unit of

the Legislature, has reported that California can expect significant state budget deficits until 2015 and perhaps beyond. In 2010 the Legislature will deal with yet another huge deficit of \$21 million. LAO recommendations include appropriating monies from Proposition 63, the Mental Health Services Act passed by voters in 2003. The Governor must deliver a budget to the legislature by January 10, 2010. The magnitude of the deficit and depleted resources in social service, health and mental health programs, from severe cuts in prior years means another year of very ugly program reductions.

2010 Legislation

The CPA will co-sponsor legislation with other members of the California Mental Health Coalition to require that utilization review become part of the parity mandate, i.e. subject to the same terms and conditions as other health conditions. CPA will also continue to fight as a co-sponsor for AB 524 (Fuentes), the Public Protection and Physician Health Program Act of 2009, which stalled in the Senate Appropriations this year. Prospects for this bill have dimmed as a punitive climate has emerged in this administration with regard to the treatment of impaired licensees of the various professional boards overseen by the California Department of Consumer Affairs. The CPA is also considering sponsorship of other bills at this time and must make those decisions by the end of January.

Department of Government Relations' Legislative Reports Feature

Monitoring the introduction and changes in key state legislation on a daily basis has helped DGR's state team identify a number of important issues affecting patients' safety, discriminatory coverage of mental illness, and efforts to expand psychologist prescribing. APA's District Branch/State Associations can *Now* view legislation introduced in their state, print the bills, and get the most up-to-date bill status by visiting DGR's **Legislative Reports** feature located on APA's website under DGR's State Affairs Section.

Just click on the state map to review tracked bills in

your state, or any other state. If you are interested in following an issue across the country (e.g., Children's Mental Health, Civil Commitment, etc.) click on any of the 38 issues we follow.

Please go to the link below and check out DGR's *New* advocacy tool. You will need your APA username/password to access the page.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/StateAffairs/LegislativeReports.aspx>

Red Flags Rule: Another Postponement for Psychiatrists

With the multitude of legal and regulatory requirements imposed on psychiatrists in recent years, many psychiatrists may have glossed over a set of regulations commonly called the “Red Flags Rule.” **Although implementation of the rule was due to take place on November 1, 2009, it was recently postponed until June 1, 2010.** The Rule originally emanated from the Federal Trade Commission (FTC) and several other government agencies, with the goal of requiring financial institutions and creditors to develop procedures to detect and prevent identity theft. “Red Flags” were defined by the FTC as **“potential patterns, practices or specific activities indicating the possibility of identity theft.”** Common red flags include: notice or warnings from a consumer reporting agency; suspicious documents or information, such as an incorrect address or social security number; dubious activity concerning a patient account; and notice of potential identity theft from the patient, victim of identity theft or law enforcement officials.

So, what does this have to do with psychiatrists and other physicians? Identity theft has become rampant in recent years, as more people are handling monetary transactions over the internet and the cost of health care has skyrocketed. Medical identity theft has taken many forms, among them the following real-life situations which have been widely reported over the internet and other media outlets:

- A woman gave birth to a baby addicted to crack and subsequently left the hospital without notice. The woman had checked in using a second woman’s identity. Police arrested the second woman and the local Child Protective Services agency removed her children from the home. The second woman had to prove that she had not given birth; she was later cleared and the children were returned.
- A person was billed for medical services which he did not personally receive. Another person wrongfully obtained the first person’s health Insurance ID card and received services.

As a result of situations like those specified above, the FTC has taken the position that **a physician is consid-**

ered a “creditor” subject to the Rule if she regularly extends credit or regularly arranges for the extension or continuation of credit. The agency has also indicated that physicians extend credit by allowing deferred payment until services are rendered and insurance payments are actually collected. Furthermore, the FTC maintains that physicians who permit payment plans are “creditors” under the Rule. The government’s interpretation of the Rule appears to define “regular” deferment of payment as anything more than a rare occurrence.

Additionally, a provider who is a “creditor” must also determine whether she has **“covered accounts”** under the Rule. Essentially, if the patient can make multiple payments, the FTC considers this a covered account. The other type of covered account is one which carries a foreseeable risk of identity theft. The Red Flags Rule mandates that physicians who are considered “creditors” with “covered accounts” must develop **written policies and procedures to identify, detect and respond appropriately to identity theft red flags.** The program must also be periodically updated and should dovetail with the physician’s HIPAA policies and procedures, if applicable.

The APA, AMA and a host of other professional associations expressed concern that the regulations should not apply to physicians. On October 30, 2009, the FTC responded by announcing that **implementation of the Rule will be postponed until June 1, 2010.** Additionally, a bill is pending in Congress that would automatically exempt healthcare, legal and accounting practices employing less than 20 people. So what should you, as a psychiatrist, do now? Nothing! Wait to see what the FTC and/or Congress does and then consult with legal counsel before June 1, 2010.

This update was provided by Anne Marie “Nancy” Wheeler, J.D., Coordinator of the APA Legal Information and Consultation Plan. For further information about the Plan, please call Nancy at 301-384-6775 or e-mail apaplan@verizon.net. The article provided above is informational in purpose and is not to be construed as legal advice.