

Issues in Missouri Health Care 2011

Treating the Whole Missourian:
Mental Health and Substance Use Disorders

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Issue Statement

While reports of the Surgeon General and numerous academic studies have supported the notion that mental health is fundamental to overall health, behavioral health issues are often ignored or marginalized in health care policy discussions.¹ As Missouri addresses the issue of how best to care for individuals whose needs include behavioral health services, including the uninsured, some questions need to be addressed:

- What are behavioral health disorders?
- How large is this problem?
- What are the policy options for addressing the problem?

This brief summarizes policy options relevant to behavioral health care issues, with specific attention focused on opportunities newly available in the Patient Protection and Affordable Care Act (ACA).

Background

Behavioral health commonly refers to health issues related to an individual's mental well being. While everyone has shifts in mood or thinking, behavioral health disorders significantly interfere with a person's ability to function, and with interpersonal relationships. Problems related to behavioral health are often referred to as mental disorders. The most significant of these mental disorders fall into two main categories: mental illnesses and substance use disorders.

Types of Mental Illnesses

- *Mood disorders:* Mood disorders include both depression and bipolar disorder. Depressive disorders are illnesses characterized by a persistent sad, anxious, or "empty" mood; feelings of hopelessness and pessimism; feelings of guilt, worthlessness, or helplessness; and loss of interest in activities that had been viewed as pleasurable. Bipolar disorder, also known as manic-depressive illness, is characterized by dramatic mood swings from overly "high," agitated, and/or irritable to sad and hopeless, often with periods of normal mood in between. These mood swings are often accompanied by severe changes in energy and behavior.
- *Anxiety disorders:* Anxiety is a normal reaction to stress. However, when a person's anxiety becomes excessive or irrational, it can be disabling. Among the common anxiety disorders are panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and phobias. Post-traumatic stress disorder (PTSD) is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which the individual has experienced or been threatened with grave physical harm. PTSD is seen in children and adults who have experienced abuse, violent crime or natural disasters, and individuals who have been in

1 U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. <http://www.surgeongeneral.gov/library/mentalhealth/summary.html> Retrieved 10/21/10

combat. PTSD has received increased attention lately because of its impact on individuals who have served in the military in Iraq and Afghanistan.

- *Schizophrenia*: Schizophrenia is a severe and chronic brain disorder. Symptoms commonly begin to appear in men in their late teens or early twenties, and women in their twenties and thirties. They can include hallucinations (e.g., hearing voices), delusions, disordered thinking, flat affect, cognitive deficits, and social withdrawal.
- *Attention Deficit Hyperactivity Disorder*: Attention Deficit Hyperactivity Disorder (ADHD) is one of the most common mental disorders in children. Children with ADHD have difficulty functioning in school, at home, and with peers. ADHD is characterized by impulsiveness, inability to focus on tasks, and an inability to sit still.²

Substance Use Disorders

Substance use disorders, including alcoholism and drug abuse, are significant behavioral health disorders as well.

- *Alcoholism*: Alcohol dependence is a diagnosis of a maladaptive pattern of substance use made when an individual meets three of the following criteria in a 12-month period:
 - Tolerance;
 - Withdrawal or use of alcohol to avoid withdrawal;
 - Use in larger amounts or for longer than intended;
 - Unsuccessful efforts to decrease or discontinue use or a persistent desire to do so;
 - Alcohol use as a major focus of time and life;
 - Abandonment of social, occupational, or recreational activities; and/or
 - Continued use despite recognized psychological or physical consequences.
- *Drug Abuse*: Drug abuse, including use of illegal substances (e.g., cocaine, heroin, and methamphetamines) and prescription substances (e.g., painkillers), takes a tremendous toll on individuals and society as well.

Co-Occurring Behavioral Health Disorders

Individuals said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. The National Survey on Drug Use and Health reports that in 2002, 4 million adults met the criteria for both serious mental illness (SMI) and substance dependence and abuse.³ SMI is highly correlated with

2 For more information about these and other mental disorders, see National Institute of Mental Health, *Mental Health Topics*, at <http://www.nimh.nih.gov/health/topics/index.shtml>. Retrieved 10/21/10.

