Financing Strategies for Expanding Systems of Care and Implications of Health Reform

Sheila A. Pires
Human Service Collaborative
Washington, D.C.

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Rockville, MD
Financing for Whom???

Financing for What???
Categorical System Reforms

Non-Categorical Reforms

System of Care Approach

Children with Behavioral Health Challenges

Prevalence/Utilization Triangle

More complex needs

Less complex needs

2 - 5%

15%

80%

Intensive Services – 60% of $$

Home & community services; early intervention–35% of $$

Prevention and Universal Health Promotion – 5% of $$

What should public purchasers be interested in financing and for which populations of children and youth?
Policy Pressures on State Purchasers of Behavioral Health Care

**National Pressures**
- Affordable Care Act (Health Reform)
- Systems of Care
- Evidence-Based/Promising Practices

**State Pressures**
- Budget Deficits
Focus of Patient Protection and Affordable Care Act

- Expand coverage and access

- Improve quality, efficiency, and cost of care especially for populations with chronic conditions
Affordable Care Act Opportunities and Challenges

*Renewed interest in:*
- Managing care for populations with chronic conditions
- Intensive care coordination models
- Managing the total cost of care
- Moving dollars from “deep end” to home and community based
- Evidence-informed approaches
- Data-informed approaches
- Use of technology
- Managed care and Medicaid re-design
Focus of Systems of Care

Care that is coordinated across multiple systems and providers and is:

- Family driven and youth guided
- Home and community based
- Strengths-based and individualized
- Culturally and linguistically competent
- Connected to natural helping networks
- Data-driven, quality and outcomes oriented

Resonance with health reform values
Types of Services and Supports in Systems of Care

**Behavioral Health**
- Behavior management
- Crisis intervention
- Day treatment
- Evaluation
- Family assessment
- Family preservation
- Family therapy
- Group therapy
- Individual therapy
- Parenting/family skills training
- Substance abuse therapy, individual and group
- Special therapy

**Placement**
- Acute hospitalization
- Foster care
- Therapeutic foster care
- Group home care
- Relative placement
- Residential treatment
- Shelter care
- Crisis residential
- Supported independent living

**Psychiatric**
- Assessment
- Medication follow-up/psychiatric review
- Nursing services

**Mentor**
- Community case management/case aide
- Clinical mentor
- Educational mentor
- Life coach/independent living skills mentor
- Parent and family mentor
- Recreational/social mentor
- Supported work environment
- Tutor
- Community supervision

**Respite**
- Crisis respite
- Planned respite
- Residential respite

**Service Coordination**
- Case management
- Service coordination
- Intensive case management

**Other**
- Camp
- Team meeting
- Consultation with other professionals
- Guardian ad litem
- Transportation
- Interpretive services

**Discretionary**
- Activities
- Automobile repair
- Childcare/supervision
- Clothing
- Educational expenses
- Furnishings/appliances
- Housing (rent, security deposits)
- Medical
- Monitoring equipment
- Paid roommate
- Supplies/groceries
- Utilities
- Incentive money

2005 CHIOCES, Inc., Indianapolis, IN
Arizona Medicaid Benefit (1115 Waiver)

In addition to traditional services, covers:

- Behavior management and behavior aide
- Respite care
- Transportation
- Living skills and health promotion
- Peer support (family and youth)
- Family education
- Supported employment
- Health promotion
- Therapeutic foster care (not room and board)
- Crisis intervention services
Where Families, Youth, and Family and Youth Organizations Fit Into the Service Array

<table>
<thead>
<tr>
<th>As technical assistance providers &amp; consultants</th>
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<tbody>
<tr>
<td>- Training</td>
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<tr>
<td>- Evaluation</td>
</tr>
<tr>
<td>- Research</td>
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<tr>
<td>- Support</td>
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<tr>
<td>- Outreach/Dissemination</td>
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<tr>
<td>- Quality Improvement</td>
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<table>
<thead>
<tr>
<th>As direct service providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Family Liaisons and Peer Mentors</td>
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<tr>
<td>- Care Coordinators</td>
</tr>
<tr>
<td>- Family Educators</td>
</tr>
<tr>
<td>- Specific Program Managers (respite, etc.)</td>
</tr>
<tr>
<td>- Youth Peer Mentors</td>
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</table>

