

Medicaid and Other Strategies for Financing Mental Health Services

NTAC Training and Technical
Assistance Workshop – Western
Regional

Albuquerque, NM

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Today's Primer

- Emphasis on Medicaid – Title XIX/XXI of the Social Security Act
- Making yourself financially smarter
- Examples of preliminary work done in other states
- Proposed Technical Assistance Activities

CMS – what are they looking for?

- Background: Centers for Medicare and Medicaid Services (CMS) – What they repeatedly say....
 - 50 states with 50 State Plans and amendments
 - More than 20 operating authorities
 - Several funding authorities including State Plan, HCBS Waivers, R&D Waivers, grant programs, 1115, 1915, a, b, & c
 - Always watch for new regulations, such as targeted case management
 - States should contact CMS to discuss what they want and then negotiate how to accomplish goals using combinations of existing authorities

CMS – what are they looking for?

- Services must
 - Promote quality of care
 - Be cost effective
 - Be Accessible
- States must
 - Be accountable for federal funds
 - Have auditing capabilities
 - Purchase what works, not what doesn't work

How States can respond...

- We all say the same thing, but where is the evidence?
- Whether you are a carve in or carve out, are in full or partial control of costs, *make yourself and your agency financially smarter.*
- If you are new, don't act like it, know your financial position
- Every state is different, yet every state has a State Medicaid Plan, a FMAP rate, and all money is green

How States can respond...

- What is in your state's long and short term financial strategy for financing mental health and addictions services?....Do you have one?
- Listen to your financial people
- At a minimum, respond with actual and projected cost data by population, fund type, and unit cost
- Although not a popular statement, work within CMS's limitations

Recent Focus on Medicaid Financing

- NASMHPD/NRI Revenue and Expenditure Reports
- CMHS/NTAC Funding Peer Reviews – Maine, Oklahoma, Virginia, July 2005 – September 2006
- Behavioral Health Policy Collaborative, Inc. and the Technical Assistance Collaborative Service and System Review – Louisiana, April 2006
- New Mexico – T-SIG State
- Experience from Arizona
- CMHS Strategies for Financing and Organization of Mental Health Services – August and October 2006
- Annual T-SIG Grantee Meeting – Financing Roundtable – November 2006

Financing Mental Health Services – how does your state measure up?

- NASMHPD/NRI Revenue and Expenditures Report
- NASMHPD/NRI State Profiles Report
- Understand which comparisons are important and what they mean
- Your state is unique, but why?

State Profile Highlights

Information from the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

No. 96-91

August 2006



FY 2004 Revenue and Expenditure Study Results

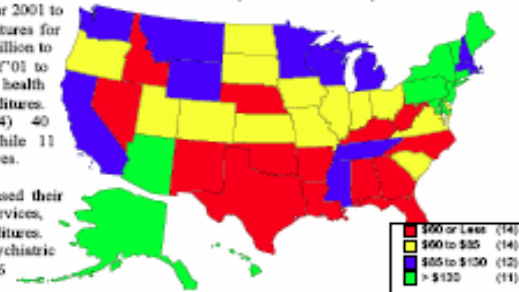
MAJOR FINDINGS:

- State Mental Health Agencies (SMHAs) expended over \$27.1 billion on mental health services in Fiscal Year 2004, an increase of 3.1% over Fiscal Year 2003.
- Adjusted for inflation, 28 SMHAs experienced a decline in expenditures from FY'01 to FY'04.
- SMHAs received most of their revenues (83%) from state and local government taxes.
- Medicaid funding represented the largest source of increases, rising over 8.5% per year between FY'01 and FY'04.
- Community mental health expenditures increased by 7.7% per year since FY'01, and now represent over 69% of total SMHA expenditures.

Preliminary Results Based on 50 States and D.C. Reporting

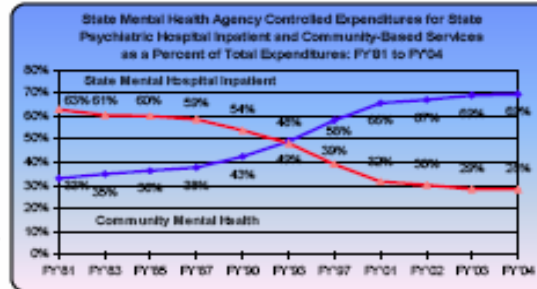
FY'04 Per Capita Mental Health Expenditures

FY'01 to FY'04 Change: From Fiscal Year 2001 to Fiscal Year 2004, SMHA-controlled expenditures for mental health services increased from \$23.1 billion to \$27.2 billion, an increase of 18%. From FY'01 to FY'04, 42 SMHAs increased mental health expenditures, while 9 decreased their expenditures. Over the last year, (from FY'03 to FY'04) 40 SMHAs increased their total expenditures, while 11 states decreased their mental health expenditures.



From FY'01 to FY'04, 45 SMHAs increased their expenditures on community mental health services, while 6 SMHAs decreased these expenditures. Fewer SMHAs, 35 increased their psychiatric inpatient hospital expenditures, while 16 decreased their expenditures.

