# Mental Health Revenue Maximization

*A DHS Report to the Legislature*

**January 1999**

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Estimated cost of preparing this report:

| | |
|---|---|
| Staff time | $ 1,500 |
| Consultants | $ 2,028 |
| Printing and distribution | $ 400 |
| Total | $ 3,928 |

# Mental Health Revenue Maximization: A DHS Report to the Legislature

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## Summary

Laws of 1998 require the Department of Human Services to report to the Legislature regarding ways to maximize federal funding for mental health services. Under federal law, Minnesota can obtain a federal match of about 52% for all services that meet federal Medicaid requirements. **Minnesota has not utilized Medicaid for community mental health services as much as other states, including Wisconsin, Iowa, North Dakota and South Dakota.**

In preparing this report, the Department consulted with stakeholders, including representatives of state and county government, private and state-operated mental health providers, mental health consumers, family members, and advocates. The Department also consulted with a number of other states and with national experts.

**We found a general consensus among stakeholders and consultants that the following principles should apply to all mental health revenue maximization proposals:**

- The services to be funded must be in keeping with the guiding principles in the Mental Health Acts, which emphasize client-centered services, provided in the least restrictive setting as close to the person's home community as possible. A key goal is to assist individuals to become as self-sufficient as possible..
- If new federal funding is accessed, it should be used for additional and improved community-based mental health services, including compliance with federal requirements regarding quality assurance and statewide access.
- Clear standards and effective monitoring procedures must be developed to assure accountability and quality services.

**For both children and adults, there is a great need for supportive services that would promote self-sufficiency by assisting families and adults before problems build to a level that requires more intensive intervention.**

**The "rehab option" is an optional service under Medicaid that states can use to cover a broad range of services which help restore people with disabilities to their best possible functional level.** For adult mental health, Minnesota now uses the "rehab option" for day treatment, and that service is limited to a narrow, clinical definition. Legislative amendments in 1998 made adult day treatment somewhat more flexible, but it is still quite limited. For children's mental health, Minnesota uses the "rehab option" for a broader range of non-residential services, but utilization has been limited due to restrictive definitions and requirements in state rules. These requirements were originally imposed partly due to concerns about controlling costs. However, it appears that partly due to these restrictions, actual use of these services has been far less than had been predicted.

**Minnesota could obtain about $13 million per year in additional federal Medicaid funding for community mental health services. To obtain that funding, Minnesota would need to design the coverage in a way that would meet federal requirements.** The services would have to be available statewide in comparable amount, duration and scope. Recipients would have to have access to any qualified provider that chooses to enroll in the program. Services would have to be available under the same conditions throughout the state.

**Additional federal funding (beyond the amounts indicated above) could be obtained if Minnesota expanded Medicaid coverage for residential mental health services. This is not recommended for further consideration this year due to concerns that expanded Medicaid residential coverage could be an incentive for more restrictive, less appropriate placements.**

In the 1998 Session, the Department proposed legislation to simplify Medicaid funding for mental health case management services and obtain about $4 million in additional federal funding for that service, without any growth in state funding. The legislation passed, with a compromise that provides for growth in state funding based on increases in county caseloads. **The Department supports the 1998 case management legislation and is proceeding with the administrative work necessary to implement that legislation by 7/1/99 as required by law.**

**This report presents pros and cons of the following options for expanding Medicaid mental health rehabilitative services:**

Adults: Option 1. Continue on the current course with limited MA coverage under day treatment only.
Option 2. Implement expanded MA rehab option including:

- Community support services, specifically medication monitoring and independent living skills training
- Crisis services, such as mobile crisis response teams and crisis services in adult foster care settings.

