GOVERNMENT, MORE OR LESS

OVERCOMING LEGACY BARRIERS TO BEHAVIORAL HEALTH INTEGRATION

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Overview of presentation

I. Behavioral Integration Project
II. Why/What integrated care
III. Barriers to integrated care
IV. Legal remedies
V. Structural remedies

I. Seton Hall Behavioral Health Integration Project

Seton Hall project: Integration

- Phase I: examination of legal barriers – licensing, finance, privacy
- Phase II: implementation assistance on licensure
- Phase III: structural/theoretical analysis and recommendations
  - *Funding from The Nicholson Foundation, US DHHS, RWJF*

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Why integration of behavioral health care? -- *two distinct problems*

- People with severe mental illness die 25 years younger than general population
  - Most early death due to physical conditions treatable in primary care
- people with mild/moderate behavioral health conditions go undiagnosed
  - Patients do not recognize BH symptoms
  - Seek treatment from PCPs not trained in BH care, practicing in unintegrated setting

II. Why/What of Integrated Care

What is integrated care?

Service provided:

- Person-focused, not disease oriented
- Capable of identifying, treating, referring for physical, MH, and SUD
- Prevent patient drop-off, lost to follow-up, confused/contradictory treatments

Settings

- *Integrated*
  - Single legal entity licensed to provide range of services
- *Co-located*
  - Distinct legal entities share space to facilitate coordination/warm handoffs

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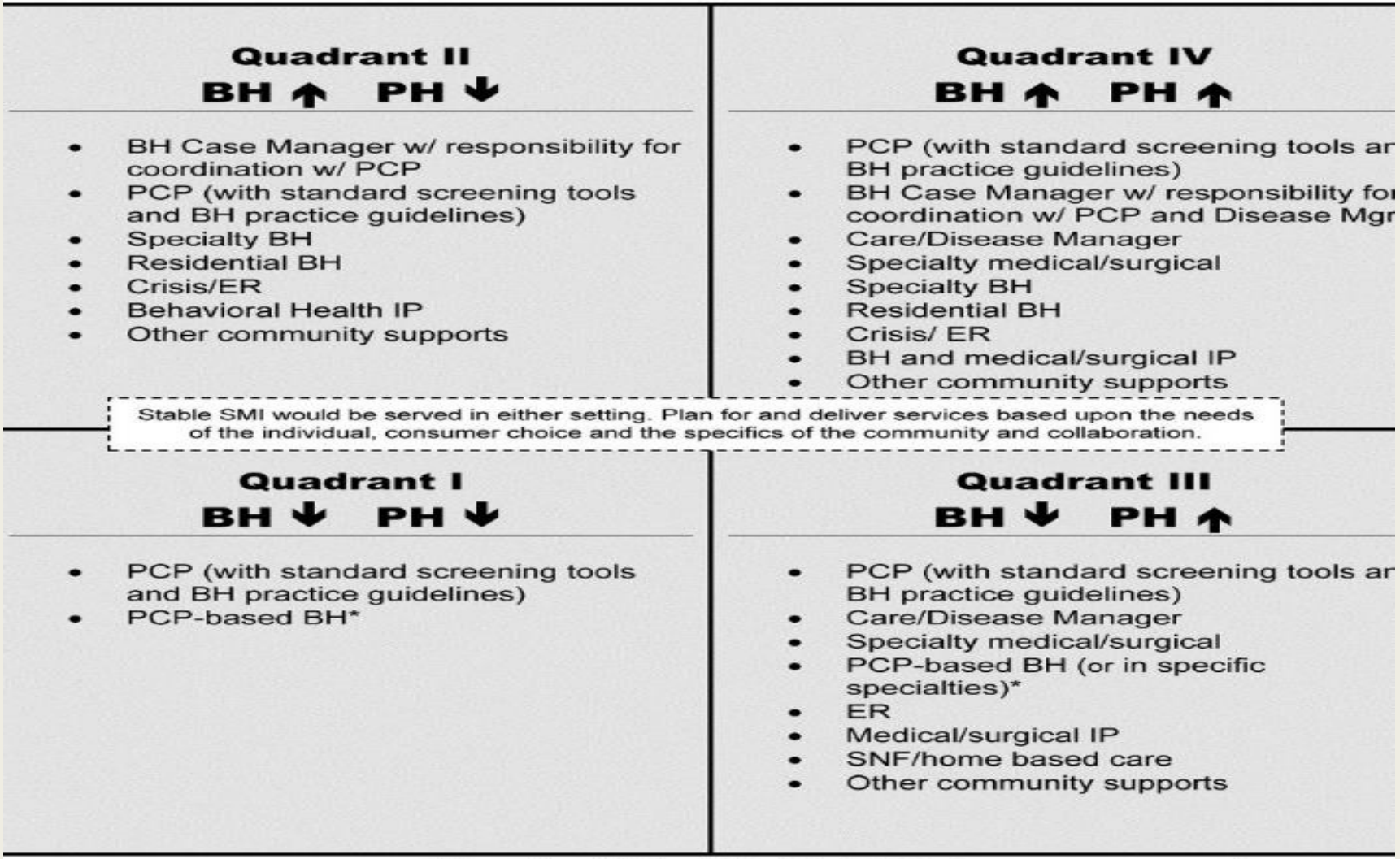
The Four Quadrant Clinical Integration Model



ased BH provider might work for the PCP organization, a specialty BH provider, or as an individual
ner, is competent in both MH and SA assessment and treatment

