



NACBHD
National Association of
County Behavioral Health
and Developmental
Disability Directors

Medicaid

Direction for the Future

National Association of County Behavioral Health and Developmental
Disability Directors

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The National Association of County Behavioral Health and Developmental Disability Directors (NACBHD), recognizes the Medicaid Commission’s dedication to improving the Medicaid program. We understand the significance of your work and your willingness to consider our perspective as managers, payers and partners of and within the Medicaid system.

Who we Are

The National Association of County Behavioral Health and Developmental Disability Directors is the only National voice for county/city governments and county sponsored behavioral health and developmental disability authorities in Washington, D.C. NACBHD is an affiliate of the National Association of Counties (NACo).

NACBHD’s membership represents county/city governments and other locally sponsored behavioral health and developmental disabilities services authorities. NACBHD has members in 23 states across the country that oversee, plan, deliver and finance services for over 70% of those with mental health needs, 60% of those with addictions, and 50% of those with developmental disabilities. In 1999, county/city governments and other locally sponsored authorities contributed over \$15 billion dollars to behavioral health and developmental disability services

Counties play a vital role in the management and delivery of services to persons with special needs. With decades of experience in managing the care of the most disabled members of their communities, county government authorities have developed effective and efficient care management models, which have demonstrated both improved outcomes for individuals, and cost savings for Medicaid. It is critically important that these long established safety net systems of care not be jeopardized as Medicaid Reform proceeds. Without this program many more people would lack access, treatment and care for mental health, substance use and developmental disabilities.

Medicaid Reform—Principles of County Government

States, counties and cities have already implemented care management models that have improved outcomes for individuals and cost savings to Medicaid. NACBHD believes that these care management models—those that produce a “win/win” or result in a positive cost benefit can be expanded upon and more widely implemented. From here and with several important modifications to the way Medicaid operates (e.g. BBA), care management models can be further developed to result in greater cost savings and improved outcomes. With that, Medicaid should support such care innovations and should be considered in any reform package and agenda. It is these types of innovations—generated by the stakeholders in communities that have the best chance maintaining the safety net.

NACBHD is well aware that the national debate is focused on larger issues than local flexibility and that there is need to improve program efficiency and its impacts on government spending and taxing. However, it is critical that policy makers carefully

consider the impacts of reforms before implementing those that will result in greater cost in terms of human experiences, Medicaid dollars or the likelihood that some reforms could trigger a new round of cost shifting between the federal government and states or between states and local governments.

Policy makers must understand that when the “right” services are delivered in the “right place” at the “right time” there are consequent cost offsets in other service areas (e.g. criminal/juvenile justice, hospital and emergency rooms, homelessness). Medicaid has provided the mechanism for providing the “right services” in the “right place” at the right time”. To improve its efficiency and effectiveness (including the delivery of high quality services) Medicaid Reform must be considered in the following context (from principles adopted by the National Association of Counties—NACo)

1. Medicaid should continue to be the safety net health care program for the country’s most disabled and vulnerable citizens.
2. In keeping with local governments’ historic role as the safety net for its citizens, responsibility for most disabled and vulnerable of members of the community should rest with county/city and other local behavioral health and developmental disability authorities. It is essential that local government authorities have access to Medicaid financing to support these essential services.
3. Medicaid must maintain a robust set of both mandatory and “optional” services to meet the full range of needs of the country’s most disabled and vulnerable citizens.
4. Medicaid services should include an array of medical, clinical and habilitative practices as well as supportive services needed to maintain disabled and vulnerable populations within their communities and to avoid over utilization of costly institutional care.
5. Medicaid regulations should be designed in such a manner as to minimize unnecessary administrative costs, and encourage innovation and flexibility at both the state and county levels so as to provide quality, cost effective services in the most efficient manner possible.
6. Medicaid reform should revise or eliminate dated or arbitrary limits, which restrict the access of persons with mental illness to necessary residential and acute hospital inpatient treatment services.
7. States and counties should have greater ability to manage the Medicaid program in terms of benefits, cost sharing, eligibility and coordination with private sector insurance.
8. Medicaid reform proposals that provide states with broader Medicaid program authority should first weigh the fiscal and health policy implications of the current financing structure and any proposed alternative means of funding.