Children: Option 1. Continue to implement current MA coverage of children's mental health services without legislative changes.
Option 2. Implement expanded MA rehab option including:

- Establish reimbursement mechanisms for mobile and short term crisis intervention services delivered in multiple settings.
- Expand the range of providers that counties and children's mental health collaboratives may contract with to provide services.
- Expand family community support services to include the services of "behavioral aide," which is a trained paraprofessional working to achieve care plan goals.
- Broaden the allowable location of service delivery in a way that better supports the delivery of therapeutic services in settings like pre-schools and summer camps.

**Any Medicaid changes that expand coverage beyond current state laws and rules will require matching funds roughly equivalent to any new federal funds.** The report analyzes pros and cons of the following options:

Option 1. New state funding;

Option 2. Transfer funds from existing state grants for adult and family community support services.

## Authorizing Legislation

*Laws of 1998, Chapter 407, Art. 4, Sec. 62:[MENTAL HEALTH REPORT.]*

*(a) By December 1, 1998, the commissioner of human services shall report to the legislature on recommendations to maximize federal funding for mental health services for children and adults. In developing the recommendations, the commissioner shall seek advice from a children's and adults' mental health services stakeholders advisory group including representatives of state and county government, private and state-operated mental health providers, mental health consumers, family members, and advocates.*

*(b) The report shall include a proposal developed in conjunction with the counties that does not shift caseload growth to counties after July 1, 1999, and recommendations on whether the state should directly participate in medical assistance mental health case management by funding a portion of the nonfederal share of Medicaid.*

In recent years, the Department's key initiatives affecting mental health services, such as the Adult Mental Health Initiatives, the Children's Mental Health Collaboratives and the Demonstration Projects for People with Disabilities, have focussed on system redesign and more efficient use of existing funds. However, as described later in this report, it is apparent that overall funding is still far less than what is needed to fully implement Minnesota's Comprehensive Mental Health Act and meet the mental health needs of Minnesota's children and adults. One way to make progress toward that goal that has been successful in other states is expanded Medicaid coverage. Under federal law, Minnesota can obtain a federal match of about 51.5% for all services that meet federal Medicaid requirements. Minnesota has not utilized Medicaid for community mental health services as much as some other states. In particular, it is the "rehab option" under federal law that Minnesota has used much less than other states, including Wisconsin, Iowa, North Dakota and South Dakota.

The Minnesota Medicaid program is called Medical Assistance (MA). Medicaid is a federal program under which each state administers its own program, based on a state plan approved by the federal government.

## Process to Develop This Report

The Department used the following process to develop this report:

- A staff work group representing all of the major program areas in DHS met during the summer of 1998 to determine whether mental health revenue maximization efforts would affect other populations and how mental health efforts could be coordinated with revenue maximization efforts for other populations.

- An advisory group was appointed regarding mental health revenue maximization, including representatives of the stakeholder groups listed in the authorizing legislation. See Appendix A for list of members.

- The advisory group regarding mental health revenue maximization met six times during July through November 1998, with extensive discussion and information sharing. Copies of the minutes are

available upon request.

- DHS consulted with leading national experts, including Colette Croze, Carl Valentine and the Bazelon Center for Mental Health Law.

- DHS consulted with states that are recognized as leaders in utilization of Medicaid for mental health services. See Appendix C for a summary of the information from these states.

**Note that the authorizing legislation requires a report from the Department of Human Services. This report includes information and discussion from the advisory group and others, but is not intended to represent the views of the advisory group.**

## General Issues Relating to Both Children's and Adult Mental Health Revenues

This section of the report presents information regarding issues that affect revenue maximization for both children's and adult mental health services. Subsequent sections address issues that are specific to children or adults.

