Community Behavioral Healthcare
Association of Illinois

Community
Behavioral
Healthcare
Association

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Medicaid Reform

Senate Special Committee
Monday, November 29, 2010
Room 400, 1:00 p.m.

CBHA would like to thank co-chairs Senators Steans and Righter and members of the Committee for the opportunity to provide comments on the issues before this Special Committee of the Illinois Senate on Medicaid Reform.

Through an array of Medicaid benefits that span the clinical and rehabilitative needs of eligible individuals, Illinois supports an array of lifesaving behavioral health care services. CBHA recognizes the importance of that support. We welcome the opportunity to participate in discussions on reforms for redesigning Illinois' Medicaid system that can lead to improvements to:

- consumer health outcomes;
- accountability;
- make access for eligible Medicaid recipients more efficient and effective;
- promote cost savings for local and state taxpayers, consumers and providers; and
- facilitate cost avoidance for local and state taxpayers, consumers and providers.

As the Senate debates which actions should be taken to reform or redesign Illinois' Medicaid system(s) during the state's sustained fiscal difficulties, the complexity of the Illinois Medicaid program will surface.

Our effort today hopefully contributes perspectives on the role community Behavioral Health Care plays in directions that support solutions being discussed during the Special Committee's deliberations. Our perspectives include:

i) The Return on Investment Community Behavioral Health Care provides for consumers and taxpayers.
ii) Leveraging new and pending federal requirements to modernize Illinois' Medicaid system(s) including its outdated IT infrastructure.
iii) The need to address legacy systems. Consumers and providers interact with various state Medicaid rules and regulations from numerous departments or divisions within departments resulting in redundancy, inefficiencies and, at their worst, systems that don't talk to each other.
iv) Behavioral health care assists consumers avoid more costly systems and contribute to healthy and safe communities in our supporting role with hospitals, schools, law enforcement and other local or state systems.
v) Illinois' Professional Shortage and Underserved Areas require solutions that reform actions taking into account specific community resources and local options for collaboration.
vi) CBHC plays a critical role in providing access to the right care at the right time through behavioral health care assessments, care management and continuity of care options for consumers.

Respecting the time of the Committee, the following written comments provide our responses to the specific questions forwarded to my office last week. We will be happy to follow up these comments with information that more completely fleshes out the items enumerated above.

CBHA's comments to the specific questions asked by the Committee.

1) What is CBHA's role in the Medicaid system?

The Provider Community
Community Behavioral Healthcare Association (CBHA) provides a number of supporting services to not-for-profit providers of community-based mental and substance use disorder care, treatment and prevention services. These safety net providers are ***the providers that support consumers on their road to recovery*** through local community behavioral health care infrastructure throughout Illinois. This infrastructure helps build Healthy and Safe Communities while providing a return on the investment of taxpayer funds as these safety net providers offer community alternatives to children, adolescents, mothers, men and families on their personal road to recovery.

The Medicaid System
Not-for-profit safety net providers of community-based mental and substance use disorder care, treatment and prevention services offer Medicaid services enumerated in Rules 140, 2090 and 132.

1. DHFS Medicaid Provider Manual listing covered services
2. DHS DASA Rule 2090
3. MRO Rule 132
4. Relevant pages of the DHFS Medicaid Handbook on Healthy Kids Services which outlines the comprehensive health plan for children as spelled out in EPSDT:
   - Foreword - pages v
   - Basic Provisions – pages 1-2
   - Other Services – page 23
   - Appendix 3 – Mental Health Screening Instrument
   - Appendix 4 – Healthy Kids Substance Abuse Screen

Community Behavioral Healthcare Association (CBHA)
CBHA represents not-for-profit providers of community-based mental and substance use disorder care, treatment, and prevention services within Illinois by performing certain services for safety net CBHC providers within:

a) legislative advocacy processes;
b) Constitutional Office representations;
c) the executive branch and the state divisions and departments funding prevention, care and treatment under Medicaid including acute, crisis, outpatient and residential services to adults children and adolescents enrolled in Medicaid and state-funded programs including those funded by the Division of Mental Health, the Division of Alcohol and Substance Abuse, the Division of Community Health and Prevention, the Department of Children and Family Services, the Illinois State Board of Education, the Department of Healthcare and Family Services and the Department of Corrections.