Arizona Medicaid System (1115 Waiver)

*Created new category of provider – Community Service Agency*

Non traditional providers that are not licensed as a behavioral health provider but are certified by the state to provide:

- Peer support
- Respite
- Family education
- Living skills training
- Behavior management
- Transportation
- Supported employment
- Health promotion

Example: Family Involvement Center, Maricopa County
Aligning Incentives Across Agencies

Child Welfare
Alternative to out-of-home care
high costs/poor outcomes

Medicaid
Alternative to IP/ER/PRTF; multiple psychotropic meds

Juvenile Justice
Alternative to detention-
high cost/poor outcomes

Education
Alternative to out-of-school placements, high special ed. costs

System Re-Design

Focus of Evidence-Based Practices and Promising Approaches

**Evidence-based Practices**
Show evidence of effectiveness through carefully controlled scientific studies, including random clinical trials

**Promising Approaches (or Practice-Based Evidence)**
Show evidence of effectiveness through experience of key stakeholders (e.g., families, youth, providers, administrators,) and outcomes data
Effectiveness Research
(Barbara Burns’ et. al. Research at Duke University)

• Most evidence of effectiveness: Intensive case management, in-home services, therapeutic foster care

• Less evidence (because not much research done): Crisis services, respite, mentoring, family education and support

• Least evidence (and lots of research): Inpatient, residential treatment, therapeutic group home

Examples of What You’d Want to Finance Based on Effectiveness Literature

Outpatient Models:
• Cognitive Behavior Therapy (various models)
• Functional Family Therapy (FFT)
• Parent Child Interaction Therapy (PCIT)

Intensive In-Home Models:
• Multisystemic Therapy (MST)

Out-of-Home Model:
• Multidimensional Treatment Foster Care

• Intensive Care Management

• Prevention
Positive Behavioral Supports and Interventions (PBIS)
Examples of Other Home and Community-Based Services You’d Want to Finance Based on Practice/Family Experience and Outcomes Data

• Intensive in-home services (not just MST)
• Respite services
• Mobile response and stabilization services
• Mental health consultation services
• Independent living skills and supports
• Family/youth education and peer support
• Wraparound service planning approaches (with fidelity)
• Telebehavioral health
Examples of What You Don’t See Listed as Evidence-Based Practice (though they may be standard practice)

- Traditional office-based “talk” therapy
- Residential treatment
- Group homes
- Day treatment

Growing Conclusion by State, Tribal, and Local Purchasers (especially in a time of deficits)

Redirect spending from out-of-home placements with high costs and/or poor outcomes to effective home- and community-based services and supports in a system of care

Implications for How RTCs are Utilized

• Movement away from “placement” orientation and long lengths of stay
• Residential as part of an integrated continuum, connected to community
• Shared decision making with families/youth and other providers and agencies
• Individualized treatment approaches through a child and family team process
• Trauma-informed care

For more information, go to Building Bridges Initiative: www.buildingbridges4youth.org
Frustrating Reality

The financing has not caught up with the intentions of the Affordable Care Act, or systems of care, or evidence-based/promising practices …

There are pockets of innovation poised (we hope not precariously) for spread
# Financing Strategies and Structures

