



NACBHD
National Association of County
Behavioral health and
Developmental Disability
Directors

NACBHD

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Although Congress was in recess during the week of the 20th, NACBHD staff was busy keeping pace with the interpretations and expectations related to the 2007 Budget season and implementation of the recently passed 2005 Deficit Reduction Act (passed in 2006). In addition, NACBHD held its 11th annual Legislative and Policy Conference. Each of these and more are discussed below.

Budget Process—Moving from the Presidential Proposal to Congress

President's Proposal

In February 2006, NACBHD reported on the President's 2006 Budget Proposal—specifically on those areas of most interest to the NACBHD membership. Briefly, the proposal includes:

Center for Substance Abuse Treatment (CSAT) - \$ 375.3 million¹

This compares to \$398.9 million for FY 2006, representing an overall decrease of approximately \$23.5 million. Within CSAT, proposals include:

¹ SAPT details provided by NACBHD by Robert Morrison, NASADAD

Access to Recovery/Voucher Initiative Program: \$98 million

TCE Program: \$21 million for the Targeted Capacity Expansion (TCE) program – representing a cut of \$10.1 million compared to FY 2006.

PPW Program: \$3.9 million for the Pregnant and Postpartum Women treatment program – representing a cut of approximately \$7 million compared to FY 2006's budget of \$10,890,000.

ATTC Program: \$8,060,000 for the Addiction Technology Transfer Centers (ATTCs) representing close to level funding compared to \$8,142,000 in FY 2006.

Elimination of Safe and Drug Free Schools

Center for Substance Abuse Prevention (CSAP) - \$180.6 million²

This compares to \$192.9 million for FY 2006, representing a decrease of approximately \$12.3 million. Within CSAP, proposals include:

SPF SIG Program: \$95.3 million for Strategic Framework State Incentive Grants (SPFSIGs) – representing a decrease of \$11.2 million over FY 2006.

Methamphetamine Prevention: \$4 million for methamphetamine prevention – representing level funding compared to FY 2006.

CAPT's Program: \$9.4 million or level funding compared to FY 2006 for the Centers for the Application of Prevention Technologies (CAPTs) program.

Mental Health Grants and Programs³

Overall, the President is proposing a \$72 million cut for the Substance Abuse and Mental Health Services Administration (SAMHSA) – dropping funding down to \$3.134 billion in FY 2007. Within the Center for Mental Health Services (CMHS), funding would be reduced by 3.8% or \$25 million, largely through termination of demonstration and technical assistance programs.

Most major activities at CMHS are proposed to be frozen at their current FY 2006 level, including:

- *The Mental Health Block Grant - \$428 million,*
- *The PATH Homeless Formula Grant - \$54 million,*
- *Childrens Mental Health - \$104 million,*
- *PAIMI Protection & Advocacy - \$34 million, and*

² Ibid

³ Details provided to NACBHD by Andrew Sperling, NAMI.

- *Mental Health Transformation State Planning Grants - \$20 million.*

The President's budget does call for a \$6 million increase in youth suicide prevention activities. This includes a \$3 million increase for grants authorized under the Garrett Lee Smith Memorial Act, boosting funding to \$35 million. Programs under the Garrett Lee Smith Act include state-wide youth suicide prevention and intervention in schools and juvenile justice systems and grants for initiatives on college campuses. In addition, \$3 million is proposed for a new cooperative program between SAMHSA and the Indian Health Service for suicide prevention activities targeted Native American and Alaska Native adolescents.

Concurrent Budget Resolution

After receiving the President's budget request, Congress generally holds hearings to question Administration officials about their requests and then develops its own budget resolution. This work is done by the House and Senate Budget Committees, whose sole function is to draft the budget resolution. Once the committees are done, the budget resolution goes to the House and Senate floor, where it can be amended (by a majority vote). It then goes to a House-Senate conference to resolve any differences, and a conference report is passed by both houses.

The budget resolution is a "concurrent" congressional resolution, not an ordinary bill, and therefore does not go to the President for his signature or veto. It also requires only a majority vote to pass, and is one of the few pieces of legislation that cannot be filibustered in the Senate.