9. The current waiver program should, to the extent possible, be revised to give states clear statutory authority with respect to states Medicaid plan amendments.
10. The federal government should pay 100 percent of the costs of any new Medicaid mandates imposed under the acts of Congress, federal regulations or court decisions, which are based on federal laws or regulations.
11. The federal government should assume full responsibility for the cost for acute, primary, long-term care and pharmaceuticals for dually eligible individuals who are enrolled in the Medicare program and who because of their low income status are also enrolled in a state's Medicaid program.
12. Medicaid reform should not create incentives which encourage states to restrict eligibility or services.
13. Medicaid reform should provide fiscal relief to states/local political subdivisions in order to allow states/local political subdivisions to maintain existing levels of services or beneficiaries.

NACBHD's reform principles and the experience of its members (those responsible for management of services to those most in need (across the behavioral health and developmental disabilities sectors) are embodied in the program opportunities and discussions that follow. Programs and discussion reflect the understanding that government must continue to be able to afford and finance Medicaid. NACBHD believes that the programs highlighted below strike an important balance between protection, care and fiscal viability.

Unintended Consequences to the Most Vulnerable and Disabled Must be Avoided

Reform of a program as large and complex as Medicaid carries with it the very real possibility of bringing about damaging unintended consequences to needy and vulnerable populations. For example, current proposals in some quarters that restrict the payment for certain rehabilitation services could result in the loss of the ability for persons with certain disabilities to live independently outside hospital or institutional settings.

Regardless of the reforms that are implemented, NACBHD is dedicated to the principle that "unintended consequences" that negatively impact advances made locally must be avoided. Below are examples of county and city innovations that have saved Medicaid dollars, focused on prevention, and improved system and individual outcomes. Several county/city and other local authorities have implemented these flexible programs and prevented such unintended consequences.

Examples of Innovations—Cost Benefits of Flexibility & Prevention

An example of Cost Savings in Medicaid in Jail Diversion (from SAMHSA newsletter July, 2005)

According to the Bureau of Justice Statistics, at mid-year 2004, 713,990 inmates were held in local jails across the Nation, up from 691,301 at mid-year 2003—an increase of 3.3 percent. (As many as 90,000 of those individuals may have a severe mental disorder." And of those 90,000, many have co-occurring substance abuse disorders as well.

According to the President's New Freedom Commission on Mental Health, the problem is inescapable in nearly every urban community. Ironically, the majority of these individuals have committed only minor offenses such as disturbing the peace. Typically poor and uninsured, these individuals often are homeless and have co-occurring substance abuse and mental disorders. They cycle in and out of shelters, hospitals, and jails, occasionally receiving mental health and substance abuse treatment services, but most likely receiving no treatment at all.

Cost studies suggest that communities (and taxpayers) can save on costs by supporting proven jail diversion programs as an alternative to incarceration.

In Bexar County Texas, according to a December 2004 policy analysis report, an estimated 14 percent of the county's jail population has severe mental illness, and 75 percent have co-occurring substance abuse problems. Many of San Antonio's large homeless population—some 25,000 to 30,000 people—have a mental illness. The Texas CHCS, the county's mental health authority, is spearheading the turnaround for Bexar County in close collaboration with city, county, and state law enforcement authorities in addition to judicial and health care entities.

To be effective, most jail diversion programs coordinate a comprehensive set of services at the community level. The cooperation of all involved agencies helps integrate mental health care and substance abuse treatment, physical health care, and social services, such as housing, food, and clothing.

Programs work to bridge the barriers between the mental health and criminal justice systems and help identify detainees who need mental health treatment and meet the jail diversion criteria. This is done through the initial screenings and evaluations at the crisis triage center, arraignment court, or jail.