**FIRST PRINCIPLE: System Design Drives Financing**

<table>
<thead>
<tr>
<th>REDIRECTION</th>
<th>REFINANCING</th>
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<tbody>
<tr>
<td>Using the money we already have</td>
<td>Generating new money by increasing federal claims</td>
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<tr>
<td>The cost of doing nothing</td>
<td>The commitment to reinvest funds for families and children</td>
</tr>
<tr>
<td>Shifting funds from treatment to early intervention and prevention</td>
<td>Foster Care and Adoption Assistance (Title IV-E)</td>
</tr>
<tr>
<td>Moving across fiscal years</td>
<td>Medicaid (Title XIX)</td>
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<thead>
<tr>
<th>RAISING OTHER REVENUE TO SUPPORT FAMILIES AND CHILDREN</th>
<th>FINANCING STRUCTURES THAT SUPPORT GOALS</th>
</tr>
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<tbody>
<tr>
<td>Donations</td>
<td>Seamless services: Financial claiming invisible to families</td>
</tr>
<tr>
<td>Special taxes and taxing districts for children</td>
<td>Funding pools: Breaking the lock of agency ownership of funds</td>
</tr>
<tr>
<td>Fees and third party collections</td>
<td>Flexible dollars: Removing the barriers to meeting the unique needs of families</td>
</tr>
<tr>
<td>Trust funds</td>
<td>Incentives: Rewarding good practice</td>
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Examples of Refinancing

**States of New Jersey, Arizona, Massachusetts, Hawaii (others)**
Expanded array of covered services to include home and community based

**Milwaukee County, Wisconsin**
Schools and child welfare contributed $450,000 each to expand mobile response and stabilization services (prevent placement disruptions in child welfare, prevent school expulsions)
Is a Medicaid-billable service; contributions from schools and child welfare generate $180,000 to the school contribution and $200,000 to child welfare’s in Federal Medicaid match dollars

**Cuyahoga County, Ohio**
Cross-walked wraparound skill sets to Medicaid billing categories
Raising New Revenue

- Prop 63 in California (1% income tax on millionaires)
- Spokane County, Washington – 0.1% sales tax for mental health
- Jackson County, Kansas – 1.3% per $100 property tax for mental health
- Florida counties – children’s trust funds
Where are State and county purchasers spending resources on high costs and/or poor outcomes?

- Residential Treatment?
- Group Homes?
- Detention?
- Hospital admissions/re-admissions?
- Too long stays in therapeutic foster care?
- Inappropriate psychotropic drug use?
- “Cookie-cutter” psychiatric and psychological evaluations?
- Alternative school placements?
Example of Redirection & Blended Funds

Wraparound Milwaukee

11.0M

CHILD WELFARE
Funds thru Case Rate
(Budget for Institutional Care for Children w/CHIPS)

11.5M

JUVENILE JUSTICE
(Funds budgeted for Residential Treatment for Youth w/Delinquency)

16.0M

MEDICAID CAPITATION
($1557 per month per enrollee)

8.5M

MENTAL HEALTH
• Crisis Billing
• Block Grant
• HMO Commercial Insurance

Per Participant Case Rates from CW, JJ and ED range from about $2000 pcpm to $4300 pcpm

SCHOOLS
youth at risk for alternative placements

Wraparound Milwaukee County BHO
Care Management Organization

$47M

Intensive Care Coordination

Individualized Child and Family Team

Families United $440,000

Provider Network
210 Providers
70 Services

Mobile Response & Stabilization co-funded by schools, child welfare, Medicaid & mental health

Plan of Care
Example of Redirection, Early Intervention, and Braided Funds

*Cuyahoga County, OH*

**County ASO:**
Management Entity

**Neighborhood Collaboratives & Lead Provider Agency**
Care Coordination Partnerships

**Child/family teams**

**Community providers and natural helping networks**

**SOC Funders Group**
Chaired by Deputy County Administrator for Human Services

- Family & Children First $$
- Family & System Team $$
- Residential Treatment Center $$$$ 
- Therapeutic Foster Care $$$
- “Unruly”/shelter care $
- Tapestry $$
- Strengthening Communities for Youth $$

**State Early Intervention & Family Preservation**
- System of care grants

**Care Coordination Bundled Rate:**
$1602 per child per mo. - Medicaid
New Jersey System of Care

**Department of Children and Families**
**Division of Child Behavioral Health Services**

**Contracted Systems Administrator (ASO) - PerformCare**

- **Family Support Organizations**
  - Family peer support, education and advocacy
  - Youth movement