The budget resolution is supposed to be passed by April 15, but it often takes longer. Occasionally, Congress does not pass a budget resolution. If that happens, the previous year's resolution, which is a multi-year plan, stays in effect.⁴

On March 16, 2006 the Senate passed by a vote of 51-49, "a \$2.8 trillion dollar budget resolution (S. Res. 83), after approving several amendments to add roughly \$16 billion to the budget's proposed \$873 billion discretionary spending cap" (NACo Legislative Bulletin, March 17, 2006).⁵

Prior to passage, several important amendments were proposed. The success of one and failure of another are welcome news to the disability community. NAMI writes, "By a 73-27 vote, the Senate added \$7 billion (known as the Specter-Harkin Amendment) in spending authority to a broad range of health and human service programs as part of the FY 2007 budget resolution. It will allow for the FY 2007 appropriations bills that fund the National Institute of Mental Health (NIMH, NIDA, and NIAAA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to reject cuts proposed in the President's budget and restore funding to FY 2005 levels. The additional resources

⁴ Center for Budget and Policy Priorities, January 2006.

⁵ S. Res. 83 is designated "S" as the Senate took first action on the resolution from the Committees.

could also be used to support other social service programs of interest to NACBHD members (e.g. foster care, CSBG).

NAMI goes on to explain that, “In addition, the Senate voted 43-57 to reject an effort to require an additional \$10 billion in cuts to the Medicare and Medicaid programs for FY 2007. This amendment was offered by Senator John Cornyn (R-TX). The underlying budget resolution also rejected proposals in the President's budget for future reductions to Medicare and Medicaid through cuts in payments to hospitals and further reductions to targeted case management services under Medicaid.

The House has yet to take action on the resolution. However, Majority Leader John Boehner (R-Ohio) has indicated that the House will “tackle” the budget resolution during the week of April 3.

NACBHD will report House action in its April DC Update. NACBHD may also update members on House activity via its list serve capability.

Presidents 2007 Proposals

Although the DC advocacy community and others are hopeful that Congress can increase discretionary programs and mitigate any further damage to the public safety net, some of the President's 2007 budget proposals are aimed directly at the safety net and do not require legislative authority for enactment.

The Medicaid Coalition (of which NACBHD is a member) reports on the Families USA website that:

The President's budget includes several provisions that would reduce federal funding for Medicaid without reducing state or local liability for such health care costs, as follows:

- **Reduce provider taxes:** This proposal would reduce the maximum amount states can tax providers from 6 percent to 3 percent [administrative change].

Budget Impact: This proposal would save \$0 in the first year, \$2.1 billion over five years, and \$5.5 billion over 10 years.

- **Cut services for children with disabilities:** The budget proposal would eliminate federal funding for certain rehabilitation services for which states are now receiving a federal match through Medicaid. It would also prohibit federal reimbursement for certain administrative and transportation costs related to Medicaid services that some children receive in school [administrative change].

Budget Impact: This proposal would save \$840 million in the first year, \$5.9 billion over five years, and \$15.2 billion over 10 years.

- **Cap Medicaid payments to government providers and cap DSH funding:** This proposal would limit the amount of money that hospitals and certain other providers can get for providing services to people with Medicaid and the uninsured by limiting payments for the cost of furnishing services to people enrolled in Medicaid. It would also build on existing CMS efforts to detect and recover overpayments to government providers that are sometimes returned to the state and used to draw down additional federal dollars. CMS is also proposing to create new regulations to clarify how states can use funds designated as Disproportionate Share Hospital (DSH) funding [administrative change].

Budget Impact: This proposal would save \$384 million in the first year, \$3.8 billion over five years, and \$9 billion over 10 years.

- **Recovery of duplicated administrative costs:** The budget proposes to prohibit states from billing Medicaid for the cost of eligibility determinations for people who are applying for or who have Medicaid, TANF, and food stamps. It also allows the federal government to recoup funds that have been paid for these determinations in the past. The Administration believes these costs were included in the TANF block grant [legislative change].

Budget Impact: This proposal would save \$280 million in the first year, \$1.8 billion over five years, and \$3.7 billion over 10 years.

- **Targeted case management:** The budget proposal would lower the reimbursement rate for targeted case management services from the full Medicaid matching rate to the 50 percent administrative rate [legislative change].

Budget Impact: This proposal would save \$208 million the first year, \$1.2 billion over five years, and \$3.1 billion over 10 years.

Increasing third party payment: Some people have both Medicaid and private insurance coverage. For these individuals, Medicaid provides coverage for services that are not covered by their private insurance company and is considered the "payer of last resort." Current Medicaid law allows states to pay these claims through Medicaid and then pursue payment from the private insurance company. The President's budget proposal would make the following changes to current policy:

- **Stop "pay and chase":** The budget proposal would require states to seek reimbursement from any applicable third party payers for all pharmacy claims before allowing Medicaid to pay the claim [administrative change].