CBHA facilitates or provides technical assistance to "the field" in state-of-the-art community behavioral health care evidence-based practices. CBHA's current offerings include facilitating "Illinois Integrated Care Learning Communities" and offering a series of "webinars" on Compliance.

CBHA and its members are active participants in coalitions and forums across the state to promote a principled, cost-effective system of community behavioral health care.

CBHA's comments to the specific questions asked by the Committee.

(continued)

2) What are our suggestions to reduce Medicaid costs without severely impacting services?

For children, women, men and families, Medicaid care is too often sporadic and fragmented, lacking continuity of care and, in the worst cases, not readily accessible. These weaknesses all contribute to inefficient care delivery.

For the state, the fragmented legacy systems need to become more efficient and cost-effective. The absence of a unifying IT infrastructure exacerbates and in some instances prevents attempts to improve critical functions the state must perform while driving up providers' delivery of care.

Legacy Fee-for-Service efforts have set the stage for the next steps to modernize legacy systems into a more effective and efficient functional system.

The multi-year effort by DHS–DMH and DHFS to reconfigure payments to behavioral health providers from a predominantly grant structure to a predominantly fee-for-service methodology has taken a significant amount of time and resources.

The FFS models used in Illinois for CBHC have not yielded a payment methodology that rewards performance and improves outcomes for children, women, men and their families nor has it addressed the fragmented legacy systems of Medicaid operations within Illinois.

The conversion has produced benefits to productivity and standardization. Illinois could decrease the rise in Medicaid expenditures and avoid future costs by:

a) considering payment methodologies that reward performance; improve health outcomes for children, women, men and their families; and reduce or avoid costs incurred at the consumer, provider, local and state level;
b) driving efficiencies through improvements to the state's Medicaid legacy systems in the areas of enrollment, governance, compliance and the array of often redundant reporting, monitoring, auditing functions conducted across various divisions and departments;
c) addressing recidivism; the overuse of institutional care; and unnecessary use of emergency room care;
d) taking actions to improve coordinated care including treatment plans and care management;
e) leveraging provisions of the Accountable Care Act including the HHS announcement for new federal support for states to develop and upgrade Medicaid IT systems and systems including guidance to help states design and implement the information technology (IT) needed to help enroll people who qualify for Medicaid or the Children's Health Insurance Program (CHIP).

Reforming Medicaid for children, adolescents and adults to decrease the rise in Medicaid expenditures and avoid future costs should include the following objectives:

a) In order to achieve continuity of care for children and adolescents, expand Illinois' behavioral health care support beyond its narrow crisis focus.
b) Develop integrative care strategies for all populations Medicaid serves.
c) Address system inefficiencies including outdated IT infrastructure and legacy redundancies.
d) For children and adolescents, develop more consistent adherence to early and periodic screening, diagnostic and testing benefits (EPSDT) service requirements.

e) Establish an executive branch structure and benchmarks for: a) the safe transition of fiscal and state management practices and capabilities to improve health outcomes in a consistently more efficient and effective manner; and b) measurements for the expected economies achieved at the consumer, state and provider levels.
f) Recognize Illinois' Professional Shortage and Underserved Areas. Flexibility within modernized, more efficient statewide accountability should be an expectation as should a call for regional and local solutions.

CBHA's comments to the specific questions asked by the Committee. (continued)

3) What can the state do to maximize federal funding?

a) As it eliminates redundancies and leverages opportunities under federal ACA requirements, the state can reallocate human and IT resources into: a) the Medicaid application process for consumers that use state-supported systems; b) streamlining accountability; and c) distributing resources to implement electronic medical records to enable coordination of care and measurement of outcomes.

b) Leverage the federal requirements under the ACA. By being cognizant of the lynchpins between the Special Committee's desire for a more efficient system and the Patient Protection and Affordable Care Act.

From the Affordable Care Act (ACA) - possible lynchpins between the ACA and the Special Committee:

I. Determining Eligibility
Section 1413 of the Patient Protection and Affordable Care Act. Single Form. Expects states to use a:
"single, streamlined form that may be used [by individuals] to apply for all applicable state health subsidy programs within the state; may be filed online, in person, by mail, or by telephone, may be filed by an Exchange or with other applicable state health subsidy programs".

