NAMD
National Association of Medicaid Directors

April 18, 2013

Chairman Tom Harkin
Committee on Health, Education, Labor and Pensions

Senator Lamar Alexander
Ranking Member
Committee on Health, Education, Labor and Pensions

Dear Chairman Harkin and Senator Alexander:

On behalf of the National Association of Medicaid Directors (NAMD), we are pleased to learn of Congress' commitment to improving the quality, scope and access to behavioral health services for individuals that have or are at risk of mental health disorders. This is a timely endeavor given national events as well as the forthcoming changes in Medicaid and other public and private health insurance coverage programs.

NAMD is a bipartisan, professional, nonprofit organization of representatives of state Medicaid agencies (including the District of Columbia and the territories). Our Association is committed to providing a focused, coordinated voice for the Medicaid program in national policy discussions and to effectively meeting the needs of its member states now and in the future.

States have a wealth of experience with developing systems and responding to challenges associated with providing timely, comprehensive screening and treatment for mental health illnesses. Amassed over many decades, their experience includes state-driven transformations to ensure that mental health systems incorporate both evidenced-based services and person-centered models of care.

As the single largest payer of behavioral health services, Medicaid has been a driver of care improvement efforts in many states. Therefore, Medicaid directors have a unique perspective to share, and, working through NAMD, we can inform congressional work on this topic. Included below, we address the following topics: areas where Medicaid is currently providing effective support for mental health services; programmatic and operational considerations as Congress seeks to advance legislation; and initial recommendations for improving the availability, coordination, and efficacy of mental health services.

The Medicaid Behavioral Health Landscape

The Medicaid program provides comprehensive coverage for behavioral and mental health services and covers over a quarter of the total expenditures for such services in the United States. In addition, states also ensure access to many supportive services that fall outside the traditional medical model. To optimize the health outcomes for individuals with severe conditions, states can and do tailor programs and services to meet a range of patient needs, for example by covering family support services, transportation assistance, supportive services in the home, respite care, and ongoing case management.

According to an analysis of the 2009 Medical Expenditure Panel Survey (MEPS) Household Component data issued by the Kaiser Family Foundation's Commission on the Uninsured, approximately nine in ten Medicaid beneficiaries with a mental illness reported that they had a usual source of care, versus six in ten uninsured low-income adults. States have carefully developed reimbursement methodologies and rates that support the needs of Medicaid beneficiaries. States also report that Medicaid reimbursement for mental health service providers is on par with or more generous than commercial payers.

Medicaid is currently an effective payer for a range of mental health services, but there are always opportunities for improvement in the scope, quality and delivery system mechanisms for mental health services. To ensure continued progress and improvement, federal policymakers must give thoughtful consideration to initiatives already underway in Medicaid and the broader health insurance market that will shape health care coverage and delivery and reimbursement models in the years ahead.

First, there are Medicaid-specific delivery system and payment innovations that are poised to strengthen the states' approach to behavioral health services as well as many other service areas. For example, a number of states are developing and implementing Medicaid "health home" initiatives that tailor the care model to a person's primary need, be it medical or behavioral, by allowing the individual to designate a primary provider. The designated provider (whether a primary care physician or behavioral health practitioner) leads a team of health care professionals and providers of support services to deliver a tailored care plan. This team-based approach facilitates care coordination between clinics, specialists, and other service providers so the whole person's care is taken into account, including their mental health needs and treatment. We believe these and similar state innovations hold tremendous promise for ensuring Medicaid enrollees are screened and receive appropriate treatment to address their behavioral health needs.

Issues for Consideration with Pending Legislation

There is an immediate need for a holistic approach to address deficiencies in the nation's mental health system and across the continuum of care for people with severe mental illness. Legislative efforts should be appropriately targeted to address identified shortcomings in public programs and support transformations that states already have underway. To this end, we urge Members of Congress to consider the following issues in your ongoing efforts to advance mental health related legislation:

- Payment methodologies. States are moving away from traditional Medicaid fee-for-service (FFS). For example, many are implementing new approaches to service delivery and payment in Medicaid, including health homes, bundled payments, managed care, and accountable care organizations (ACOs). These models have been designed with input from providers, beneficiaries and other key stakeholders. Yet Medicaid is still required to reimburse federally qualified health centers (FQHCs) on a per-visit basis based on cost. As a result, a number of states are encountering barriers to incorporating FQHCs in these care improvement initiatives because of the statutory Medicaid payment methodology known as the prospective payment system (PPS).

  States are working closely with community behavioral health centers on integrated physical and mental health care models and other new Medicaid delivery and payment initiatives. We believe that establishing a PPS payment methodology for federally qualified community behavioral health centers (FQCBHCs) would not align with the next generation of Medicaid payment and delivery systems states are pursuing. Further, implementing a new FQCBHC PPS would disrupt the promising new initiatives states already have underway.