Budget Impact: This proposal would save \$105 million in the first year, \$430 million over five years, and \$685 million over 10 years.

- **Third party liability:** The budget proposal would require states to collect payments for prenatal or pediatric services owed by third party payers (such as

non-custodial parents) before allowing Medicaid to pay the claim [legislative change].

Budget Impact: This proposal would save \$90 million in the first year, \$525 million over five years, and \$1.2 billion over 10 years.

Impacts of 2006 Activities Still Being Sorted Out—Deficit Reduction Act of 2005

As NACBHD has reported, on February 1, 2006 Congress passed what is now called the Deficit Reduction Act of 2005 (DRA). NACBHD reported to the members those provisions of the DRA of most concern. These include: (1) redefinition of Targeted Case Management, (2) Third Party Liability, (3) cost sharing, (4) benefit package flexibility and (5) citizenship verification.⁶ In addition to these potential threats, the DRA also included some new flexibilities associated with Home and Community Based Waivers (HCBW) and Medicaid coverage options—Money Follows the Person and Keeping Families Together.

Targeted Case Management/Third Party Liability

Provisions that impact targeted case management services in communities are of particular interest of our members. One expert provided NACBHD with the following insights on TCM changes that are part of the DRA. This expert writes that, “Changes: (1) clarify that Medicaid is not available for the non-Medicaid eligible or non-targeted individual or when other Third Parties are liable for payment, (2) codify existing cost allocation process (OMB A-87) and (3) define third party liability as including other medical, social, educational, or other programs...” The DRA goes on to “expand the list of entities considered third parties under Medicaid statute:“*...a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.*” The NACBHD expert speculates that this will impact a large number of states and communities.

Home and Community Based Waivers

NACBHD’s DRA expert also explained changes to Home and Community Based Waiver authority. These include “three new provisions for State flexibility using State Plan Amendments rather than waiver authority: (1) Self-directed personal assistance, (2) Expanded access to HCBS and (3) Medicaid buy-in for the disabled.⁷ With each of these new provisions (and several others not described here), CMS has a wide range of polices and guidance yet to enact. There are many unanswered questions related to implementation and the future of HCBW.

⁶ This provision was added late in the process and learned about after passage. It requires states to verify citizenship (via birth certificate or immigration status) prior to establishing Medicaid Eligibility).

⁷ NACBHD has the details associated with these three proposals. Please contact staff for information.

NACBHD asks the Centers for Medicare and Medicaid (CMS) and SAMHSA to Clarify—NACBHD’s Legislative Conference

Federal Representatives from CMS and SAMHSA agreed to participate in a dialogue with NACBHD members regarding the DRA as well as 2007 proposals to further curb the role of Medicaid in the public behavioral health system. Overall, both CMS and SAMHSA indicated that the intent of the DRA is to prohibit the use of Medicaid for services that are beyond the program’s legislative scope and authority (e.g. not medically necessary, social service in nature). Further, the federal government will not support services for which another third party is legally responsible regardless of medical necessity. In all instances Medicaid is the payer of last resort.

When asked about how communities will continue to provide services without the use of Medicaid (even though communities were encouraged by their states to do so), both representatives suggested that private insurance must be held accountable and considered a resource. This sentiment was also shared by a representative from the National Governor’s Association during presentation on the previous day.

Lastly, the NACBHD participants questioned CMS about their process for implementing the provisions of the DRA. CMS informed the members that it will work with the National Association of State Medicaid Directors on a series of “Dear State Medicaid Director” letters. These letters will include implementation guidance. CMS will issue an Interim Final Rule on implementation for Targeted Case Management. This rule is not subject to comment.

Opportunities to Impact the Process—NACBHD meets with the National Association of State Medicaid Directors and the National Governors Association

In an effort to more completely inform the NACBHD membership about potential impacts of the DRA and 2007 Budget Proposals, Melissa Staats and Maeghan Gilmore met with the staffs of the National Association of State Medicaid Directors and the National Governors Association.

The National Association of State Medicaid Directors confirmed plans shared by CMS representatives—implementation guidance will be issued via “Dear State Medicaid Director” letters. Collaboratively, CMS and the State Medicaid Directors are attempting to find the balance between limiting inappropriate billings (e.g. lack of documentation) and maintaining flexibility and access. For the most part, implementation of the DRA provisions is in the hands of CMS. There is essentially no opportunity for NACBHD to influence this process at the CMS level. Regarding third party liability, the staff reported a lack of understanding at various levels of the intent of this provision.

