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Strategic Financing

- **Strategic Financing Plan Defined**: A strategic financing plan, analyzes existing funding streams and structures from multiple sources including (federal, state, local, private) in different departments and includes a plan to realign, redirect ,and/or maximize entitlement funding.

- **What does it enable**
- It enables one to understand current structure, spending, and utilization patterns.
- It enables one to identify strategies to maximize federal revenue.
- It enables one to redirect, realign or coordinate various funding steams.
- It enables one to have different strategies for one or more fund sources.

The Total Population of Children, Youth and Families Who Currently Depend on Public Systems

Children/youth/families eligible for Medicaid.

Families who are not poor or uninsured but who exhaust their private insurance, often because they have a child with a serious emotional/behavioral challenge.

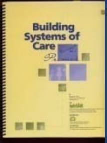
Families who are not poor or uninsured and who may not yet have exhausted their private insurance but who need a particular type of service not available through their private insurer and only available from the public sector.

Children/youth/families eligible for the State Children's Health Insurance Program (SCHIP)

Children/youth/families eligible for Tribal Authority funding.

Poor and uninsured children/youth/families who do not qualify for Medicaid or SCHIP.

Pires, S. (1997). *The total population of children and families who depend on public systems*. Washington, DC: Human Service Collaborative.



System of Care Functions Requiring Structure

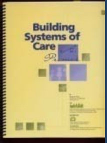
- Financing state, local, interdepartmental
- Purchasing/Contracting
- Provider Payment Rates
- Revenue Generation and Reinvestment
- Billing and Claims Processing
- Information Management
- Quality Improvement
- Evaluation
- System Exit
- Technical Assistance and Consultation

Pires, S. (2002). *Building Systems of Care: A Primer*. Washington, D.C.: Human Service Collaborative.

System of Care Functions Requiring Structure

- Decision Making and Oversight at the Service Delivery Level
  - Care Planning
  - Care Authorization
  - Care Monitoring and Review
- Care Management or Care Coordination
- Crisis Management at the Service Delivery and Systems Levels
- Utilization Management

Pires, S. (2002). *Building Systems of Care: A Primer*. Washington, D.C.: Human Service Collaborative.



Core Elements of an Effective System-Building Process

The Importance of Being Strategic

- A strategic mindset
- A shared vision based on common values and principles
- A clear population focus
- Shared outcomes
- Community mapping—understanding strengths and needs
- Understanding and changing traditional systems
- Understanding of the importance of “de facto” mental health providers (e.g., schools, primary care providers, day care providers, head start)
- Understanding of major financing streams
- Connection to related reform initiatives
- Clear goals, objectives, and benchmarks
- Trigger mechanisms—being opportunistic
- Opportunity for reflection
- Adequate time

Pires, S. (2002). *Building Systems of Care: A Primer.* Washington, D.C.: Human Service Collaborative

EXAMPLES OF BEHAVIORAL HEALTH FUNDING TO PURCHASE MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES

MEDICAID
Psychosocial Rehabilitation
Inpatient and Psychiatric Residential
EPSDT
1915(b) & (c) Waivers
Clinic Services

CHILD WELFARE
Federal Title IV-E (foster re/adoption)
Federal Title IV-B (CW services)
Federal Family Preservation
State General Fund
County Child Welfare General Fund

HEALTH
Medicaid/SCHIP
State General Fund
County General Fund
Substance Abuse Block Grant
Title V

MENTAL HEALTH
State Medicaid Match
State General Fund
County General Fund
Federal MH Block Grant

JUVENILE JUSTICE
State General Fund
Federal Grants
County General Fund

EDUCATION
State/County General Fund
Local General Fund
Federal Education Funds (Spec Ed)

OTHER
County General Fund
City General Fund
Federal, state or local grant funds
Foundation Revenue

Financing For Whom?
Financing for What?

✓ Population(s) of focus

✓ Agreed on underlying values and intended outcomes

✓ Cost out your system of care

✓ Identified services/supports, EBP's or Wraparound to achieve the outcomes

✓ Identified how services/supports will be organized (so that all key stakeholders can draw the system design)

✓ Identified the administrative/system infrastructure needed to support the delivery system

Pires, S. 2006. Human Service Collaborative. Washington, D.C.