- **Care Management Organizations**

**Provider Network**

- **Family peer support, education and advocacy**
- **Youth movement**

**Care Management Organizations**

**UMDNJ Training & TA Institute**

- **BH, CW, MA $$ - Single Payor**
  - No waiver

**Dept. of Human Services**
**Div. of Medical Ass’t.**

- **1-800 number**
- **Screening**
- **Utilization management**
- **Outcomes tracking**

Any licensed DCF provider and Medicaid providers

Lead non profit agencies managing high utilizing child/youth populations; care coordination rate of about $1100 per child per month
NJ System of Care Funding Streams

- State appropriations:
  - Mental Health
  - Child Welfare
  - Medicaid

- Federal revenue sources
  - Medicaid/SCHIP
New Jersey System of Care

Federal Funding Mechanics

- Rehab Option: In-home Services, EBPs, Mobile Response, Group Homes/Therapeutic Foster Care
- TCM: Care Management, Youth Case Management
- Cost Allocation Plan: Family Support, Administrative Services Contract, State Services
Maryland System of Care

Children’s Cabinet

- DOE
- DHMH
- DHR
- DJS

ASO

Regional Care Management Entities

- Contracted private non profit agencies managing care for children/youth with multisystem, complex challenges, e.g. Medicaid PRTF, DHR group home, DJS detention diversion

State Governance Entity

University of Maryland Innovations Institute

Maryland Coalition of Families

- Child and family team
- Intensive care management
- Utilization management
- Develop broad provider network
- Monitor outcomes
- Link families and youth to peer support
Maryland System of Care

Summary of Funds Supporting CMEs

Maryland has blended a variety of funding sources to support the CMEs:

<table>
<thead>
<tr>
<th>Source</th>
<th>Services and Supports Financed</th>
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<tbody>
<tr>
<td>GOC (Children's Cabinet)</td>
<td>- General funds budgeted for RTC youth</td>
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<tr>
<td></td>
<td>- Rehab option funds available when Maryland chose to use Medicaid to pay for group home</td>
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<tr>
<td></td>
<td>health care</td>
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<tr>
<td>Federal Medicaid</td>
<td>- Match for Public Mental Health System services and PRTF Waiver services</td>
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<tr>
<td></td>
<td>- Match for administrative funding for care coordination</td>
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<tr>
<td>Title IV-E</td>
<td>Federal matching funds for placement cost for eligible youth</td>
</tr>
<tr>
<td>Dept. of Human Resources</td>
<td>Child Welfare general fund share of placement cost</td>
</tr>
<tr>
<td>Dept. of Juvenile Services</td>
<td>Juvenile Justice general funds share of placement cost</td>
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<tr>
<td>System of Care Grants</td>
<td>Federal funds awarded to Maryland to carry out specific proposed projects</td>
</tr>
</tbody>
</table>
Louisiana System of Care

- Interagency Governance Body
- 1915 b and c waivers
  - Medicaid, Behavioral Health and Child Welfare dollars
  - Statewide Management Organization (ASO)
    - Magellan
  - Regional Care Management Organizations
  - Family Support Organizations

Private, nonprofit orgs managing care for children with complex needs
Regional Care Management Entities

- Ensure Child & Family Team Plan of Care; High quality wraparound
- Ensure Intensive Care Coordination
- Link to peer supports and natural helpers
- Manage utilization, quality and outcomes at service level

Georgia Care Management Entities: Locus of Management Accountability for Children with Complex, Multisystem Needs

Use Same Decision Support Tool to determine need for CME

Examples of Outcomes

**Wraparound Milwaukee**

- Reduction in placement disruption rate in child welfare from 65% to 30%
- School attendance for child welfare-involved children improved from 71% days attended to 86% days attended
- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- Decrease in average daily population in residential treatment centers from 375 to 50
- Reduction in psychiatric inpatient days from 5,000 days per year to less than 200
- Average monthly cost of $4,200 (compared to $7,200 for RTC, $6,000 for juvenile detention, $18,000 for psychiatric hospitalization)