3 "Substance Abuse Treatment for Persons with Co-Occurring Disorders: Treatment Improvement Protocol (TIP) Series 42. Substance Abuse and Mental Health Service Administration/Center for Substance Abuse. <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A74073> Retrieved 10/26/10.

substance dependence or abuse. Among adults with SMI in 2002, 23.2 percent were dependent on or abused alcohol or illicit drugs, while the rate among adults without SMI was only 8.2 percent. Among adults with substance dependence or abuse, 20.4 percent had SMI; the rate of SMI was 7 percent among adults who were not dependent on or abusing a substance.⁴ Individuals with co-occurring behavioral health disorders can often get caught between mental and substance abuse treatment systems designed to focus on one or the other condition instead of both. However, increasing numbers of treatment settings require that clinicians be cross-trained in mental health and substance use disorders. Organizational changes may also be necessary to integrate behavioral health care services.

How Many People Are Affected?

It is estimated that about one in four American adults experiences a diagnosable mental disorder in a given year. Even though mental disorders are common, a much smaller number of individuals – estimated to be about 6 percent – suffer from a serious mental illness each year.⁵ Major depressive disorders are the leading cause of disability for those aged 15 to 44 in the U.S. and Canada.⁶ In addition, about 17.6 million adults in the U.S. have an addiction to alcohol.⁷

Suicide is a common adjunct to behavioral health disorders. The most common underlying cause of suicide is depression; 30 to 70 percent of suicide victims suffer from major depression or bipolar disorder. Substance use disorders are thought to be involved in half of all suicide situations. Each year, 30,000 Americans commit suicide; an additional 500,000 Americans will attempt suicide in a given year. Suicide is the eighth leading cause of death in the United States, accounting for more than 1 percent of all deaths.⁸

Based on national prevalence data, approximately 1.54 million of Missouri's 5.9 million residents are likely to experience a diagnosable mental disorder in a year. Of these, approximately 354,000 (6% of the total population) will likely have a serious mental illness.⁹ The Missouri Department of Mental Health estimates that 485,000 Missourians have substance use disorders.¹⁰

4 Ibid.

5 National Institute of Mental Health, *The Numbers Count: Mental Disorder in America*. <http://www.nimh.nih.gov/health/publications>. Retrieved 10/21/10.

6 National Council for Community Behavioral Healthcare, *The Uninsured: The Impact of Covering Mental Illness and Addictions Disorders*. At www.nccbh.org. Retrieved 10/21/10.

7 National Institute of Health. <http://www.nlm.nih.gov/medlineplus/alcoholism.html>. Retrieved 10/21/10.

8 Mental Health America, *Factsheet: Suicide*, at <http://www.mentalhealthamerica.net/go/suicide>. Retrieved 10/21/10.

9 Missouri prevalence figures extrapolated from national prevalence data cited in: National Institute of Mental Health, *The Numbers Count: Mental Disorder in America*. <http://www.nimh.nih.gov/health/publications>. Retrieved 10/21/10.

10 Missouri Department of Mental Health <http://dmh.mo.gov/diroffice/mmhf.htm>. Retrieved 10/21/10.

Issues in Access to Behavioral Health Care

Access to Mental Health Care and Substance Use Disorder Treatment

Although effective treatments are available, only two in every five people experiencing a mood, anxiety, or substance use disorder seek assistance in the year of the onset of the disorder.¹¹ This lack of intervention and treatment has clear financial costs for public systems and results in quality of life costs for people with behavioral health disorders. According to the landmark “Global Burden of Disease” study, commissioned by the World Health Organization and the World Bank, four of the ten leading causes of disability for persons age 5 and older are mental disorders.¹²

In recent years, significant attention has been paid to addressing unmet behavioral health needs through increased coordination and integration within primary care. This strategy is logical, given that the majority of people (65%) with behavioral health problems, particularly those with mild to moderate problems, are treated in primary care settings. Furthermore, nearly 70 percent of all primary care visits have a psychosocial basis.¹³ Substance use and mental health disorders, taken together, are by far the most frequently diagnosed encounters at health centers, outnumbering hypertension and diabetes.¹⁴

In addition to clinical services, individuals with serious and persistent mental disorders need access to ongoing services and supports in order to manage their illnesses. These may include supportive housing, supportive employment, peer supports, and care management services. People with serious mental illnesses are likely to try to access such services and supports in the public mental health system. In doing so, they are apt to encounter barriers to access. The Missouri Department of Mental Health (DMH) reports a lack of timely access to mental health services as a “preeminent criticism of the DMH system.”¹⁵