### Guiding Principles for Mental Health Service Design

The Minnesota Comprehensive Adult Mental Health Act (M.S. 245.461) provides the following guiding principles for service system design:

*Subd. 2. Mission statement. The commissioner shall create and ensure a unified, accountable, comprehensive adult mental health service system that:*

*(1) recognizes the right of adults with mental illness to control their own lives as fully as possible;*
*(2) promotes the independence and safety of adults with mental illness;*
*(3) reduces chronicity of mental illness;*
*(4) eliminates abuse of adults with mental illness;*
*(5) provides services designed to:*
*(I) increase the level of functioning of adults with mental illness or restore them to a previously held higher level of functioning;*
*(ii) stabilize adults with mental illness;*
*(iii) prevent the development and deepening of mental illness;*
*(iv) support and assist adults in resolving mental health problems that impede their functioning;*
*(v) promote higher and more satisfying levels of emotional functioning; and*
*(vi) promote sound mental health; and*
*(6) provides a quality of service that is effective, efficient, appropriate, and consistent with contemporary professional standards in the field of mental health.*

*Subd. 4. Housing mission statement. The commissioner shall ensure that the housing services provided as part of a comprehensive mental health service system:*
*(1) allow all persons with mental illness to live in stable, affordable housing, in settings that maximize community integration and opportunities for acceptance;*

*(2) allow persons with mental illness to actively participate in the selection of their housing from those living environments available to the general public; and*
*(3) provide necessary support regardless of where persons with mental illness choose to live.*

The Minnesota Comprehensive Children's Mental Health Act (M.S. 245.487) provides similar principles:

*Subd. 3. Mission of children's mental health service system. As part of the comprehensive children's mental health system established under sections 245.487 to 245.4888, the commissioner of human services shall create and ensure a unified, accountable, comprehensive children's mental health service system that is consistent with the provision of public social services for children as specified in section 256F.01 and that:*

*(1) identifies children who are eligible for mental health services;*
*(2) makes preventive services available to all children;*
*(3) assures access to a continuum of services that:*
*(I) educate the community about the mental health needs of children;*
*(ii) address the unique physical, emotional, social, and educational needs of children;*
*(iii) are coordinated with the range of social and human services provided to children and their families by the departments of children, families, and learning, human services, health, and corrections;*
*(iv) are appropriate to the developmental needs of children; and*
*(v) are sensitive to cultural differences and special needs;*
*(4) includes early screening and prompt intervention to:*
*(I) identify and treat the mental health needs of children in the least restrictive setting appropriate to their needs; and*
*(ii) prevent further deterioration;*
*(5) provides mental health services to children and their families in the context in which the children live and go to school;*
*(6) addresses the unique problems of paying for mental health services for children, including:*
*(I) access to private insurance coverage; and*
*(ii) public funding;*
*(7) includes the child and the child's family in planning the child's program of mental health services, unless clinically inappropriate to the child's needs; and*
*(8) when necessary, assures a smooth transition from mental health services appropriate for a child to mental health services needed by a person who is at least 18 years of age.*

Although it is already more than ten years since most of the above legislation was passed, there is still general consensus among stakeholders that these are appropriate principles to follow in making any major changes to the mental health service system. We have strived to keep these principles in mind in developing this report.

## Does Funding Affect Service Design?

It is tempting to think of revenue maximization simply in terms of financing and how much additional federal revenue can be obtained. However, under a fee-for-service payment system, any change in Medicaid service coverage will clearly affect service design.

In Minnesota, most Medicaid funding for people with disabilities is still paid on a fee-for-service basis. Experience has shown that, in general, fee-for-service funding creates an incentive to provide the services that are covered. Services which are not covered, regardless of effectiveness, tend to not be provided unless a different funding source is available.

Many of the services being considered for possible Medicaid funding are now funded in limited amounts through state appropriations and local taxes, usually under the control of the local county board of commissioners. If these services are shifted to Medicaid, a number of new requirements will have to be met. Certain key federal requirements that apply to Medicaid, but do not apply to current state and federal funding for these services, include:

- **Comparability** -- services will have to be available in comparable amount, duration and scope to all MA recipients who demonstrate a medical need. This means that counties would not be able to maintain waiting lists, or limit coverage to "available funding.".

- **Free choice of vendor** -- recipients must have access to any qualified provider that chooses to enroll in the program.

- **Statewide administration** -- states must administer Medicaid services under equitable standards throughout the state.