II. Single Eligibility Engine*
"States are expected to establish a single portal – potentially feeding into a single eligibility engine – that will determine eligibility for Medicaid, CHIP, the Exchange(s), and other state health insurance programs."
*page 9 HIE Key Issues for State Implementation Robert Carey September 2010 Academy Health; State Coverage Initiatives Robert Wood Johnson

III. Administrative Simplification
Section 1104 of The Patient Protection and Affordable Care Act section on administrative simplification is to be adopted by July 01, 2012:

- Section 1104 calls for more efficient health insurance administration practices, mandating a single set of operating rules for electronic funds transfer and health care payment and remittance, to be adopted by July 01, 2012.

c) The state could use the new Medicaid Health Home State Option and allow BHC providers to be "homes" for BHC consumers with chronic or complex conditions. Provides an enhanced match of 90% FMAP for two years to states that take up this option.

New Medicaid Health Home State Option is Available.
On November 16, the Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Directors Letter providing guidance on how states may take advantage of the new Medicaid Health Home Option under the health care reform law. This

provision of the law creates a new option for states to enroll beneficiaries with two or more chronic conditions, including serious mental illness or substance use disorders, into health care homes for the coordinated treatment of their conditions.

The letter indicates that CMS will provide financial support to states for their health home program planning efforts and clarifies that states can target populations for inclusion, but must specify how they will address behavioral health disorders in the health home model.

CMS also identifies community mental health centers and other behavioral health entities as eligible health home providers. In addition, it stipulates that the basic requirements for meeting the criteria for a health home include the provision of behavioral health prevention and treatment services. All states applying for this option must consult with SAMHSA to ensure that they are adequately addressing behavioral health disorders.

d) Use rate models that capture reimbursable administrative costs and provide incentives for improving health outcomes and collaboration.

e) Pursue Programs for Healthy Lifestyles, an ACA grant program for states. Incentives to Medicaid beneficiaries who participate in programs to develop a healthy lifestyle including co-morbidities such as depression associated with conditions known to compromise health.

f) Strengthen home- and community-based service infrastructure to reduce reliance on institutional care; use community behavioral health care providers and integrated healthcare to:
    - Lower the costs to the state and improve the health of those the state already serves.
    - Create medical homes at Community providers for those who are seen there.
    - Insure RFP's include:
        - role for consumers,
        - outcomes measures,
        - collaborations within and across departments,
        - staging.
    - Prevent unnecessary institutional care:
        - preventive BHC care and services,
        - expand screenings that include BHC.
    - Ensure choice for consumers.
    - Develop adequate alternatives to institutional care.
    - Develop targeted care, treatment and services inclusive of BHC to high risk and recidivistic populations.
    - Ensure efficient accountability and service delivery by eliminating redundant and duplicative state requirements and processes.

g) Mine the lessons learned from CBHC experiences across the state. BHC healthcare community safety net providers are located throughout the state as part of larger health care systems, public health care departments, or as providers providing quality community behavioral health services though community 501 (c) 3 organizations:
    - These BHC health care community safety net providers have a history of innovation and making things work. In recent years, these efforts include partnerships for integrated care and systems of care that are being considered as the new directions for health care delivery systems.

CBHA's comments to the specific questions asked by the Committee.
(continued)

4) How can inefficiencies within Illinois State's Medicaid System be corrected?

a) The ACA focuses on care management as a central theme of health care reform, with the goal of bringing together primary care physicians, specialists, hospitals, long-term care and social service providers to organize care around the needs of the patient to achieve improvements in health:
   i) develop unified IT strategies,
   ii) improve accountability,
   iii) improve integrated care,
   iv) improve continuity of care.

b) Establish the governance for and benchmarks of a redesigned system:
   1. The "markers" of a true system of care with statewide significance should include a shared vision with principles and outcomes including:
      a) evident openness of consumer/family voice,
      b) organizational support for development of consequential provider/consumer/family voice,
      c) cabinet level or subcabinet level unifying structure,
      d) metrics from the provision of care though the provider and state systems that measure effective efficiencies have produced the desired consequences,
      e) a wraparound or child and family team process in which numerous systems can participate as the primary way they plan and deliver services and supports,
      f) a commitment to Medicaid flexibility through EPSDT.

c) Improve accountability through non-redundant requirements:
   1. consolidate Rules,
   2. standardize administrative requirements,
   3. reduce or eliminate multiple licensure and certification requirements,
   4. expand Deemed Status for accredited organizations,
   5. streamline the contracting process,
   6. streamline Medicaid processes and regulations.