Access to Physical Health Care

Additionally, people with mental disorders often lack access to needed physical health care services. Linkages between the primary care and behavioral health systems, where they exist at all, are often ineffective. Research indicates that people with a serious mental illness (i.e., major depressive disorder, bipolar disorder, or schizophrenia) die an average of 25 years earlier than

11 World Health Organization, “Gender disparities and mental health: The Facts,” Geneva, 2001.

12 U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. <http://www.surgeongeneral.gov/library/mentalhealth/summary.html> Retrieved 10/21/10.

13 Fries, J, Koop C, and Beadle C. “Reducing Health Care Costs by Reducing the Need and Demand for Medical Services.” 1993 *New England Journal of Medicine* 329(5):321-325.

14 Based on 2009 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS. http://www.hrsa.gov/data-statistics/health-center-data/StateData/2009/MO/2009_mo_summary.pdf. Retrieved 10/21/10.

15 Missouri Mental Health Commission, *Mental Health Issues and Priorities*. <http://dmh.mo.gov/admin/budget/2011Budget%20Development%20Letter.pdf> Retrieved 10/21/10.

the general population.¹⁶ Sixty percent of these premature deaths occur not because of the mental illness itself, but because of medical conditions such as those related to diabetes, hypertension, and cardiovascular disease.¹⁷ A large percentage of people with mental illnesses have co-occurring physical ailments that go undetected in their behavioral health treatment.

Lack of access to health care services means individuals are more likely to use hospital emergency departments (EDs) for care. Psychiatric patients remain in hospital EDs more than twice as long as other patients, with 42 percent spending nine or more hours in the emergency room. This is often due to the challenges associated with finding mental health services once a psychiatric crisis is stabilized. In one study, staff reported spending twice as much time to find beds for psychiatric patients as they did to find beds for non-psychiatric patients.¹⁸

Public and Private Health Care Benefits

Among the major barriers to health care, and particularly behavioral health care, is the lack of access to health care benefits, either through private insurance or public programs. Individuals with mental illness are disproportionately represented among the nation's uninsured or underinsured, in many cases because they have difficulty obtaining and retaining employment that includes health care coverage, or because there is no mental health parity in health insurance.

Nationwide, adults with serious mental illnesses and substance use disorder issues have difficulty accessing and retaining Medicaid benefits. For most people with serious mental illnesses, access to Medicaid is tied to eligibility for federal Supplemental Security Income (SSI) benefits. Individuals who receive SSI because of a mental disorder are vulnerable to losing benefits when they obtain employment, which may not come with health insurance coverage, but likely does cause them to be ineligible for Medicaid due to their increased income. They are also subject to loss of benefits if they become incarcerated, since Medicaid is terminated when clients enter criminal justice facilities; when they become homeless, which frequently leads to Medicaid termination when eligibility cannot be re-verified; or when the symptoms of their illnesses interfere with their ability to seek help.

DMH estimates that, despite the fact that its target population includes individuals with the most serious and chronic behavioral health disorders, only about 58 percent of the people it serves receive Medicaid benefits.¹⁹

16 Parks, J., Svendsen, D., et al. "Morbidity and Mortality in People with Serious Mental Illness." National Association of State Mental Health Program Directors Medical Directors Council. www.nassmhp.org. October 2006. Retrieved 10/21/10.

17 Ibid.

18 Salinsky, Eileen and Christopher Loftis, PhD., *Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?* National Health Policy Forum, Issue Brief No. 823, August 1, 2007, p.10.

19 "10 Strategic Initiatives from Substance Abuse and Mental Health Services Administration" Missouri Mental Health Commission meeting July 8, 2010. <http://dmh.mo.gov/diroffice/commission/MeetingHandouts.htm> Retrieved 10/21/10.

Availability of Services/Health Care Professionals Shortages

Throughout the nation, access to health care and behavioral health care in particular is hampered by workforce shortages. These shortages create significant barriers to the availability of services. Public sector providers note the challenges of recruiting and retaining adequate numbers of trained personnel for key positions. DMH reports that vacancy and turnover rates within the Department pose significant challenges to care and safety.²⁰

Throughout the country, initiatives to address workforce issues are taking place. For example, there has been an increased attempt to incorporate psychiatry into primary care training programs as a means of improving access for the large numbers of people who receive behavioral health care services in primary care settings. However, this option alone will not solve the workforce issues related to behavioral health care, and more will need to be done.