Milwaukee County Bureau of Children’s Behavioral Health. 2010

**New Jersey**

- Estimates the state has saved $30m in psychiatric inpatient expenditures alone over last three years
  Hancock, B. NJ Division of Child Behavioral Health. 2010

**Maine**

- Experienced 30% net reductions in Medicaid spending, comprised of decreases in PRTF and inpatient psychiatric with increases in targeted case management and home and community services
  Bruns, E. 2011
Care Management Entity (CME) Model

- An organizational entity that serves as the “locus of accountability” for defined populations of youth with complex challenges and their families who are involved in multiple systems.

- Is accountable for improving the quality, outcomes and cost of care for populations historically experiencing high-costs and/or poor outcomes.

www.chcs.org
Populations Served by CMEs

- Children and adolescents with serious emotional and behavioral challenges at risk of out-of-home placement in residential treatment, group homes, and other institutional settings

- Youth at risk of incarceration or placement in juvenile correctional facilities

- Children in child welfare

- Children and adolescents returning from institutional placements in residential treatment, correctional facilities, or other out-of-home settings

- Children and adolescents at risk of or returning from psychiatric inpatient settings

- Detention diversion and alternatives to formal court processing for juveniles

- Other populations (e.g., youth at risk for alternative school placements)
Care Management Entity Functions

At the Service Level:
- Child and family team facilitation using a wraparound practice model
- Screening, assessment, clinical oversight
- Intensive care coordination
- Care monitoring and review
- Peer support partners
- Access to mobile crisis supports

At the Administrative Level:
- Information management – real time data; web-based IT
- Provider network recruitment and management (including natural supports)
- Utilization management
- Continuous quality improvement; outcomes monitoring
- Training

Care Management Entity Financing Mechanisms

- Use of Multiple Funding Streams
- Blended or Braided Funding
- Use of Case Rates
Potential of Care Management Entity as Health Home

- Comprehensive care management
- Care coordination and health/mental health promotion
- Transition care across multiple settings
- Individual and family support services
- Linkage to social supports and community resources

Focus on improving the quality and cost of care for populations with –
- Co-occurring chronic conditions
- Serious behavioral health challenges, including children
- At risk

For more information, go to www.chcs.org, Child Health Quality Program, CHIPRA Care Management Entity Quality Collaborative
Medicaid Re-Design Caveats

*Our experience has been that* –

- When adult and child behavioral health dollars are integrated, there is a risk of child behavioral health dollars being absorbed by adult services.

- When physical and behavioral health dollars are integrated, there is a risk of behavioral health dollars being absorbed by physical health services.

*Especially in the absence of strong contractual performance measures and monitoring mechanisms.*
Integration of Physical and Behavioral Health Care

Health Care Reform Tracking Project Findings*
for children with serious behavioral health challenges –

- Better coordination of care in behavioral health carve outs
- Access to a broader array of behavioral health services and to extended care in carve outs
- More customization in carve outs (e.g., risk adjusted rates, intensive care management, wraparound approaches, interagency coordination)
- Greater family involvement, use of peer supports, contracts with family-run organizations in carve outs
- Requirements for reinvestment back into behavioral health

*A series of publications and issue briefs published by the Health Care Reform Tracking Project can be found at: http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm.
Integration of Physical and Behavioral Health Care

Health Care Reform Tracking Project Findings*

➢ Coordination between physical and behavioral health occurs when it is paid attention to *at the practice level*, not because physical and behavioral health dollars are combined in an “integrated” financing design

*A series of publications and issue briefs published by the Health Care Reform Tracking Project can be found at: http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm.*
Medicaid Re-Design Caveats

- Examples are lacking of states that have fully integrated all Medicaid adult and child physical and behavioral health dollars for all Medicaid populations (e.g., TANF, SSI and Foster Care) in a capitated managed care arrangement .... So can’t learn much from other states

- Are examples of states that have integrated child physical and behavioral health Medicaid dollars *with a partial behavioral health carve out* for children with serious behavioral health challenges
Example: Hawaii (1115 waiver)

Use of:

- Integrated physical/behavioral health managed care with a partial behavioral health carve out for high need children

- Partnership with school-based behavioral health services and HMOs for early intervention, short-term services

- Family organizations

- University partnership
Hawaii System of Care

Dept. of Health
Child & Adolescent
MH Division

Dept. of Human
Services
Med-Quest Div.