In a trend welcomed by providers and consumers alike, the state has been applying standards of quality and accountability to the contracts it executes with community providers. They represent laudable attempts to continuously improve the standard of excellence set for the publicly funded behavioral health care system.

Although well intentioned, these new requirements often work at cross purposes for the accountability they seek to achieve as well as becoming "unfunded mandates." Collectively, the lack of integration within the Department of Human Services and across Departments has led to an overlap and inconsistency of state regulation and oversight while the added cost of these additional mandates has eroded service delivery.

CBHA's comments to the specific questions asked by the Committee.

(continued)

4) How can inefficiencies within Illinois State's Medicaid System be corrected? (continued)

CBHA believes that significant efficiencies could be gained through the elimination of unnecessary or duplicative rules, regulations, policies or processes.

1. **Consolidate Rules**
   a. Consolidate Rules into a set of regulations with consistent application across services.

2. **Standardize administrative requirements**
   a. Consolidate forms and reporting processes and apply them across services.

3. **Reduce or eliminate multiple licensure and certification requirements**
   a. Community providers are required to comply with multiple licensure and certification requirements. These multiple regulations and standards are sometimes conflicting, frequently redundant, thereby wasting staff resources at the provider and state agency levels.

4. **Expand Deemed Status for accredited organizations**
   a. Grant accredited community agencies "Deemed Status" for certain regulations, meaning the provider is viewed as being in compliance with state regulations by virtue of having achieved accreditation.

5. **Streamline the contracting process**
   a. Wherever possible, contract language and structure should be uniform. In addition, further efficiency could be achieved through the establishment of a comprehensive schedule for coordination of contracting activities and through the use of a multi-year contracting approach.

6. **Streamline Medicaid Regulations**
   a. Medicaid regulations are based primarily on a single set of controlling federal statutes and regulations. Reforming various divisional or department Medicaid rules and regulations into a more consistent set of regulations; review process, documentation procedures, forms and formats, and guidelines for surveyor interpretation of regulations should be considered.

CBHA's comments to the specific questions asked by the Committee.

(continued)

5) Can you identify any loopholes within state statute or administrative code that have allowed for Medicaid fraud?

a) The removal of redundant processes and functions and streamlined governance could allow state government to focus its efforts based on the determinations of risk of fraud, waste and abuse.

b) Improvements sought through the Patient Protection & Affordable Care Act that requires all health providers (regardless of size) to have a compliance program and requires the Secretary to determine the level of screening to be conducted according to the risk of fraud, waste and abuse with respect to the category of provider of medical or other items or services or supplier.

The proposed regulations provide further detail on this requirement:

i) Section 6401(a) of the ACA, as amended by Section 10603 of the ACA amends Section 1866(j) of the Act to add a new paragraph:

   (2) "Provider Screening." Section 1866(j)(2)(A) of the Act requires the Secretary, in consultation with the Department of Health of Human Services' Office of the Inspector General (HHS OIG), to establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under Medicare, Medicaid, and CHIP. Section 1866(j)(2)(B) of the Act requires the Secretary to determine the level of screening to be conducted according to the risk of fraud, waste, and abuse with respect to the category of provider of medical or other items or services or supplier. The provision states that the screening shall include a licensure check, which may include such checks across State lines; and the screening may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse, include a criminal background check; fingerprinting; unscheduled or unannounced site visits, including pre-enrollment site visits; database checks, including such checks across State lines; and such other screening as the Secretary determines appropriate.

ii) The regulations can be accessed by going to: http://www.regulations.gov/search/Regs/home.html#documentDetail?R=0900006480b5b5a9

Reference materials used in preparing these comments include:

- FY 2010 Checklist for States: The National Conference of State Legislatures has compiled a checklist for state policy-makers outlining the components of state-level planning and decision-making that must occur under health care reform during FY 2010.

  http://www.ncsl.org/documents/health/2010CLHlthRef.pdf

- Timeline for Medicaid Provisions: shows the implementation date for each provision related to Medicaid.

  http://www.thenationalcouncil.org/galleries/policy-file/Healthcare%20Implementation%20Timeline%20Medicaid%20Provisions.pdf

Health Professional Shortage Areas

CBHA Excerpts
December 2009

Designated Health Professional Shortage Areas Statistics
Health Resources Services Administration (HRSA)
U.S Department of Health & Human Services