Stigma

It is estimated that 40 percent of people with behavioral health disorders never seek help at all.²¹ Clearly, the barriers to access described above are contributing factors. Yet there remains a significant stigma associated with mental disorders. Negative portrayals of people with mental illnesses contribute to fear and mistrust and interfere with individuals' willingness to seek help for themselves or a loved one. Overcoming the stigma associated with behavioral health disorders requires effort to educate people that these are, in fact, illnesses that can be treated. It also requires ensuring that people who need services have access to timely, informed treatment.

Policy Options

There are a variety of strategies to address barriers to behavioral health care and improved access to services for individuals who experience behavioral health disorders. The options include:

- Increasing the integration of behavioral and physical health care;
- Exploring strategies to increase access to health insurance benefits; and
- Focusing on prevention, early intervention, and disease management strategies.

Integration of Physical Health and Behavioral Health Care

The need to develop better linkages and coordination between the behavioral health and physical health systems has become a major theme in recent years. Developing effective models to integrate behavioral and physical health care has received increased attention. Initially, many of these efforts focused on integration at the individual clinic and practitioner level through strategies such as locating mental health professionals in primary care clinics. For example, in

20 Missouri Mental Health Commission, *Mental Health Issues and Priorities*.
<http://dmh.mo.gov/admin/budget/2011Budget%20Development%20Letter.pdf> Retrieved 10/21/10.

21 "Healthy People 2010: Mental Health and Mental Disorders" national Institutes of Health and Substance Abuse and Mental Health Services Administration.
<http://www.healthypeople.gov/document/html/volume2/18mental.htm>. Retrieved 10/21/10.

recent years, funding has been made available to the nation's network of federally qualified health centers (FQHCs) to increase their ability to provide behavioral health services to Medicaid and uninsured populations through their primary care clinics. This development has had a positive impact on access and integration of care. While this and other clinic-level efforts have shown promising results and furthered the dialogue on this issue, they have, by their nature, a limited impact.

An emerging trend in behavioral and physical health integration has been the development of models that insert integration at the system level, either through health plans or state-sponsored initiatives. Achieving broader system level integration often requires state policy support or modifications such as changes in regulatory requirements to enable co-location of services, and changes in financing practices to allow primary care physicians to bill for behavioral health services and psychiatric consultations. These system level integration efforts have the ability not only to reach a broader population, but by their nature, to also address the various financial and structural barriers to integration that many clinic-level models have noted.

Opportunities Available in the Patient Protection and Affordable Care Act

Significant improvement in access to care should occur for people with mental illness and substance use disorders with the expansion of Medicaid to include all non-Medicare individuals under age 65 with income up to 133 percent of the federal poverty level (FPL). Historically, single childless adults would only be covered if they met the SSI Medicaid and disability requirements. Those requirements are difficult for many to meet, especially those with substance abuse disorders. Many people who experience those disorders are often unemployed or under-employed and would likely qualify under the new eligibility level.

Integration of payers and community-based delivery models can provide the system-level coordination that is required to facilitate and manage services for individuals with behavioral and physical health needs. The ACA contains provisions for Medicaid and Medicare coordination, Medicaid community-based care coordination, and integration of behavioral and physical health services. Specific provisions include:

- *Medicaid Integrated Care Hospitalization Demonstration Program:* Up to eight states will be selected to use bundled payments to promote integration of care regarding hospitalization.
- *Medicaid emergency psychiatric demonstration projects:* The projects will provide Medicaid payments to psychiatric institutions for adult enrollees who require stabilization of an emergency condition. \$75 million is available for 2011.
- *The Prevention and Public Health Fund:* The Fund is designated to expand and sustain public health and prevention infrastructure.²² Recently, the Obama administration designated \$20 million to assist communities with the coordination and integration of primary care services

22 Section 4002, Affordable Care Act (ACA).

into publicly-funded community mental health and other community-based behavioral health settings.²³

