Accomplishments and Challenges in Medicaid Mental Health Services

Innovation, Financing and Change

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DMA Health Strategies
Accomplishments

- There has been significant reductions in state hospital utilization since its peak in 1955 and dramatic growth in community systems.
- There is increasing recognition of the economic impact of substance abuse and mental disorders:
  - Depression is the 4th leading contributor to the global burden of disease (WHO); Substance abuse has indirect costs of more than $260B in the US (NIH 2000).
- Significant advances in research and increased treatment efficacy.
- The results of the CATIE study have reshaped thinking about prescribing practice and the Schizophrenia PORT study documented the wide gap between guidelines and practice.
- Growth of recovery and of the consumer movement.
- Growth in the role of family run organizations and communities.
- Increasing focus on interagency collaboration – Between Mental Health and Medicaid, Criminal Justice, Schools, Courts, employment, housing and other agencies.
Innovations

► Enhancing consumer centered care:
  ➔ Georgia Peer specialists
  ➔ Florida Self-Directed Care
  ➔ Magellan – Iowa and others

► Systems Integration efforts: New Jersey (kids), New Mexico, Washington State

► Effective use of disease management strategies in Wyoming for depression and schizophrenia

► Medication Algorithm projects – TMAP, CalMAP and increasing numbers of others. Reducing multiple prescribers, poly-pharmacy etc.

► Process and Quality Improvement initiatives – IA, NIATx

► Performance incentives and financing of evidence based practices – KY and Delaware


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Positive Movement

- Increasing recognition of the need to integrate mental health with physical health care services
- Beginning to address the physical health needs of people with serious mental illness – diabetes, heart disease and the impact of smoking
- There is an increasing effort at the federal level for collaboration between CMS and SAMHSA – A long road is ahead
- Increased recognition of the value of and need for wrap-around services as alternatives to residential and psychiatric placements for children
- Expanded use of and recognition of the need for and value of family to family and adult peer services: Home based services, respite, peer support, bridgers, and other strategies
- Increasing though still limited use of performance contracting
- Increasing focus on evidence and IT to drive practice – most notably on prescribing practices, expanded use of EMRs, and adoption of evidence based practices
Challenges

► There is a need for radical change – Transformation - and yet resistance throughout the system
► Most states have very limited competition among providers either through licensing rules, deficit funding strategies or county operated services
► There are often archaic models of case management
► In the public sector there are wide gaps between change agents and those resistant to change
► There is a workforce crisis of educating, training, recruiting and retaining qualified and skilled people
► There is an extraordinary level of variation in state mental health programs resulting from
  ➔ Agency structure for MHA and Medicaid
  ➔ Child and Adult system structure
  ➔ County role and funding levels
  ➔ Medicaid financing and delivery system
  ➔ Provider Financing methods – grants, FFS, Cost reimbursement, etc.
  ➔ Other state Agency Spending – Child residential; housing; etc.
Financing Challenges

► State budget limitations have limited funding growth to zero or well below the cost of living in most states
► Public systems are increasingly reliant on Medicaid funding which is now a majority of public mental health funding
► New CMS regulations
  ➔ Rehabilitation Option
    • Requires very specific rehab plans
    • Documentation required of progress to goals or changes in plans
    • Billing practices may be significantly changed
  ➔ Targeted Case Management (TCM)
    • Case management limited to treatment planning and referral
    • Other activities – life skills, assistance with housing, etc. would need to be billable as another code.
    • Billing in 15 minute increments
  ➔ Blended Rates
    • Most states use some form of blended rate strategy for their Rehab and TCM related claiming
    • Questions linger about residential rate setting for children and adults – where per diem rehab (active treatment) rate percentages are developed to exclude the room and board
Variations on Organization and Financing of Mental Health
Medicaid Managed Behavioral Health Models

- **Carve-Out - Risk**
  - MBHO
  - State/County
  - Provider
  - Provider
  - Provider

- **Carve-Out – with ASO**
  - BH ASO
  - State/County/Provider
  - Provider
  - Provider
  - Provider

- **Integrated MCO**
  - Medicaid
    - Provider
    - Provider
    - Provider
  - Managed Care Organization (HMO)
    - Providers
    - Providers
    - Providers

- **Regional/County BHO**
  - Regional/County BHO
    - Regional/County BHO
    - Regional/County BHO
    - Regional/County BHO
  - Providers

- **State SMI Carve-Out**
  - Medicaid Agency
    - MCO
    - Provider
    - Provider
  - SMHA - SMI Only
    - MCO
    - Provider
    - Provider

**No BH benefit**

DMA Health Strategies
Michigan Public Mental Health System

CMS
Federal Match

General Funds
State Match
$\$ $\$

SAMHSA

MI Department of Community Health
MH/SA Administration

Health Plans
MH Benefit
20 Outpt. visits; No Inpt.