Financing Strategies

IDENTIFY FINANCING STRUCTURES

Waivers using existing organizations

Care Management Entities (Milwaukee, Choices, Maryland, New Jersey)

Braiding, Blending, or Fund pools: Breaking the lock of agency ownership of funds

Fiscal Incentives: Rewarding community based services

REFINANCING

Generating new money by increasing federal claims

The commitment to reinvest funds for families and children

Medicaid (Title XIX), Foster Care and Adoption Assistance (Title IV-E)

REDEPLOYMENT

Using the money you already have

Shifting funds from residential or hospital care to community based care

Shifting from treatment to prevention

RAISING NEW FUNDS

New Targeted Taxes, Juvenile Justice millage or Millionaire Tax in California

State Options for Serving Individuals with Mental Disorders

- Establish Section 1915(c) waiver for children
- Establish Section 1915(c) waiver for adults
- Utilize Section 1915(i) to provide services to those with chronic mental illness
- Establish Section 1915(b) waiver for managed mental health care
- Examine Section 1915(a) authority for voluntary managed care contracts
- Explore the Benchmark Benefit for children/adults with mental disorders
- Utilize self-direction through the State plan, Section 1915(c) waivers, and/or Section 1915(i)
- Work with CMS to evaluate coverage options

Key State Plan Requirements

- States must follow the rules in the Act, the Code of Federal Regulations (generally 42 CFR), the State Medicaid Manual, and policies issued by CMS
- States must specify the "amount, duration, and scope" of each covered service
- States may not place limits on services or deny/reduce coverage due to a particular illness or condition
- Services must be *medically necessary*
- Generally, services must be available Statewide
- Freedom of choice of providers
- Provider qualifications
- Payment for services
- Reimbursement methodologies must include methods/procedures to assure payments are consistent with economy, efficiency, and quality of care principles

Medicaid State Plan Services

MANDATORY

- Physician services
- Laboratory & x-ray
- Inpatient hospital
- Outpatient hospital
- **EPSDT**
- Family planning
- Rural and federally-qualified health centers
- Nurse-midwife services
- Nursing Facility services for adults
- Home health

OPTIONAL

- Dental services
- Therapies – **PT/OT/Speech/Audiology**
- Prosthetic devices, glasses
- **Case management**
- **Clinic services**
- **Personal care, self-directed personal care**
- Hospice
- **ICF/MR**
- **PRTF for <21**
- **Rehabilitative services**
- **HCBS (1915 (c), 1915 (i)**

Mental Health -Medicaid Services

- Inpatient hospital services [other than those provided in an Institution for Mental Diseases (IMD)]
- Outpatient Hospital Services
- Physicians' Services
- Medical/Other remedial care furnished under State law, provided by other licensed practitioners
- Home Health Services
- Clinic Services
- Rehabilitative Services
- Services for individuals 65+ in IMDs
- Intermediate Care Facility Services for the mentally retarded /related conditions (ICFs/MR)
- Inpatient psychiatric facility services for individuals <22
- Case management services

Optional Rehabilitative Services

- Includes “any medical or remedial services provided in a facility, a home, or other setting…for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level”
- States use this section of the State plan to cover many services for individuals with mental disorders

Optional Case Management Services

- Covered under various sections of the Act: 1905(a)(19), 1915(g), 1915(c), 1915(b), 1915(i), 1115
- Defined as “services that will “assist individuals eligible under the State plan in gaining access to needed medical, social, educational and other services”
- Described in the Deficit Reduction Act of 2005 (DRA) to include: assessment, development of a care plan, referral/related activities, and monitoring/follow-up

Medicaid in Schools

Three federal laws have impacted Medicaid coverage provided in school settings:

- 1965 – the Early and Periodic Diagnostic, Screening, and Treatment Service (EPSDT)
- 1975 – The Education for All Handicapped Children Act (now the Individuals with Disabilities Education Improvement Act of 2004 (IDEA)
- 1988 – Section 1903(c) of the Act

The Early & Periodic Diagnostic, Screening, & Treatment Service

- Includes screening, vision, dental, and hearing services "as well as such other necessary health care....whether or not such services are covered under the State plan"
- Required for categorically needy children, optional for medically needy children (37 States)
- For children birth to age 21

Medicaid Eligibility

- Individuals must be in a “group” covered by the State’s Medicaid program
- Some groups are mandatory, others are optional
- Almost all groups include people who are:

- aged, blind, or disabled
- under 21
- pregnant
- parent/caretaker of a child

Basic Eligibility Requirements

- Financial
  - Income and resources

- Non-financial:
  - State resident
  - Citizen or qualified alien
  - Social Security Number
  - Assignment of rights to medical support & payment

Waivers

- Title XIX permits the Secretary of Health & Human Services - through CMS - to waive certain provisions required through the regular State plan process:

- Comparability (amount, duration, & scope)
- Statewideness
- Income and resource requirements
- Freedom of choice of all willing and qualified providers

Waiver Authorities Under the Act

- Section 1915(a) – voluntary contract with organization that agrees to provide care
- Section 1915(b) – managed care that restricts providers, selective contracting, locality as central broker, additional services generated through savings
- 1115 demonstrations – managed care, expand eligibility, impose cost-sharing, provide different benefits, budget neutral

Section 1915(c) of the Act

- Permits States to provide HCBS to people who would otherwise require Nursing Facility (NF), Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) or hospital Level of Care (LoC)
- Is the major tool for meeting rising demand for long-term services and supports
- Serves diverse target groups – including those with mental disorders
- Gradual addition of optional participant-direction of services