- *Grants to co-locate primary care and behavioral health care:* The grants will be made available for community mental health programs to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.²⁴
- *Community-based care approaches:* The Medicaid Community First Choice Option provides enhanced federal match for states to offer Medicaid home- and community-based services (HCBS) to disabled individuals rather than institutional care, with maintenance of effort requirements for state support of programs for people with disabilities. States that take up the option will receive a 6 percentage point increase in the federal medical assistance percentage (FMAP) for providing HCBS for people with disabilities who require an institutional level of care (as amended by Section 1205 of the Reconciliation Act).²⁵ Additionally, the ACA allows the Medicaid programs to implement HCBS through their state plans instead of requiring waiver approval.²⁶ The Home-Based Primary Care Team demonstration programs²⁷ and Community-Based Care Transitions Programs²⁸ will further facilitate the community-based care models focusing on primary care, and have the potential to facilitate integration with behavioral health care services.
- *Medicaid health home for chronic conditions:* This is a new Medicaid state plan option to provide health homes for enrollees with chronic conditions at a 90 percent federal match rate during the first eight fiscal year quarters the state plan amendment is in effect. Up to \$25 million in planning grants will be awarded per state.²⁹ Community Health Team provisions in the ACA complement these initiatives by providing grants for the establishment of the medical home model.³⁰

Access to Behavioral Health Care Benefits

Millions of Americans with behavioral health disorders lack access to health insurance, or have health insurance with limited or no behavioral health benefits. Initiatives to address access to insurance coverage for mental disorders have occurred at the federal and state levels.

23 HealthCareReform.Gov newsroom press release: <http://www.healthreform.gov/newsroom/acaprevention.html>. Retrieved October 18, 2010.

24 Section 5604, ACA.

25 Section 2401, ACA.

26 Section 2402, ACA.

27 Section 3024, ACA.

28 Section 3026.

29 Section 2703, ACA.

30 Section 3502, and 10321, ACA.

While opponents of insurance parity fear a rise in insurance premiums, parity advocates believe that insurance parity is affordable and that premium cost increases are ultimately more than offset by increased productivity of workers, the overall reduction in medical costs, and a lessened burden on other sectors of the economy.

Parity legislation was enacted by Congress in 2008. The legislation closes major loopholes that existed in previous federal parity initiatives. For instance, if insurance plans cover behavioral services, the number of visits can no longer be limited, and co-pays must be the same as those for medical conditions.

The State of Missouri has taken some steps toward parity with requirements for plans to offer the option of mental health coverage that is equal to coverage for other medical conditions (although buyers are not required to take it), and limited substance use disorder coverage; but allowances for different co-pays, deductibles, and co-insurance are permitted.³¹

Opportunities Available in the Patient Protection and Affordable Care Act

- *The Essential Health Benefit Package*: Newly defined in ACA, this requires that all qualified health plans include behavioral health services that meet standards established by the Secretary of HHS.³²
- *Non-excludable drugs in Medicaid*: This is a provision in ACA that prohibits state Medicaid programs from excluding coverage for barbiturates, benzodiazepines, and tobacco cessation products.³³
- *The primary care extension program*: Run through the Agency for Health Care Research and Quality (AHRQ), this program will provide support and assistance to primary care providers to educate them about preventive medicine, health promotion, chronic disease management, mental and behavioral health services including substance use disorder prevention and treatment services, and evidence-based and evidence-informed therapies and techniques. This will enable providers to incorporate such matters into their practices and improve community health by working with community-based health connectors (Health Extension Agents). Grants will be provided to states to establish state or multi-state Primary Care Extension Program State Hubs.³⁴
- *Pediatric specialty loan repayment programs*: Loan repayment programs will be available under ACA for child and adolescent mental and behavioral health professionals.³⁵

31 Insure.com, *Mental Health Parity Laws by State*. At <http://www.insure.com/articles/healthinsurance/mental-laws-by-state.html>. Retrieved 10/20/10.