- Medicaid provider entitlements. Requirements to contract with specific provider types have proved challenging for state Medicaid programs to operationalize, particularly when their payment methodology is mandatory. These requirements, commonly referred to as "any-willing-provider" laws, can restrict the ability of states – and Medicaid managed care entities – to selectively contract with higher quality providers, undermine incentives for quality improvement and efficiency, and generally lead to increased aggregate costs for the federal and state governments. We urge federal policymakers not to implement a new entitlement to a specific type of mental health service provider. Doing so could create upward cost pressures on all insurers and payers, potentially with little or no improvement in quality of care.

- Inter-agency coordination. As Congress considers changes to mental health services programs, we urge you to consider the cross-cutting programmatic impact. For example, currently FQHCs are administered by the Department of Health and Human Services' Health Research and Services Administration (HRSA), but the FQHCs patients mix is increasingly enrolled in

the Medicaid program which is overseen by the Centers for Medicaid and CHIP Services (CMCS). States have found it extremely challenging to navigate these federal dynamics and, in turn, have difficulty aligning the federal and state goals for delivery and payment reforms.

Potential Solutions

Working through our Association, Medicaid directors are prepared to offer ongoing, constructive input so that Congress can advance policies that amplify the effective ways that Medicaid is delivering and paying for mental health services, and provide a glide-path for continued improvements. In addition, Medicaid directors support the elimination of a critical barrier for Medicaid programs and the beneficiaries—the exclusion policy for Institutions for Mental Disease (IMDs).

- IMD exclusion. We support immediate removal of the so-called IMD exclusion so that all states may create greater capacity in the mental health system and provide long-term care services for beneficiaries with mental illnesses on par with services provided to beneficiaries with physical health needs. The IMD exclusion prohibits federal Medicaid funds from being used to pay for the cost of medically necessary inpatient care provided to individuals 21 to 64 years of age who reside in IMDs. IMDs are inpatient facilities of more than 16 beds whose patient roster is more than 51 percent people with severe mental illness.

  The severely mentally ill usually are unable to obtain employment –and in turn do not have access to employer sponsored insurance. However, federal Medicaid policy, with some technical exceptions, prohibits states from covering long-term treatment for the mentally ill ages 21 to 64. This arcane federal payment exclusion policy has been in place since Medicaid was enacted in 1965 – a time when state and local psychiatric hospitals housed and funded care for the large numbers of persons with severe mental illness. The policy leaves adults with severe mental illness as the sole category for whose inpatient care Medicaid will not reimburse except under circumstances which narrowly limit choice, and likely compromise quality. Not only is this outdated policy discriminatory, it also impedes advancement of the federal and state government's policy priorities and preferred delivery system structures.

  The Medicaid Emergency Psychiatric Demonstration was a positive step that has allowed some states to test altered service delivery and financial models for funding high-quality, cost-effective community and hospital services appropriate for people with mental illness. For example, states have sought to increase community based mental health services, including transitional services, with the targeted impact of reducing inappropriate psychiatric boarding in emergency departments. Initial reports from the participating states indicate there are financial and programmatic successes to serving those individuals requiring behavioral health services in a less restrictive environment, including reducing lengthy emergency department

stays for people with mental illness; decreasing re-admission for psychiatric needs of persons served; increasing the overall quality of service delivery of persons served; and enhancing coordination of services with community mental health center providers.

Unfortunately, this demonstration effort is limited in scope and hampered by burdensome demonstration approval and reporting requirements. In addition to removing barriers to Medicaid reimbursement for IMD, we recommend that Congress amend the Money Follows the Person (MFP) to give states the authority to enroll individuals from IMD's into MFP – and other care coordination programs – and receive the MFP's enhanced match rate for their Medicaid eligible individuals.

- Continuity of mental health services. We also recommend that Congress examine the unique set of issues that will impact individuals with mental illness who transition between Medicaid and Qualified Health Plans (QHPs) offered through Exchanges. Medicaid is one of the largest payers for mental health services and offers a robust level of benefits. However, when a person transitions to a QHP, there may be a difference in the breadth of mental health services covered. Medicaid also may have a different network of mental health professionals and facilities as compared to a QHP's network. These issues present challenges as states try to facilitate continuity in the scope and type of care for low-income individuals, including those with mental and behavioral illnesses.

Medicaid directors are committed to increasing access to appropriate mental health care services and improving the quality of that care. Again, one of the most impactful steps Congress could take with regard to doing so for low income individuals with severe mental illness is to remove the Medicaid IMD exclusion. We stand ready to work with you on this and other proposals under consideration to address the mental health needs. Please contact Andrea Maresca, NAMD's Director of Federal Policy and Strategy, to discuss our recommendations and ways that we can continue to inform your work.

Sincerely,

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Cc: Members of the Senate Health, Education, Labor and Pensions Committee