Bexar County's diversion program relies on three phases of intervention. The first phase uses Deputy Mobile Outreach Teams and Crisis Intervention Teams to divert offenders with mental illness before they are arrested or booked in the county jail. During the second phase, the program identifies persons with mental illness within the system and makes recommendations for alternatives to incarceration, such as mental health bonds or

release to treatment facilities. The third phase focuses on providing appropriate services upon their release from jail or prison.

Deputy Mobile Outreach Teams, composed of county deputies and mental health clinicians, are available for onsite mental health assessments and interventions 24 hours a day, 7 days a week. Their mission is to screen high-risk individuals with mental illness and refer or transport them to the CHCS Crisis Center for further evaluation.

Crisis Intervention Teams are staffed by police officers trained to work with persons with mental illness. Their goal is to respond and to resolve conflict so that individuals with mental illness can be safely transported to the Crisis Center or, if necessary, the jail.

CHCS representatives also make home visits, helping people order their lives through cognitive adaptive training (CAT). CAT involves strategic placement of objects and lists of things they need to do, to keep them on track and taking their medications. "Jail diversion is also about identifying people who need additional supports and helping them maintain their good mental health and reintegrating them into the community," said Mr. Evans.

The CAT program also employs recovering people with schizophrenia to help gain the trust and participation of persons with mental disorders. Paul Eisenhauer, a 45-year-old man who suffers from the disorder, is doing well. He hasn't heard voices for more than a decade. Early diversion efforts helped him get out of jail and into a state hospital conducting clinical trials of a new antipsychotic medication. Today, he teaches police officers (who used to arrest him) about schizophrenia. "They really want to know what it's like to be schizophrenic," said Mr. Eisenhauer. "One officer came up to me and said, 'A lot of people are scared of schizophrenics,' and I said, 'A lot of people are scared of cops.' "

So how is the San Antonio program doing? Interim results show a significant number of jail diversions and potential savings in criminal justice costs. County officials are optimistic that added costs for mental health care will diminish as the long-term benefits of the program take hold.

What's very impressive about the San Antonio program is the way they brought all these services together—the small providers, the big providers, the county judges, the university, primary health care, and the state legislature. They are transforming the way mental health services are delivered. And this is exactly what we had in mind with this program—to help bring about this kind of transformation and to change the public's view of people struggling to overcome co-occurring mental illnesses and substance abuse.

Texas is currently making plans to apply the Bexar County jail diversion model throughout the state.

A case example of cost savings for Medicaid in Long Term Care

Valley Mental Health a Utah non profit corporations has developed in partnership with the State Medicaid agency an exciting project relative to nursing home long term care. The efforts have been to develop community based alternatives to a nursing home placement and the integration of physical and mental health. The project is called “Flex Care”

What is the FlexCare Program?

A program designed to help Medicaid nursing home residents receive their care in the most appropriate and least restrictive setting possible. Many options are potentially available through FlexCare including home placements, residential settings, and other innovative community options. Once an individual is enrolled in the FlexCare Program, many ongoing services are available to help support the person in the setting that best meets their needs. The services will include:

- Medical and hospital needs.
- Coordination with the person’s doctor
- Coordinate needed services with mental health or substance abuse provider
- Care coordination in all health care settings including any moves that may occur between community placement, hospitals, and nursing homes
- Meet with individual and their family members on a regular basis to update care plans, assess for any changing needs, and monitor success in their current placement
- Assist in obtaining other needed community resource in transportation
- Monitor all medical and community support services for quality care
- Advocacy and mediation services to resolve problems as they arise.

Who is Eligible?

- Must be 18 year of age or older
- Must be financially approved for the Medicaid nursing Home Program
- Must have resided in a nursing home for a minimum of 90 days and be medically eligible for long term care services under Medicaid.

OR

- Must currently reside in nursing home on a Medicare stay and be medically eligible for long term care services under Medicaid.

OR

- Must currently be in a hospital setting and be medically eligible for long term care services under Medicaid.

How does FlexCare Work?