III. Barriers to Integrated Care

Barriers to integration

- Clinical failure to recognize value
  - *Advances in past 15 years resolves*
- Payment/sustainability
  - *Need for payment for care coordination, case management, Medicaid rate reform*
  - *Progress being made – slowly…*
- **State licensure laws**
  - ***In many states prohibit integration of needed services and co-location***

Licensing issues

- General concerns
  - *Rules read as requiring only one modality of care*
  - *Co-location: agencies need clear "person to blame"*
- Specific, problematic requirements
  - *Separate ingress/egress*
  - *Separate waiting rooms*
  - *Separate restrooms*
  - *Separate lunch/break rooms for staff*
  - *Separate staff*

Why do state licensing laws prohibit clearly beneficial clinical configurations?

- History: structure rooted in protective/paternalistic past
- Regulatory lag: administrative structures fail to keep pace with clinical developments
- Hollowing out of state governments: staffing levels in many states have dropped

IV. Approaches to Address Regulatory Lag

Approaches to address lag

1. Collaborative efforts: advocates, caregivers, agency personnel
2. Petition for rulemaking
3. Litigation: ADA violation
    A. Title II integration mandate
    B. “Reverse *Olmstead*” claim

1. Collaborative efforts

- Advocates and regulated parties can reach out to agencies to engage in collaborative efforts for change
- Con
  - *Elective – agency must initiate/respond*
  - *Control remains with agency*
  - *One-shot*
- Pro
  - *Benefits of deliberation*
  - *Informality permits free(er) exchange*
  - *[but see "new governance" discussion, below]*

2. Petition for rulemaking

- Most states permit interested party to petition agency for rulemaking; might this serve to advance policies?
- State rules permit agencies to review petitions under generous/deferential timelines
- Court review of denials employs deferential standard
- Process seen as largely symbolic, absent clear legal infirmity in agencies' current rules/practices
- May, however, open dialogue – but clumsily?

3A. Litigation: Integration mandate

- ADA requires public entities to provide services “"in the most integrated setting appropriate to the needs of qualified individuals with disabilities."
  - *Olmstead v. LC by Zimring;* 42 CFR 35.130(d)
- To comply, public entity must make “reasonable modifications in policies, practices, or procedures”
  - 42 CFR 35.130(b)(7)
- State licensure requirements for separate facilities, without clinical justification, are not “most integrated,” but who is doing the discriminating?\
  - *Agency not providing health services*
  - *Care provider following state law*

3A, con't – who is responsible?

- Public entity – here, licensing agency – may not regulate in a manner that requires inappropriate segregation:
  - "[A] public entity may not establish requirements for the programs or activities of licensees that would result in discrimination against qualified individuals with disabilities. For example, a public entity's safety standards may not require the licensee to discriminate against qualified individuals with disabilities in its employment practices."
    - U.S. Dep't of Justice Title II Technical Assistance Manual, §II-3.7200

3B. Litigation: "reverse *Olmstead*"

- Argument: licensure regulations that restrict access to care for people with mental disabilities creates risk of institutionalization, violating "least restrictive setting" mandate of *Olmstead.* Three-step argument

  1. *Olmstead*: maintaining clinically inappropriate institutionalization violates ADA, where Medicaid-supported community settings available

  2. Reverse *Olmstead:* restriction of Medicaid funding for community services *may* violate ADA, as it could lead to inappropriate institutionalization

     - *See M.R. v. Dreyfus*, 663 F.3d 1100 (9th Cir. 2011), opinion amended, 697 F.3d 706 (9th Cir. 2012) ("Olmstead does not imply that disabled persons who, by reason of a change in state policy, stand imperiled with segregation, may not bring a challenge to that state policy under the ADA's integration regulation without first submitting to institutionalization.") (internal quotes omitted)

3B, con't

3. Application in non-Medicaid setting: *Olmstead* and "reverse *Olmstead*" cases arise in settings in which Medicaid funding supports services at issue.

- Challenges to licensure rules would not occur in that setting
- But, licensure restrictions inhibit access to services for which Medicaid funding applies (*e.g.*, FQHCs, outpatient mental health clinics)
- So, purposes of Olmstead integration mandate are present: state has funding for services (or may interpose defense), and state's failure creates risk of inappropriate institutionalization

V. Strucural Issues in Administrative Law

Three approaches to administrative law/agency rulemaking

1) Centralized, command and control regulation, identified with New Deal
   a) Expert-driven, technocratic
   b) Governed largely by APA-style notice and comment rules
   c) Criticized for rigidity, complexity, lack of nimbleness

Three approaches, con't

2) Devolution/deregulation, identified with market-oriented, small government

a) Decentralized, relies on competition for consumer protection

b) Goals include fostering efficient methods; fostering growth

C) Criticized for weakness in consumer protection

Three approaches, con't

3) "New Governance"/Experimentalism

a) Centralized but diffused power
b) Methods include recognition of fallibility, need for responsiveness, collaboration, openness to citizen participation

C) Criticized for indeterminacy, loss of government control, complexity of process

Some observations about “new governance”

- Pro
  - Responds to endemic regulatory lag
  - Allows for outside expertise to be employed at the outset
  - Enhances community engagement
- Con
  - Depends on good faith…
  - Risk of cooption
  - Worst of both worlds?
- But: worth a try?