Illinois Health Professional Shortage Areas
Regardless of Metropolitan / Non-Metropolitan Status
As of November 23, 2009

Mental Health Professional Shortage Areas (PSA)		***Illinois***
Illinois' shortages and unserved populations.		
Total Designations of MH Professional Shortages Only five states with more designations.		**126** 6/50
Service Areas with MH Professional Shortages Only one state with more service areas with shortages.		**31** 2/50
Population in Professional Shortage Areas Only two states with more people in PSA.		**4,101,300** 3/50
Estimated Unserved Population Only four states with greater population unserved.		**2,784,986** 5/50
Primary Health Care		
Illinois' shortages and unserved populations.		
Total Designations of Primary Professional Shortages Only two states with more designations.		**266** 3/50
Service Areas with Primary Professional Shortages Only three states with more service areas with shortages.		**40** 4/50
Population in Health Professional Shortage Areas Only four states with more people in PSA.		**3,649,123** 5/50
Estimated Unserved Population Only three states with greater population unserved.		**2,247,522** 4/50

Health professional(s) shortage area means any of the following which the Secretary determines has a shortage of health professional(s): (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility.

Health service area means a health service area whose boundaries have been designated by the Secretary, under section 1511 of the Act, for purposes of health planning activities.

Mental Health HPSA Designation Overview

There are three different types of HPSA designations, each with its own designation requirements:

- Geographic Area
- Population Groups
- Facilities

Geographic Areas must:

- Be a rational area for the delivery of mental health services.
- Meet one of the following conditions:
  - A population-to-core-mental-health-professional ratio greater than or equal to 6,000:1 and a population-to-psychiatrist ratio greater than or equal to 20,000:1; or
  - A population-to-core professional ratio greater than or equal to 9,000:1; or
  - A population-to-psychiatrist ratio greater than or equal to 30,000:1.
- Have unusually high needs for mental health services, and
  - A population-to-core-mental-health-professional ratio greater than or equal to 4,500:1 and a population-to-psychiatrist ratio greater than or equal to 15,000:1, or
  - A population-to-core-professional ratio greater than or equal to 6,000:1, or
  - A population-to-psychiatrist ratio greater than or equal to 20,000:1
- Mental health professionals in contiguous areas are over-utilized, excessively distant or inaccessible to residents of the area under consideration.

Population Groups must:

- Face access barriers that prevent the population group from use of the area's mental health providers.
- Meet one of the following criteria:
  - Have a ratio of the number of persons in the population group to the number of FTE core mental health professionals serving the population group greater than or equal to 4,500:1 and the ratio of the number of persons in the population group to the number of FTE psychiatrists serving the population group greater than or equal to 15,000:1; or
  - Have a ratio of the number of persons in the population group to the number of FTE core mental health professionals serving the population group greater than or equal to 6,000:1; or
  - Have a ratio of the number of persons in the population group to the number of FTE psychiatrists serving the population group are greater than or equal to 20,000:1.

Facilities must:

- Be either Federal and/or State correctional institutions, State/County mental hospitals or public and/or non-profit mental health facilities.

- Federal or State Correctional facilities must:
  - Have at least 250 inmates; and
  - Have a ratio of the number of internees per year to the number of FTE psychiatrists serving the institution of at least 2,000:1.

- State and county mental health hospitals must:
  - Have an average daily inpatient amount of at least 100; and
  - The number of workload units per FTE psychiatrists available at the hospital exceeds 300, where workload units are calculated using the following formula: Total workload units = average daily inpatient census + 2 x (number of inpatient admissions per year) + 0.5 x (number of admissions to day care and outpatient services per year).

- Community mental health centers and other public and non-profit facilities must:
  - Be providing (or responsible for providing) mental health services to an area or population group designated as having a shortage of mental health professionals; and
  - Have insufficient capacity to meet the psychiatric needs of the area or population group.

NAMI's Position (summarized from the NAMI Policy Platform)

NAMI supports health care for all persons with brain disorders that is affordable, nondiscriminatory, and includes coverage for effective and appropriate treatment. NAMI supports federally mandated minimum standards for health insurance coverage. NAMI supports efforts of states to gain waivers of ERISA (Employee Retirement Income Security Act) so self-insured employer health plans would comply with state-mandated minimum benefit laws. Managed care organizations must be held accountable for delivering a comprehensive array of community support services, and appeal and grievance procedures must be in place that are user-friendly and time-sensitive.