Once a referral is made by the family, nursing home or hospital and the individual is determined to meet the eligibility requirements as above the following steps will take place:

- A comprehensive medical, cognitive, mental health, and resource assessment will be completed in order to determine what types of community placement options are available to meet the medical and safety needs of the individual.
- Meetings with the individual and their family or representative to discuss these potential options and work towards a mutually agreeable placement site
- Not all individuals are able to live in a less restrictive setting and FlexCare may enroll the person but have them remain in a nursing home. This however allows an increase in coordination and advocacy of services not generally available to the traditional Medicaid nursing home resident.
- Co-ordinate the discharge planning process with the nursing home and work with the family or other support systems to co-ordinate all the necessary medical care and the move out process.

What are the program advantages?

1. COST SAVINGS TO THE MEDICAID PROGRAM

Since the provider is paid a capitation rate with the financial risk resting with the provider. The incentive is to move the patient to the less restrictive and less costly placement site. The provider is paid a daily rate that is significantly below the daily nursing home rate.

2. INCREASED ADVOCACY AND CARE COORDINATION FOR THE PERSON

3. APPROPRIATE BUT LESS RESTRICTIVE COMMUNITY BASED SETTINGS

4. DEMONSTRATED INCREASE IN FAMILY INVOLVEMENT IN CARE

5. DEMONSTRATED BY OUTSIDE INDEPENDENT EVALUATORS AN INCREASE IN PATIENT SATISFACTION IN THE QUALITY OF THEIR CARE AND INCREASED INDIVIDUAL CONTROL OF THEIR CARE

Essential Services to Vulnerable Populations Must be Preserved—A Reform Proposal

Essential Services Category

Current Medicaid regulations provide that payments will be made for mandatory services and optional services. Mandatory services are those acute hospital and physician directed medical services (including pharmacy) that states are required to provide and the federal government is obligated to reimburse. Optional services are services that states can elect to provide in the Medicaid plan and that the federal government deems appropriate for

reimbursement. Optional services tend to be those services that are more preventive or rehabilitative in nature. Currently the only mental health services that are mandatory services are acute inpatient hospitalization and outpatient medication evaluation. All other mental health services are optional services and subject to the discretion of each individual state.

Because many of the essential services, which enable individuals to live in their communities and avoid either acute hospitalization, institutional or custodial care, are considered optional services, any Medicaid Reform proposal that would discourage or limit access to such services will have a significant detrimental effect on children and adults who are psychiatrically and/or developmentally disabled. Such would also go against the principles established in Olmstead. Currently, the optional services prevent cost increases in the more expansion mandatory services.

In order to ensure that *essential* services remain intact and are not eliminated or significantly curtailed resulting in the re-hospitalization or re-institutionalization of thousands of individuals with psychiatric and developmental disabilities, the National Association of County Behavioral Health and Developmental Disability Directors proposes that any Medicaid Reform effort reframe how mental health and developmental disability services are categorized in order to ensure that due deliberation is given to considering the range of services that need to be available and reimbursable under Medicaid.

Definition of Essential Services and Populations

There is a set of *essential* services that are critical to maintaining children and adults with psychiatric and/or developmental disabilities in their communities in the least restrictive, most appropriate setting possible. These *essential* services have proven over time to be the key ingredients to successful treatment and rehabilitation. These *essential* services for each of the identified disabled populations include the following:

For children and adults with psychiatric and developmental disabilities:

1. Case Management
2. Mobile Treatment Teams
3. Evaluation and Diagnostic Services
4. Outpatient Services
 - Medication Evaluation, Monitoring and Provision
 - Individual, family and group therapy
 - Crisis Residential Programs
 - Transitional Residential Programs
 - Rehabilitative and Habilitative services
 - ICF/MR

Underlying Medicaid Reform Concept for Essential Services

In order to ensure that essential services are available in order to maintain identified disabled individuals within their communities in the least restrictive and most appropriate settings possible and to avoid unnecessary re-hospitalization and or institutionalizing, the National Association of County Behavioral Health and Developmental Disability Directors propose that the federal government create a new category of services entitled *essential services*. *The federal government will designate certain existing optional services into the new category of essential services.*

States would still have the authority to provide or not provide *essential* services. Medicaid Reform efforts should stipulate, however, that if a state elected not to make available an *essential* service, the state legislature would be required to hold a public hearing (s) to determine what the impact of the elimination of these services would be on the health and well-being of its citizens who are psychiatrically and developmentally disabled.