There is a continued shift from spending on state psychiatric hospitals to community-based services. From FY'01 to FY'04, community mental health expenditures increased 24.8% while state psychiatric hospital expenditures increased only 5.5%. Community-mental health expenditures accounted for 69% of total SMHA-controlled expenditures and state psychiatric hospital expenditures were 28%. This is a major shift from FY'81, when Community-mental health expenditures accounted for 33% of SMHA expenditures and state psychiatric hospitals were 63% of expenditures.



The SMHA Profile System was developed by the NASMHPD Research Institute, Inc., under contract No. 200-99-0502 from the Substance Abuse and Mental Health Services Administration/Center for Mental Health Services (CMHS)/Division of State and Community Systems Development/Survey and Analysis Branch. Cited reproductions, comments and suggestions are encouraged. Please contact Ted Lattimore (ext.121) with any questions or concerns.

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Take a look at this data on the web at www.nri-inc.org

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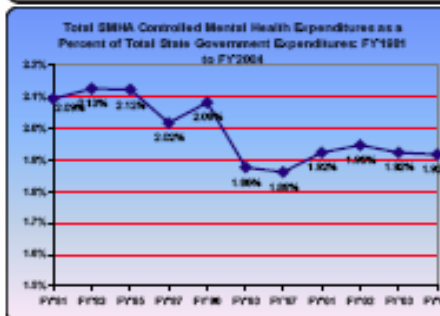
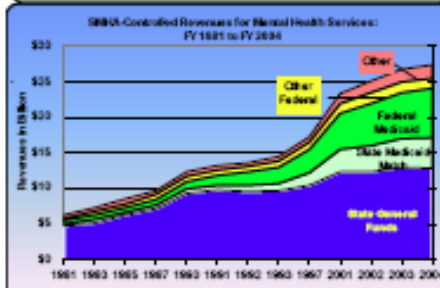
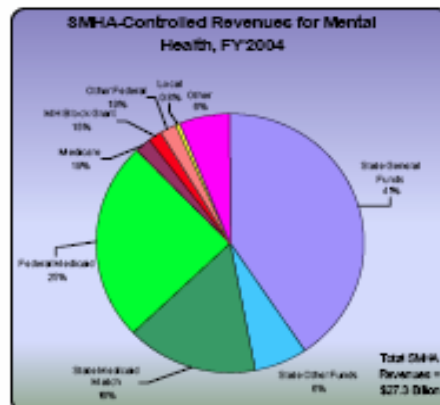
State Tax Dollars Remain the Major Source of Funding of SMHAs:

In FY'04, 63% of SMHA funding came from state government sources. This is a slight decline from 67% in FY'01. In FY'04, state tax dollars accounted for \$17.1 billion of funding for SMHA mental health services. These funding sources included State General and Special funds of over \$12.8 billion, and state Medicaid match of almost \$4.3 billion. The federal government was the second largest funder of SMHA services, with FY'04 dollars totaling \$8.36 billion (31% of total SMHA funding). The majority of federal revenues came from Medicaid (\$6.9 billion), followed by Other Federal Funds (\$1.53 billion), Medicare (\$51 billion), and the Community Mental Health Block Grant (\$41 billion). Local and other funds contributed the remaining \$1.9 billion of funds expended by SMHAs. Total Medicaid funds (State Match and Federal Share) received by SMHA-funded programs represented \$11.2 billion (41%) of SMHA resources.

FY 01 to FY 04 Revenue Trends: During the Fiscal Years 2001 to 2004 state governments were undergoing major budget shortages and total state government spending slowed greatly. During this time period, total SMHA-controlled health revenues for mental health services increased by 5.6% per year from FY'01 to FY'04. Medicaid funding (federal and state match) increased 9.5% per year to \$11.2 billion, representing a slower increase than the prior decade (FY'90 to FY'01 increased an average of 16% per year.) Still, Medicaid funding represented the largest source of new funds and came during a period of major state budget shortages. From FY'01 to FY'04, 65% of new SMHA funds came from Medicaid. Only 19% of new SMHA funds came from State General Revenues to the SMHA.

SMHA-Controlled Mental Health Spending and Total State Government Expenditures:

Over the last two decades, total state government expenditures for all purposes have grown at a faster rate than SMHA-controlled expenditures. According to the U.S. Census Bureau, in FY'81, State governments expended \$291.5 billion of which 2.09% were for mental health services that SMHAs controlled. Twenty-three years later, SMHA-controlled expenditures for mental health were 1.92% of total state government expenditures. If SMHAs had received, in FY'04, the same percentage of total state expenditures, their expenditures would be \$2.2 billion, or over 8% higher than reported FY'04. However, for the last 14 years, SMHA expenditures as a share of total state government expenditures have increased slightly. This growth is largely due to the increase in Medicaid used for mental health. State general fund expenditures for mental health have increased slower than state general fund expenditures for other state services over this time period.