The Need to Stand and Deliver

A crisis of confidence in health plans exists throughout the nation. National mandated legislative solutions are required to restore consumer confidence in health plans.

In September 1997 NAMI published *Stand and Deliver: Action Call to A Failing Industry*. The report observed that managed care plans failed to deliver on the following expectations: publicly available and current practice guidelines, easy hospital admission and flexible hospital length-of-stay, PACT programs, immediate access to all effective medications, suicide attempt viewed as a medical emergency, consumer and family participation in their treatment planning and care, measurement of clinical outcomes, access to psychiatric rehabilitation, and access to secure and supportive housing.

In an October 1998 NAMI survey of consumer and family experiences with managed care, 25 percent of respondents had positive experiences with managed care in four areas: improved access to treatment, emphasis on preventing crisis, focus on consumer satisfaction, and decreased unnecessary hospitalization.

The five areas of most negative experience with managed care were: don't know how to file an appeal (55 percent); seeing the patient's doctor (41 percent); problems getting medications (34 percent); problems getting crisis services (33 percent); and problems getting admitted to a hospital (28 percent). Twenty-five percent of respondents had filed an appeal with their health plan; families were successful 54 percent of the time and consumers were successful 42 percent of the time.

Managed Care: A National Overview

According to a July 1998 SAMHSA-Lewin study, 46 states are implementing 88 different managed behavioral healthcare programs. Only Maine, Mississippi, Nevada, and Wyoming have no public-sector managed behavioral healthcare programs. Of these 88 programs, 83 have mental health and 66 have substance abuse. Sixty-one (69 percent) include both mental health and substance abuse. However, 41 of these programs had been in operation less than one year. There is a roughly 50/50 split between at-risk programs and administrative services organization (ASO) arrangements. Fifty-five percent of the programs use behavioral healthcare carve-outs, but only 17 percent use non-Medicaid funds.

Colorado, Iowa, and the city and county of Philadelphia are generally viewed as the most positive of these initiatives but even there access problems exist.

Iowa and Massachusetts seem to be more advanced in terms of the development and use of performance-based measurements. Philadelphia leads the nation in the use of consumer satisfaction teams, teams staffed by consumers and family members to ascertain enrollee dissatisfaction.

Montana and Tennessee have reputations as having the most problematic public-sector managed behavioral health care in the nation. After 23 months of operation, the Montana Legislature terminated the program. These states share common mistakes. There was no previous managed care experience in the states, yet they quickly implemented a managed care program statewide. Historic patterns of service utilization by the Medicaid population were unknown, yet the states added non-Medicaid-eligible, uninsured populations to the managed care program and even included a pharmacy benefit, even though historic patterns of utilization were not known. Both states reduced spending, anticipating budget savings from the program's financing before any actual implementation experience occurred.

NAMI's Advocacy Strategies and Goals

NAMI's *Stand and Deliver* report identified nine measures of success. These measures have been updated into 10 suggested action steps:

1. Authentic, early, and continuing consumer and family involvement in all stages of programming. *Authentic* means that the involvement was not token, but actually had an impact.
2. Standardized benefit packages based on parity for mental illness so that consumers can compare health plans based on performance.
3. Public release of comparative performance by health plans and treating providers. Performance data should be explicit, benchmarked, standardized, publicly available, and independently validated.
4. Public release of consumer satisfaction data, complied by consumer satisfaction teams, staffed by consumers and families, external to the health plan, but with the health plan's commitment to immediately respond to complaints, grievances, and dissatisfactions.
5. Consumer and family surveys, such as NAMI's *Stand and Deliver.*
6. Publicly available practice guidelines, which are adhered to by a health plan's treating providers.
7. Immediate access to needed care.
8. Effective and timely grievances, appeals, and decisions using third-party, independent, binding clinical review. The use of independent, third party consumer and family facility and program monitoring teams and the use of independent ombudsmen programs are helpful.
9. Suicide attempts viewed as a medical emergency.
10. Standardized premium-rate structures so that consumers can compare health plans based on performance and risk-adjustment cost reimbursement so no plan is penalized because it enrolls and serves a population with more severe illness.