Managed Mental Health Care

Section 1915(b) waivers that cover mental health services:

- North Carolina
- Florida
- Michigan
- New Mexico
- Iowa
- Kansas
- Colorado
- Nebraska
- Utah
- California
- Washington

A federal team of reviewers including representatives from SAMHSA, the Health Resources and Services Administration, CMS, and OMB works together during the approval/renewal process

Section 1915(i) HCBS Optional State Plan

- **Homemaker**
- **Home Health Aide**
- **Personal Care**
- **Case management**
- **Adult Day Health**
- **Habilitation**
- **Respite Care**

For chronic mental illness:

- **Day Treatment/Partial Hospitalization**
- **Psychosocial Rehabilitation**
- **Clinic Services**

National Health Care (Structures)

H.R. 676-United States National Health Care (USNHC)

- Director appointed by the secretary, director of mental health, director of long term care, director of quality control
- Regional and State Directors
- National Board of Quality established
- All Americans will receive an application form no longer than 2 pages
- No deductibles, co-payments, co-insurance or other cost sharing shall be imposed with respect to covered benefits

National Health Care (Structure)

- Must be a public or not for profit institution
- Private physicians, clinics and private health care providers shall continue to operate as private entities but are prohibited from being investor owned.
- Non-profit HMO’s may participate
- Other HMO’s that principally contract for services by non-employees shall be classified as insurance plans and shall not be participating providers
- Regional payments to states
- Must meet state quality and licensing guidelines

National Health Care (Structure)

- Regional offices with regional directors having regional budgets
- USBNHC trust fund made up of existing funds form Medicare, Medicaid, SCHIP and new taxes.
  - Increasing personal income tax on the top 5 % income earners.
  - Modest and progressive excise tax on payroll and self employment income
  - Small tax on stock and bond transactions
  - Reduce paperwork,
  - Bulk procurement of medications
  - Improved access to preventive care

Services

- Primary care and prevention
- Inpatient
- Outpatient
- Emergency
- Prescription drugs
- Durable medical equipment
- Long-term care
- Palliative care
- Mental Health services
- Full scope of dental services
- Substance abuse services
- Chiropractic services
- Basic vision
- Hearing services
- Podiatric

Mental Health Services H.R. 676

- "Medically necessary mental health care on the same basis as other coverage for other conditions" In other words Parity
- "Favoring community based care, shall cover supportive residences, occupational therapy, and ongoing mental health and counseling services outside the hospital for patients with serious mental illness. In all cases the highest quality and most effective care shall be delivered, and for some individuals, this may mean institutional care."

National Health Care

- Electronic patient record
- National Board of universal quality and access
  - Health care professionals
  - Institutional providers of health care
  - Advocacy groups
  - Labor Unions
  - Citizen patient advocates
- Supports public health and prevention
- Reduction in health disparities a priority

Changes to expect

- Coverage Expansion YEEEEEEEEEEEES
- Workforce Shortages YEEEEEEEEEEEES
- What will happen to all of the pots of money currently being used for mental health services for children in juvenile justice, child welfare, education and other systems. (This money could go away) Noooooooooooooo
- What about funding for underfunded states Medicare, Medicaid, SCHIP. ???????????????

Boundary Issues

- Who will treat individuals with mild MH/SA problems?
- Will Medical Homes, prevention, early intervention and care management strategies prevent the need for more intensive services?
- Who will serve the individuals with moderate and severe conditions?
- Who will serve individuals involved with juvenile justice, child welfare**? Is it time to build that system of care?**
- What will happen to this funding?
- What will happen to school based mental health care for children?

Boundary Issues

- The organization that can manage deep end services will become the organization of most value to the payer and the community. Do this for one or more systems.
- Child welfare and juvenile justice will want deep end psychiatric residential treatment provided for their children.
- Will care management entities will become a valuable entity to states?
- Will the responsibility for managing the care become the responsibility of the local mental health agency in some states?
- Who has a full array of specialty services will be able to keep children out of institutions

Boundary Issues

- How will mental health link with health care in your state?
- Will their be mental health carve outs?
- Will this be used as a time to integrate health care and mental health care, carve ins?
- How will fee for service fair? Will it finally go away?

Preparing for the future at a Federal level

- Financial modeling
- System models or service delivery redesign
- Benefit designs
- Payment reform

Preparing for the future

- Who will be doing your financial modeling?
  - Demand-Capacity, Medicaid, Medicare, Child Welfare, Juvenile Justice, Education.
- Who will be on your states health and mental health design team? What are the staff resources? Who are the staff resources? How can you become a resource?
- What assessments may need to be done ahead of time to prepare to make your case for the children?
- What data will you need to build your case?
- What will the structure look like? How will mental health fit within the health care structure and vice versa?

Preparing for the future

- Building partnerships across systems, CW, JJ, ED.
- Making sure you are on certain committees
- Building structures (care management entities to blend funding and manage out of home care)
- State level structures will effect the local level structures

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