Electronic copies of *Funding Sources and Expenditures of State Mental Health Agencies, 2004* will soon be available via the NRI's website at www.nri-inc.org. Printed copies will also be available for a small charge. July 2006

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CMHS/NTAC Funded Peer Reviews

- States request Peer Review through NTAC, team is assembled and focus areas are identified. There is always a financial component.
- Maine
 - Moving towards managed care for primarily Medicaid and some non-Medicaid funding
 - Recommendations included immediate steps to prepare claims data for rate setting processes, hiring actuary

CMHS/NTAC Funded Peer Reviews

- Oklahoma
 - Changing responsibility for determination assessments for persons with a serious mental illness to ODMHSAS from Medicaid agency
 - Recommendations included changes to statutes for claims payment lag, new financial monitoring requirements for the state and providers
 - As a sidebar...State has presented the costs associated with untreated behavioral health and domestic violence on the budget. Has recommended health care calculators for estimating behavioral health costs

CMHS/NTAC Funded Peer Reviews

- Virginia
 - Services provided through Community Service Boards (local)
 - Medicaid is one of many payors—none are > 50%
 - State received more than \$194 million to lead transformation efforts
 - Recommendations included development of CSB (provider) financial reporting that would track transformation appropriations at the provider level

Behavioral Health Policy Collaborative - Services and System Review

- Louisiana Governor's Executive Order
- Recommendations:
 - Develop a financial strategy that includes:
 - 1) cost neutral component
 - 2) growth and expansion strategy
 - Analyze current expenditures MH and SU across all state agencies, all funding sources
 - Develop matrices that clearly display eligibility segments, provider types, service codes, and funding sources

Behavioral Health Policy Collaborative

- Services and System Review

- Develop, implement, and bill for new Medicaid services that meet the State Medicaid plan for eligible populations; for example, residential treatment for children
- Develop, implement, and bill for new Medicaid services that do not meet the State Medicaid plan; for example, EPSDT services for children
- Prepared short, mid, and long term implementation timeframes

T-SIG New Mexico

- Purchasing Collaborative makes many of its decision in public, including financial decisions.
- Transformation includes new services to be covered under Medicaid, alignment with other agency definitions, rates, and licensing.

Arizona's Covered Services Project

- Contracted with qualified, respected consultants who knew Medicaid in Arizona and nationally
- Prepared for eligibility expansion, lawsuit compliance
- Aligned and modified eligibility, service codes, service definitions, provider types, licensing, certification, training and funding mix
- Developed new fee schedule: Used both a top down and bottom up approach to analyzing costs, including analysis of administrative costs, national labor data, no-show and training allowances for per unit rates. Selected rates continue to be reviewed each year

Arizona's Covered Services Project - Results

- Added peer support and family support, living skills, foster care treatment (now home care training to client), respite care, and more
- Produced HIPAA compliant transaction set changes and DSM/ICD 9 crosswalk
- Room and board rates adopted by child welfare
- Provider and MBHO contracts changed and aligned with state objectives and reporting requirements
- Received additional funding based on credible data analysis and complete understanding of financial information

CMHS Strategies for Financing and Organizing Mental Health Services

- Generated more than 50 recommendations
- Focused on what CMHS, but also states can do.
- Six approaches to reveal the “mysteries” of financing
 - Making the case for investment
 - Responding to the need for accountability
 - Identifying opportunities for CMHS concerning Medicaid policies
 - Developing an inventory of resources
 - Identifying models for financing and organization
 - Filling the need for basic information
- Contact Diane Abbate (240) 276-1824 for a copy of the report

Annual Transformation State Incentive Grantee Meeting

- Request from T-SIG states
- Conducted a roundtable discussion
- State's really wanted to know:
 - What is working in other states?
 - How to work with CMS and the state's Medicaid agency?
 - How do states effectively use Medicaid, Medicare, MHBG, State GR, DSH, and other funds?
 - How do states fund wellness, prevention and other early intervention strategies through Medicaid?

Technical Assistance – A Beginning

- Develop clear statement (expression) of what the state mental health authority wants to accomplish
- Gather background materials –
 - Medicaid waivers, state plan coverage, including population, services and limitations, and state plan amendments. Is there a State Medicaid in Brief paper?
 - Budget and expenditure history for Medicaid and non-Medicaid funding, preferably for 5 years
 - Copies of regular and ad hoc financial reports with detailed descriptions of information in each report

Technical Assistance – A Beginning

- Conduct focused interviews
 - Medicaid policy office and financial staff
 - Mental health and addictions policy office and financial staff
 - State budget office, other state agencies or other government financial stakeholder, if necessary
 - Consumers and family members

Technical Assistance – A Beginning

- Examples of questions
 - Has there been a CMS, state, or internal audit of mental health expenditures and oversight? Does your state have a corrective action plan to address the findings? How can this be used to strengthen the need for additional funding?
 - What is your state's staffing capacity to conduct systematic financial oversight and review?

Technical Assistance – A Beginning

- Data collection. What are the sources of data collection? Are the sources monitored? Is the data valid? How does your state know?
- Provider contracts and contract requirements. What financial information is required? Is it accurate and is it audited?
- What do your state's payors want to purchase?

Technical Assistance – A Beginning

Questions?

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