The State Medicaid Directors seemed to indicate that implementation of the 2007 proposals may be more open to influence. The NACBHD Medicaid Committee will work on behalf of the Association to provide information that may be useful.

Following this, NACBHD met with staff from the National Governor's Association. The Governors staff shared part of the Associations agenda with NACBHD. This agenda includes making Medicaid less necessary. The Governors Association is interested in long-term care and other types of coverage that can be used prior to accessing Medicaid benefits.

Staff from the Governor's Association also confirmed the implementation process and timeline for DRA and the 2007 Budget Proposals.

NACBHD's Next Steps

Based upon dialogue with various colleagues and other advocacy groups, it appears that the next level of policy making is at the states. NACBHD strongly encourages its members to collect information regarding how your agency or program utilizes case management and rehabilitation services. Information must be presented in a manner that clearly shows a cost/benefit for maintaining case management and rehabilitation services (e.g. increased ER use, jail costs). This is the type of information that will resonate with state and therefore federal policy makers.

As indicated above, the NACBHD Medicaid Committee will be working on a plan that may assist all NACBHD members as they work in their communities to protect the public behavioral health and developmental disability systems.

Other Legislative Activity

The National Association of State Drug and Alcohol Directors (NASADAD) provided NACBHD with a summary of the following legislative action.

President Signs Patriot Act – Includes NASADAD-Supported Authorization for Program to Treat Pregnant and Parenting Women Offenders for Methamphetamine Addiction

Last week (March 15), the President signed into law a bill (H.R. 3199, H REPT 333) reauthorizing an anti-terrorism law known as the USA PATRIOT Act that also included a number of provisions related to Methamphetamine. Of particular interest is a section that authorizes a grant within the Department of Justice (DOJ) to address Methamphetamine use among pregnant and parenting women offenders. Other Methamphetamine related provisions in the USA PATRIOT Act came from individual proposals introduced last year both in the House and Senate. In the Senate, S. 103, the Combat Meth Act was authored by Senators Talent (R-MO) and Feinstein (D-CA). In the House, H.R. 3889, the Methamphetamine Epidemic Elimination Act, was introduced by Congressman Souder (R-IN).

The purpose of the DOJ grant is to "...facilitate or enhance collaboration between the criminal justice, child welfare and State substance abuse systems in order to carry out programs to address the use of Methamphetamine drugs by pregnant and parenting

women offenders.” The section defined child welfare agency and criminal justice agency – but excluded a definition of State substance abuse agency.”

Given that NACo worked with NASADAD on getting support for this grant, there is a requirement that the state “certify it has worked with local units of government.” In a conversation with staff, NACBHD learned that NASADAD and NACo are working to secure appropriation for the grant (program was authorized with no appropriation). Therefore, NACo, NASADAD and NACBHD will collaborate in this effort.

NASADAD Reports Other Provisions Regarding Methamphetamine

Programs for Drug Endangered Children – The bill authorizes \$20 million for FY 2007 and an additional \$20 million in FY 2008 to “provide comprehensive services to aid children who are living in a home in which methamphetamine or other controlled substances are unlawfully manufactured...”

Retail sales of products containing precursor chemicals – The bill requires retail outlets to place products containing pseudoephedrine/ephedrine behind the counter. In addition, outlets will have to ask purchasers of such products to sign a log and present ID. Purchasers will be able to buy nine grams a month and 3.6 grams a day.

Hot Spots Program – The bill authorizes an additional \$99 million each year for the next five years through DOJ’s Meth Hot Spots program to train State and local law enforcement to address the methamphetamine problem.

Smuggling of Methamphetamine from Mexico – The bill authorizes \$4 million to allow the Department of State to work with Mexico to improve the ability of Mexican law enforcement authorities to combat the production and distribution of methamphetamine.

International standards – The legislation establishes new reporting requirements and certification procedures of the largest exporting and importing countries of precursor chemicals.

Environmental aspects – The bill requires a report to Congress from the Administrator of the Environmental Protection Agency (EPA) “setting forth information...that identifies the byproducts of the methamphetamine production process” and whether such byproducts are hazardous.

If you have questions on this DC Update or any other issue, please do not hesitate to contact Melissa Staats mstaats@nacbhd.org or Maeghan Gilmore mgilmore@nacbhd.org or via phone at (202) 661-8816.

Thank you for your attention and consideration.