HMOs

1115 waiver

Dept. gets bundled per child per month rate from Medicaid

Children with more intensive needs*

In-house EBP Committee & Partnership with U of Hawaii

Hawaii Families
As Allies

Youth Council

Family Guidance Centers-public entities

Contracted Providers

Dept. of Education
School-Based Mental
Health Services

Children with less intensive needs

* Determined by standardized tool (CASII)

Hawaii System of Care
Delaware System of Care (1115 Waiver)

Dept. of Health and Soc. Svcs. Division of Medicaid and Medical Ass’t.

HMOs

Dept. of Services for Children, Youth and Their Families Division of Child Mental Health Services

Children with more intensive needs

In-house training and EBP development

1115 waiver

OP benefit financial equivalent of 30 OP visits

Contracted Provider Agencies

Clinical Services Management Teams Public entities

Children with less intensive needs

Department gets bundled per child per month rate from Medicaid
Summary of Financing Characteristics of Innovative Behavioral Health Systems for Children and Families

✓ Maximize Medicaid (e.g., flexible Rehab Option)
✓ Blend, braid, or intentionally coordinate funding streams across systems
✓ Re-direct spending from high cost and/or poor outcome services to effective practices
✓ Manage dollars through managed care arrangements that are tied to values and goals
✓ Risk adjust payment for complex populations of children (e.g., risk-adjusted capitation rates to MCOs; case rates to providers)
✓ Finance locus of accountability – e.g., care management entities for most complex, cross-system
✓ Finance family and youth partnerships at policy, management and service levels
✓ Finance training, capacity building, quality and outcomes monitoring
Financing for the Future Requires:

- Models of care, payment mechanisms and services/supports that improve the quality and cost of care

- Educating Medicaid and commercial insurers to the quality and cost/benefit implications of home- and community-based effective practices

- Educating Medicaid to the need for customizing aspects of the delivery system and payment structure for children with serious behavioral health challenges

- Building relationships with managed care organizations, especially those with Medicaid portfolios

- Incorporating new relationships with primary care providers (e.g., consultation models, care management entities)
Financing for the Future Requires:

✔ Getting involved in planning and implementation of health reform
  • Health exchanges
  • Health homes
  • Accountable Care Organizations (ACOs)
  • Medicaid changes (e.g., managed care designs, benefit parameters)
  • Grant opportunities
For further information, contact:

Sheila A. Pires
Human Service Collaborative
sapires@aol.com
Financing Strategies for Expanding Systems of Care and Implications of Health Reform

Jim Wotring, Director

National Technical Assistance Center for Children’s Mental Health, Georgetown University
What to Expect From the Affordable Care Act

America has 50.7 million uninsured people. How will the Act affect this?

• Coverage for an additional 41 million people:
  - 16 million through CHIP and Medicaid expansions
  - 25 million through Health Exchanges

Congressional Budget Office, 2010
What to Expect From the Affordable Care Act

• Increased access to a broad range of mental health, addiction, and disability-specific services for the 1 in 5 Americans that live with a mental illness and the 1 -3% that live with an intellectual disability.

• More affordable health insurance coverage for individuals and families with incomes up to 400% of poverty (up to $43,320 for individuals and $88,200 for a family of four) and for small businesses.
General Provisions of the Affordable Care Act
Provisions of the Act Are Already Helping Families

Starting 2010:

• Temporary High Risk Pools.

