

Maryland's Public Mental Health System (PMHS)

Medicaid – Financing Mental Health Transformation A Collaborative Approach

Brian Hepburn, M.D.

December 2007

Public Mental Health System Pre-1997 Disadvantages

- Two funding streams – confusing and less flexible for individualized approach to care
- Lack of freedom of consumer choice
- Limited access to services – Services limited to clinics in ‘catchment areas’.

Public Mental Health System Post 1997 – Advantages

- In FY 1998, under Maryland's 1115 Medicaid Waiver, the Department's Mental Hygiene Administration redesigned the public mental health system (PMHS) under managed care.
- This provided the creation of a one-tiered funding system for mental health services, and increased access to mental health services and increased consumer choice.

Post 1997 *(continued)*

- Provider network increased – private practitioners as well as outpatient mental health centers now part of the PMHS.
- Maryland has focused much effort on a consumer-centered or consumer-driven service system, and has emphasized the development of employment opportunities, affordable housing and consumer-operated support programs.
- Service provision continues to be directed toward the recovery model with increased emphasizes in evidenced-based and best practices.

1115 MA Waiver (Carve- Out)

How we did it

- Working with stakeholders
- Working with Medicaid in general, and now on a daily basis.
- Equal Partners– PMHS is considered “Medicaid” for mental health

Public Mental Health System Oversight Authority

- The Mental Hygiene Administration (MHA) has overall responsibility for the oversight of the delivery of public mental health services in Maryland, which includes community programs and ten (10) State psychiatric facilities.
- MHA, in collaboration with the local mental health authorities, known as Core Service Agencies (CSAs), has responsibility for local planning and monitoring of services, manage the system.

Management Structure of PMHS

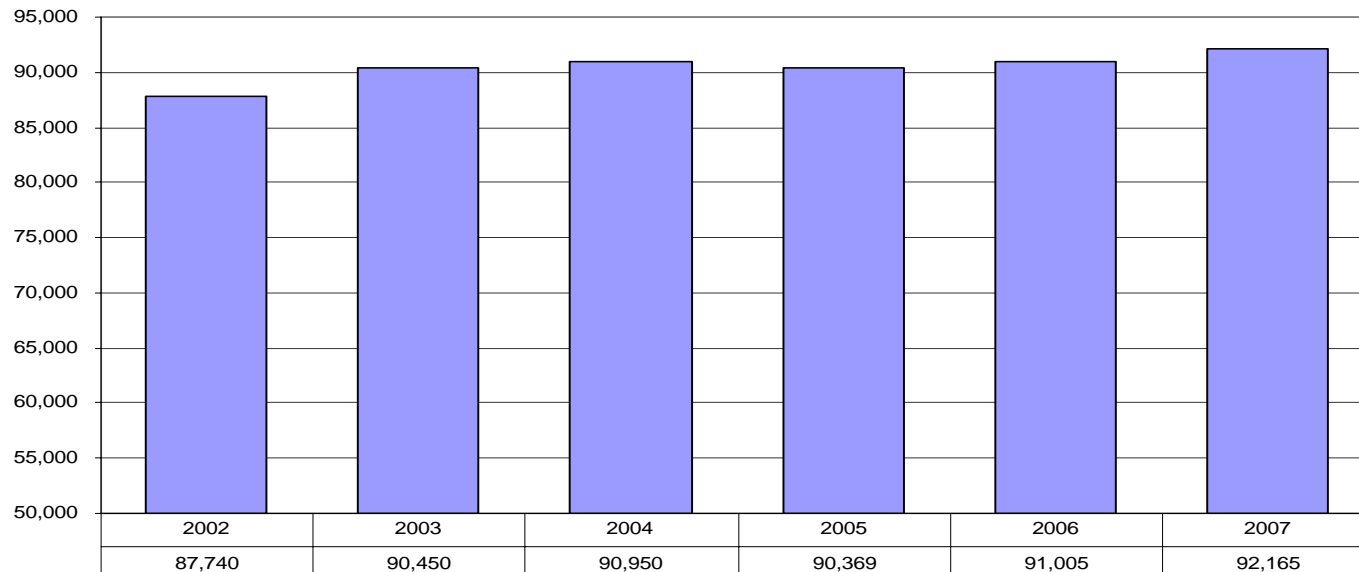
- MHA and the CSAs are assisted in managing the PMHS by an Administrative Services Organization (ASO), which operates under contract with MHA.
- The ASO authorizes services, processes claims, provides utilization management, evaluation services, and is responsible for data management, which includes compilation and analysis of statistical information in furthering systems improvement.

Individuals Served: Medicaid Recipient

(uninsured) Non-Medicaid Eligible

- **The PMHS' provision of services is based on medical necessity criteria. MHA funds community mental health services for Medicaid (MA) eligible individuals.**
- **MHA funds services to individuals who, because of the severity of their illness and their financial needs, are qualified to receive state subsidized services (uninsured individuals).**

Maryland Public Mental Health System Consumers Served



3.1% increase from 2002 to 2003
0.6% increase from 2003 to 2004
-0.6% decrease from 2004 to 2005
0.7% increase from 2005 to 2006
1.3% increase from 2006 to 2007

Note: Based on claims data through 9/30/2007

Includes Baltimore Capitation

FY 2003 PRP and RRP services for the Uninsured were provided through grants and not included in this data.

Payment of Medicaid claims for Medicare/Medicaid eligible individuals were assumed by the Maryland Medical Assistance Program beginning 7/1/2003.

These expenditures/consumers are not included beginning FY 2004.

Institutes of Mental Disease (IMD)

- The IMD exclusion waiver began in 1997, and had increased access for adults between 21 and 64 who need acute psychiatric care.
- The IMD exclusion waiver allowed individuals with acute episodes of mental illness to receive Medicaid-covered treatment in IMDs rather than general acute hospitals.
- FY 06, the IMD rate was \$650 and HSCRC rate \$1,050.
- Average length of stay (ALOS) in general acute facilities is 6 days; ALOS is 9 days in IMDs.
- CMS does not want to continue IMD waivers because standing policy has been to hold states accountable for inpatient treatment of mental illness.
- CMS phased out & subsequently discontinued the use of IMDs by FY '07.

Results of the Loss of IMD

- Increased costs to the State and to Federal Government.
 - More individuals with MA will be treated in acute care hospitals, which are more expensive.
 - More consumers will be treated in State hospitals.

CMS PROPOSED AMENDMENT TO MEDICAID PROGRAM – COVERAGE FOR REHABILITATIVE SERVICES

- CMS proposed use of “restorative services” and the regulations overall definition of rehabilitation.
- CMS definition of “reasonable expectation of improvement.”
- CMS requirement of “measurable reduction of disability.”

Results of Implementation of Proposed Changes to MA Rehab Option

- It will create barriers to the recovery process for persons currently receiving rehabilitation services.
- It will reduce the number of individuals eligible for rehabilitation services.
- It will make it more difficult for individuals to live in the community.
- It will increase the number of individuals in State hospitals.