32 Section 1302, ACA.

33 Section 2502, ACA.

34 Section 5405, ACA.

35 Section 5203, ACA.

- *Mental and behavioral health education and training grants:* Grants will be made available for learning institutions, defined in ACA, to fund training and recruitment of mental and behavioral health professionals.³⁶

Focus On Prevention, Early Intervention, and Disease Management Strategies

Currently, behavioral health services are too often crisis-driven and focus on traditional clinical interventions. Yet, like other chronic diseases, behavioral health disorders can benefit from a public health approach that emphasizes wellness, prevention, early intervention, and disease management. Examples of approaches include:

Suicide Prevention

Suicide is a serious but preventable public health problem. Addressing the problem involves a multi-pronged strategy that includes:

- Increasing awareness about suicide as a serious and preventable public health problem;
- Strengthening collaboration among public health, mental health, and other leaders with a focus on the issue;
- Making information available to health care providers, educators, and others about suicide, its risks and prevention strategies; and
- Ensuring access to crisis prevention and intervention services for those most at risk.

Early Intervention

There is growing evidence that stressful early childhood experiences increase the risks faced by adults for high-risk behaviors and diseases, such as alcoholism, drug abuse, depression, suicide attempts, and others. The Adverse Childhood Experiences (ACE) study found a relationship between stressful childhood experiences such as abuse or violence and a variety of measures of adult risk behaviors and disease. The ACE study resulted in recommendations for:

- Primary prevention of adverse childhood experiences;
- Secondary prevention to ameliorate or heal the impairments associated with adverse childhood experiences; and
- Tertiary intervention to address these problems in children and adults.³⁷

Disease Management

Disease management (DM) is defined as a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are

³⁶ Section 5306, ACA.

³⁷ Vincent Felitti, et al, "The relationship of adult health status to childhood abuse and household dysfunction," *American Journal of Preventive Medicine* Volume 14, (May 1998) pages 245-258. <http://www.ajpm-online.net/article/PIIS0749379798000178/abstract>. Retrieved 10/20/10.

significant.³⁸ Despite the prevalence of DM programs, few have focused specifically on behavioral health. However, the same forces that prompted the growth of DM programs for physical health also exist in the behavioral health arena, specifically:

- The gap between research and practice;
- The high cost of care for clients with chronic disorders; and
- The need to better manage how care is delivered to high need and high cost clients.

Behavioral health disease management practices focus on:

- Using evidence-based and promising practices that have a track record for improving consumer outcomes;
- Incorporating assessments that ensure the matching of individual need with services;
- Focusing on individual and system outcomes; and
- Ensuring that individuals have the support they need – through peer support and care coordination strategies – to self-manage their illnesses.

Opportunities Available in the Patient Protection and Affordable Care Act

- *Grants for medication management services:* These will be provided to support programs that improve health system efficiency, including grants that will implement medication management services in the treatment of chronic disease.³⁹
- *Incentives for behavior modification programs:* These are included in ACA by providing funds for Medicaid programs to cover evidence-based preventive services⁴⁰ and providing incentives to Medicaid beneficiaries who complete behavior modification programs.⁴¹
- *Community health center wellness plan demonstrations:* These will be used to test the impact of providing individualized wellness plans for at-risk populations who use community health centers. Risk factors include alcohol and tobacco use. Ten community health centers will participate.⁴²
- *Support for innovation in prevention and treatment:* This is another way ACA plays a significant role in improving the future of mental and behavioral health care. For instance, Community Transformation Grants will be available on a competitive basis to states and local governmental agencies for the implementation, evaluation, and dissemination of evidence-based community

38 Rosenbaum, S., et al. "Negotiating the New Health System at Ten: Medicaid Managed Care and the Use of Disease Management Purchasing." Center for Health Care Strategies. May 2008. At http://www.chcs.org/usr_doc/Negotiating_the_New_Health_System_at_Ten.pdf. Retrieved 10/20/10.

39 Section 3503, ACA.

40 Section 4106, ACA.

41 Section 4108, ACA.

42 Section 4206, ACA.

preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base of effective prevention programming.⁴³ Other provisions such as the Centers for Excellence for Depressive Disorders⁴⁴ and the Qualifying Therapeutic Discovery Project Credit⁴⁵ promote research and the development of new treatments for mental and behavioral health care.

Implications

Mental illness and substance use disorders affect a quarter of all Americans. Improving access to and coverage of behavioral health services can improve the lives of millions of Americans and reduce the number of suicide attempts each year. Expanded coverage and health benefits, the integration of mental health and physical health services, and targeted programs and grants will present Missouri with many new opportunities to improve care and outcomes for those impacted by mental health and substance use disorders.

43 Section 4201, ACA.

44 Section 10410, ACA.

45 Section 9023, ACA.