Psych Pharmacy
Carve-Out (reconciled to
Health Plans

County MH
Program

State Hospital

$\$$ $\$

State Match
10%
County Match –
GF and POS

-$\$$-$\$$-$\$$-$\$$

- Capitation
Payments for
Medicaid
- GR
- Block Grant

Many are Prepaid
Inpatient Health Plans;
Many Counties are
Consolidating

DSH
and GF
California

CA Dept. of Health Services

Health Plans

Psych Pharmacy
Carve-Out (FFS) for Anti-Psychotics

County Funds

CMS
Federal Match

General Funds

SAMHSA

State Match

CMS
Federal Match

Global
Budgets for Medi-Cal

- Short
Doyle Medi-Cal

Global
Budgets for Medi-Cal

- Short
Doyle Medi-Cal

County MH
Program

State
Hospital

$\$\$\$

MHSA
funding

* Medi-Cal Billing by Counties is for 50% Federal Share only. Counties have the match. County EPSDT spending is 90% matched by state and federal
Pennsylvania

State Office of Mental Health

- County Allocation
  - Grants – Adult/Child - GF; PATH; Other
- Health Choices:
  - County Right of First Opportunity: Capitation

County MH Programs

- Provider Grants
- Provider FFS (MA)

CMS Federal Match

State Funds

SAMHSA

General Funds

Physical Health $

MH Funds

State Match

Medical Assistance

Health Plans

Psych Pharmacy

Health Choices
- County Capitation Rates
  - Experience-based
  - Surplus rolls over with reinvestment plan;
  - Reserve requirements

State Hospitals

Closure Funds

State Match

County Funds?
New Mexico

Before

Interdepartmental Behavioral Health Purchasing Collaborative (IBHPC)

State Agencies Currently Purchasing Behavioral Health Services

After

New Mexico Human Services Department
Children’s Mental Health Overlapping Populations

- Mental Health Authority
  - Children with Disabilities
  - Children with SED
  - Foster Children
  - Incarcerated Children

- Juvenile Justice Agency
  - Medicaid and SCHIP Expansion

- Child Welfare Agency
  - Separate SCHIP Programs

- Income Eligible Children

- Schools

- DMA Health Strategies
Mental illnesses, like substance use disorders, have an extraordinary impact across all sectors of government.

While state Mental Health Authority and Medicaid spending have been a focus for much research, the growing use of prisons for people with mental illness and disruption in schools and communities have focused attention on spending and utilization in other agencies.

NASMHPD Research Institute: Other State Agency Study” began in 2004 and expanded with a second round of states in 2006.

This focus on Other State Agencies is in fact a major focus for SAMHSA Transformation Grants.

### Fiscal Year 2002: Total Mental Health Spending Estimates

**Rhode Island**

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<tr>
<th>Agency</th>
<th>Estimate</th>
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<tbody>
<tr>
<td>DMHRH (Includes DMHRH Medicaid)</td>
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<td>DCYF (Includes DCYF Medicaid)</td>
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<tr>
<td>Rite Care Medicaid</td>
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<td>School Based Health Centers N/A</td>
<td>N/A</td>
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<tr>
<td>DOC $1,000,000</td>
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<tr>
<td>OTHER $252,474,659</td>
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Conclusion

- In 1972 Medicaid covered about 24% of people with SPMI; by 1998 that population was 60%. 20% are uninsured.*
- Treatment is but one of the major challenges faced by people with serious mental illnesses. Poverty and unemployment are huge issues.
- SSI and SSDI are mainstays of life for people with severe mental illness but they are insufficient to pay the cost of housing.*
- Vocational training and employment support and accommodations are needed.
- Rehabilitation and support services, however they are financed, are essential to the recovery of people with serious mental illness.
- Community prevention and early intervention with trauma informed treatment hold promise for reducing incidence of some conditions.
- Perhaps the largest challenge is the ongoing stigma faced by people with mental illness in their communities and in society.

* Frank and Glied “Better but not Well” (2007)
Thank you.

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