Other lessons learned can be action steps in advocating accountable and responsible managed care programs. These include:

11. Precisely define in the public domain, preferably in authorizing legislation, key terminology such as the actual benefits, how benefits are actually accessed, and medical necessity.
12. Consider using the Massachusetts practice where 100% of the capitation is devoted to clinical care; where pharmacy is not included in the behavioral health benefit capitation; where a separately funded, adequately funded, and separately negotiated administrative budget (currently 9% of the total expenditures) operates; and where profit is entirely tied to the achievement of performance goals. Massachusetts also uses risk corridors where potential profits and losses are capped.
13. Use other successful state capitation rates when examining the adequacy of your state or local capitation rate.
14. Implement detailed seamless systems of care between the Medicaid and public mental health systems. Even in states with more positive managed care experiences, such as Colorado and Massachusetts, the responsibility line between Medicaid and the public mental health system is not clear and people are denied or delayed access to care.

For more information about NAMI's activities on this issue, please call Clarke Ross at 703/312-7894. All media representatives, please call NAMI's communications staff at 703/516-7963

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A Unique Opportunity to Integrate Behavioral Health Into the Person-Centered Medical Home

The Patient Protection & Affordable Care Act (PPACA) established a new **medical home pilot program** which allows states to enroll Medicaid beneficiaries with chronic conditions, which include serious and persistent mental illness and substance use disorders, into medical homes beginning in 2011. Health homes will be composed of a team of health professionals that will provide a comprehensive set of medical services, including care coordination.

What Does this Mean for States?

States that apply for and receive a State Plan Amendment (SPA) to operate this pilot program will receive a **90% federal match** (FMAP) for medical home services provided to beneficiaries through the pilot program.

The Patient-Centered Medical Home (PCMH) is an approach to care delivery that emphasizes appropriate care that is structured, delivered and coordinated around the specific needs of each patient. Given that patients bring their medical *and* mental health problems with them to *both* medical care and specialty behavioral health care, planned care for behavioral health must be articulated in the PCMH model in order to successfully address a patient's whole health.

Primary Care Services for Individuals Served in Behavioral Health Settings

People living with serious mental illnesses are dying 25 year earlier than the rest of the population, in large part due to unmanaged physical health conditions. In addition, many individuals served by the mental health system are not able to access primary care settings due to coverage issues, stigma, and the difficulties of fitting into the fast-paced visit model of primary care. Without careful consideration of how to assure access for and engagement of persons living with serious mental illnesses, this health disparities population may not benefit from the healthcare delivery system improvements that are being proposed for the general population.

> *"Efforts to provide everyone with a medical home will require the inclusion of mental health care if it is to succeed in improving care and reducing costs."*
> The Graham Center, American Academy of Family Physicians

What Does a Healthcare Home Look Like for People Living with Serious Mental Illness?

PCMH models that support partnerships between primary care and behavioral health providers must assure mission alignment and be deliberate about designing clinical mechanisms for collaboration, supported by structural and financial arrangements appropriate to their local environment. Ideally, the following six components will be available as part of the partnership. The first three should be in place at a minimum:

- Regular screening and registry tracking/outcome measurement at the time of psychiatric visits
- Medical nurse practitioners/ primary care physicians located in behavioral health
- Primary care supervising physician
- Embedded nurse care manager
- Evidence-based practices to improve the health status of the population with serious mental illnesses
- Wellness programs

Moving to person-centered healthcare homes forward will require thoughtful, deliberate and adaptive leadership at every level, across sectors that currently segment how people are served. Key questions to address include how the delivery of their care is organized, how communication among providers occurs, and how care is reimbursed.

Examples of Behavioral Health and Patient-Centered Medical Home Initiatives

The Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND) program is improving health care for people with depression and reducing costs because it changes the way the care is delivered and how it is paid for.

Washington State passed legislation to amend their state privacy law in support of communication and collaboration between primary and behavioral health providers.

California has a number of Primary Care, Mental Health, and Substance Use Services Integration Policy Initiatives exploring the legislative and regulatory opportunities and barriers.

Colorado's vision for medical home addressed the need for a team approach to coordinating mental, oral and physical health care.

Medical Home pilots in North Carolina are embedding community behavioral health staff in the Community Care Teams responsible for coordinating care.

For more information contact Laura Galbreath, Director of Health Integration and Wellness Promotion at LauraG@thenationalcouncil.org or 202-684-7457, x 231.

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