• No more denials of insurance for children under age 19 because of pre-existing conditions. Extends to adults January 1, 2014.

• Coverage for young adults to age 26 on parents’ insurance policies.
Maternal, Infant, and Early Childhood Home Visiting Programs

• Grants to start Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Programs.

• “…help at-risk families voluntarily receive home visits from nurses and social workers to improve maternal and child health, child development, school readiness, economic self-sufficiency, and child abuse prevention.” (HHS, September 2011)

• $88 million awarded in 2010 and $225 million in 2011 to 49 states, DC, and 5 U.S. territories.
Provisions in the Affordable Care Act

Starting 2014:

• Young adults previously in foster care will qualify for Medicaid to age 25.

• Full implementation of the prohibitions of annual and lifetime limits on covered benefits in health plans.
Health Insurance Exchanges
Health Insurance Exchanges

• An Exchange is a single place where an array of qualified health insurance plans are available for purchase by individuals and businesses.

• It is run by a governmental agency, state government/non-profit partnership, or nonprofit entity. Exchanges must be in place by January 1, 2014.

• Exchanges must include both plans offered to individuals and a Small Business Health Options Program (SHOP).
Health Insurance Exchanges

• Exchanges also will enroll individuals in CHIP, Medicaid, and Basic Health Plans.

• States can choose to establish an Exchange or default operations to the federal government.

• States have wide discretion in setting the standards, requirements, and rates for plans offered in the Exchange and for monitoring plans to ensure quality and hold down costs.
Health Insurance Exchanges
Time Line

2011:
HHS Secretary will likely establish “benchmark” standards for health plans offered in Exchanges. Institute of Medicine Report is out for review.

By 2013:

• States can choose to establish an Exchange or default operations to the federal government.

• HHS Secretary will determine if a state will not have an operational Exchange by 2014.
Health Insurance Exchanges

Eligibility for Participation in Exchanges:

• U.S. citizens, legal immigrants, and individuals not incarcerated with incomes up to 400% of the Federal Poverty Level.

• Small businesses.

• After 2017, large employers can participate in Exchanges.
Health Insurance Exchanges

Easy Access:

• “Express Lane Eligibility” allows individuals to apply for and enroll in Medicaid, CHIP, Basic Health Program, or Exchange plans using a single application form.

Assistance in Enrolling:

• Exchanges are required to have mechanisms to assist individuals in filling out the applications and getting into the correct plan.
Health Insurance Exchanges

• Exchange Health Plan Benefits Packages must offer essential benefits, including **rehabilitative and habilitative services**, and allow for additional mental health and addiction services.

• Exchanges will offer plans with different levels of benefits, deductibles, and co-pays.
Health Insurance Exchanges
Basic Health Program

• A significant proportion of the low-income population can be expected to experience income fluctuations over a year and move back and forth between Medicaid and a state Exchange, including 50% (approximately 28 million adults) of new enrollees over a 12-month time period.
  • Sommers and Rosenbaum, February 2011.

• This will be administratively problematic for states and disruptive for families requiring extensive behavioral health services.
Medicaid and CHIP
Medicaid and CHIP

Why Is This Expansion Important For Behavioral Health and Developmental Disability Agencies?

• Expansion of Medicaid to 133% of poverty and increased CHIP coverage to about 6.5 million additional children is estimated to increase enrollment in the programs by 33% by 2019.

• Medicaid and CHIP expansion will account for the second largest reduction in uninsured populations, behind the Health Exchanges.

• Large numbers of uninsured individuals, estimated at around 20%, have mental health or substance use problems. Kaiser Family Foundation, 2009.
Medicaid

Why Is This Expansion Important For Behavioral Health and Developmental Disability Agencies?

• Federal Medical Assistance Percentage (FMAP) for new eligible populations (incomes of 100% – 133% of poverty) increases:
  – 2014, 15, and 16  100%
  – 2017  95%
  – 2018  94%
  – 2019  93%
  – 2020 and beyond  90%

• States can reduce their general fund costs for serving newly eligible populations.
CHIP

Starting 2010:
• States must maintain current eligibility levels for CHIP through September 2019.