For example state would be required to demonstrate the following:

- That there was adequate acute hospital capacity and institutional care to provide for the mental health needs of those individuals who psychiatrically disabled and current utilize *essential* community mental health services.
- The ability to track the rate of re-hospitalization and re-institutionalization, which results from the elimination or significant decrease in the availability of *essential* mental health services.
- The ability to monitor the number of individual with psychiatric disabilities who enter the criminal justice system in either county jails, state prisons or on probation.

That the elimination or significant reduction of *essential* mental health service would cost neutral over time when compared to the cost of hospital and/or institutional care.

In order for the programs and reform proposal described above to obtain the maximum benefit, several operational issues need resolution. Some of these issues require resolution regardless of future reforms given their impact on service delivery and access to necessary resources.

Making Reform Work—A case example of Medicaid unintended consequences

Beginning in the early 1990's Utah converted its Medicaid reimbursement system for the mental health system to a prepaid capitation system, contracting with the local public mental health authorities to provide the mental health services. Significant savings resulted by shifting the emphasis on in-patient care to residential and community based care which was less costly and more in line with best clinical practices as well as

emerging patient and community values about mental illness.

This allowed the local mental health systems to reinvest these savings to develop, enhance, and stabilize the important community support systems required to maintain chronically mentally ill Medicaid eligible people in their local communities. This was good public policy as it both controlled Medicaid costs and provided for the needed supports for Medicaid persons to live in their communities rather than continuing cycle of expensive institutional care.

The prepaid capitation system was granted under a freedom of choice waiver and the main financial test was cost neutrality. However the Balanced Budget Act of 1997 and the development of managed care regulations, including changes to the financial tests imposed by the Centers for Medicare and Medicaid (CMS) have created constraints. These factors have led to a rate setting methodology that is based on the actual cost of traditional Medicaid services in the prior base year with some adjustments allowed for inflation, administrative costs and risk. In essence, this translates to a cost based reimbursement system—eliminating the opportunity for reinvestment in a system that keeps individuals from expensive and often inappropriate institutional levels of care. CMS actions have also created an increased burden and additional administrative costs—end of year audits and outside external reviews (EQRO) process coupled with the time intensive actuarial rate setting process—will in the long run increase the costs of Medicaid and likely send consumers back to more expensive, although traditional, treatments.

The net effect is significant unintended consequences for the most vulnerable Medicaid eligible individual. This leaves little room for any expenditure on important community based services that in the past were able to be provided from savings. The President's New Freedom Initiative is a comprehensive plan to remove barriers to community living for people with disabilities by working to ensure that all Americans have the opportunity to learn and develop skills, engage in work, make choices about their daily lives and participate fully in community life. The CMS developed rules and regulations governing the managed care system in fact puts financial incentives in the wrong direction and causes—in the field—a serious disconnect between the goals of the President's New Freedom Commission, and the Medicaid funding plan. Although under the application of the present rules and regulations there will be savings to Medicaid in the short run, in the long run the costs to Medicaid will dramatically increase. Because, the incentives are such that needed community support systems will collapse and consumers will de-compensate thereby requiring expensive and mandatory Medicaid inpatient care.

Conclusion

State and localities continue to struggle to maintain comprehensive programs. Many innovations have been developed and counties serve individuals in the places where they work and live through a combination of funding mechanisms. Should these funding streams disappear or reduce, the entire system will experience alterations that will likely produce unintended consequences of short sided, short term savings.

Counties play a vital role in the management and delivery of services to persons with special needs. With decades of experience in managing the care of the most disabled members of their communities, county government authorities have developed effective and efficient care management models, which have demonstrated both improved outcomes for individuals, and cost savings for Medicaid. It is critically important that these long established safety net systems of care not be jeopardized in the event of movement away from previously CMS approved state Medicaid plans which will result in cost shifts to states and counties.