Starting 2013:
• States will receive a 23% increase in the CHIP match rate through 2019.

Opportunity:
This will create a significant amount of state general funds savings that could be used to fund other behavioral health services.
Medicaid 1915(i)

Starting 2010:

• 1915(i) State Plan Amendment (SPA): States can amend their State Plans to offer Home and Community-Based Services as State Plan option benefits.

• Income eligibility is up to 150% of federal poverty level or 300% of the maximum SSI payment.

• States can do one plan amendment with several target populations:
Examples of the Population of Focus

• States can do one plan amendment with several target populations:
  – Child or young adult in need of supportive services for activities of daily living (ADL) because he/she is not functioning in home, school, or community and is at eminent risk of removal from their home (risk factor). Age can be specified e.g. 0-3.
  – Adult in need of supportive services for ADL because he/she is not functioning in the community and is at risk of psychiatric hospitalization (risk factor).
Medicaid 1915(i)

• States must provide services statewide.

• States must serve all children who meet their CMS approved 1915(i) population definition.

• However, states may identify a very specific population in order to limit costs.

• The 1915(i) SPA may be phased in over a five-year period, allowing states time for providers to develop new, flexible, home- and community-based services, and time to secure the necessary financing.
Medicaid 1915(i)

- Children no longer must meet the criteria for institutional care to receive “waiver-type” services like respite or wraparound facilitation that are part of the state’s 1915(i) SPA.

- States are not required to demonstrate “cost neutrality” for 1915(i) services.
Money Follows the Person

• This initiative encourages states to reduce their reliance on institutional care while developing individualized, community-based, long-term care alternatives.

• Eligible children must have stayed in a PRTF, inpatient psychiatric unit, or state psychiatric hospital for at least 90 consecutive days.
Money Follows the Person, continued

Starting 2010:

• $2.25 billion in grants to extend the Money Follows the Person (MFP) Rebalancing Demonstration to more states.

• Under the MFP Demonstration, states will receive an enhanced Federal Medical Assistance Percentage (FMAP) for a one-year period for each individual they transition from an institution to a qualified home- and community-based program.

• The extension of the MFP Demonstration program goes through 2016.
Medicaid Health Homes

Starting January 1, 2011

• States can choose to enroll Medicaid beneficiaries with chronic conditions into a Health Home through a State Plan Option.

• Health Homes can be established in community behavioral health or developmental disability organizations.

• Funded by increased FMAP - 90% for certain services for two years.
Medicaid Health Homes

- Required Health Home services reimbursed at 90% Federal FMAP are:
  - Comprehensive care management;
  - Care coordination;
  - Health promotion;
  - Comprehensive transitional care from inpatient to other settings;
  - Individual and family support;
  - Referral to community and social support services; and
  - Use of health information technology, as feasible and appropriate.
Medicaid Health Homes

- Waives comparability 1902(a)(10)(B).
- Waives statewideness 1902(a)(1).
- Medicaid eligible individuals must have:
  - two or more chronic conditions;
  - one condition and the risk of developing another;
  - or at least one serious and persistent mental health condition.

- The chronic conditions listed in statute include: a mental health condition, a substance abuse disorder, asthma, diabetes, heart disease, and being overweight (as evidenced by a BMI of > 25).
Citations and Resources

This presentation utilized the following organization web-sites:

• Government Health Care Website

• National Council for Community Behavioral Healthcare
  www.TheNationalCouncil.org

• The Arc
  www.thearc.org

• The Kaiser Family Foundation
  www.kff.org

• The Robert Wood Johnson Foundation/George Washington University
  www.healthreformgps.org

• The Bazelon Center for Mental Health Law
  www.bazelon.org

• The Federal Centers for Medicare and Medicaid
  www.cms.gov
Jim Wotring

jrw59@georgetown.edu

202-687-5052