Appendix B provides more information regarding these federal requirements. It is possible to obtain waivers of some of these requirements, but the waivers usually require a year or more to obtain, and require that the alternatives to the provisions waived are not more expensive.

A shift in funding from state appropriations and local tax dollars to MA fee-for-service will require changes in the role of the county as the local mental health authority. For example, while expanding the range of reimbursable services, counties will lose the ability to limit the range of qualified MA providers.

## The Need for Additional Funding

Minnesota recently completed a federally mandated state plan for mental health services during 1999-2001. As required by federal law, the plan describes current services and evaluates the need for additional services. It uses recently developed federal methodology to estimate the number of Minnesotans who need publicly funded services. The federal methodology is based on the latest available research, including sample household surveys conducted in various parts of the country. The methodology is primarily based on census data and takes into account economic differences among the states. Based on that methodology, these are the **estimated** numbers of people needing publicly funded mental health services in Minnesota, compared to the number actually served:

- About 40,000 children with severe emotional disturbance need services. About 19,000 were served in calendar year 1997.

- About 67,000 adults with serious and persistent mental illness need services. About 25,000 were served in 1997.

Another recent document which discusses the need for additional mental health services is a report by the

State Advisory Council on Mental Health. The Council is a legislatively mandated body which is appointed by the Governor and is required by law to present its findings every two years. In their *1998 Report to the Governor*, the Council describes a number of unmet needs for both adult and children's mental health services. The report suggests that not meeting these needs will result in more costly services in the long term.

In addition to the overall numbers, the above documents indicate that many people who were served often did not receive the full range or amount of services needed. For both children and adults, there is a great need for supportive services that would promote self-sufficiency by assisting families and adults before problems build to a level that requires more intensive intervention.

Copies of both documents are available from the Mental Health Division of the Department of Human Services.

## The "Rehab" Option

Under federal law, section 1905 (a) (13), states can elect to obtain federal Medicaid funds for:

> *... rehabilitative services ... including any medical or remedial services ... recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level; ...*

This is what is commonly referred to as the "rehab option". For adult mental health, Minnesota now uses the "rehab option" for day treatment, and that service is limited to a narrow, clinical definition. Legislative amendments in 1998 made adult day treatment somewhat more flexible, but it is still quite limited. For children's mental health, Minnesota uses the "rehab option" for day treatment, home-based treatment, family community support services and therapeutic support of foster care. However, utilization of MA children's mental health services has been limited due, in part, to restrictive definitions and requirements in state rules. These requirements were originally imposed partly due to concerns about controlling costs. However, it appears that partly due to these restrictions, actual use of these services has been far less than had been predicted.

## Federal IMD Law and Its Impact on MA Eligibility

An MA eligibility issue which is specific to mental health and chemical dependency is the Institution for Mental Diseases (IMD) issue. An IMD is defined as any facility of more than 16 beds that is primarily for the treatment of mental illness or chemical dependency. Under federal law, a resident of an IMD who is less than 65 years old is ineligible for all Medicaid services (certain exceptions apply to children under age 21). Any efforts to expand the scope of services covered by MA are of no benefit to a resident of an IMD. Over the past 15 years, Minnesota has made a number of successful efforts to downsize its adult IMDs and develop alternatives which are more appropriate clinically, thus removing the IMD barrier to MA eligibility. Outside of the Regional Treatment Centers, this issue now affects only about 300 adults with mental illness at any given time, and the number continues to decline each year. This issue as it relates to children is addressed further in a later section of this report.

## Medical Assistance Rates

Within broad federal restrictions, each state can determine the rates it pays for Medicaid covered services. The rates set by most states, including Minnesota, usually are less than the actual cost of the services provided. Many providers and advocates contend that a good way to maximize federal revenue, and improve access and availability of services, would be to raise rates to more closely approximate the actual cost of service. As long as the rates comply with broad federal restrictions, the state receives a full federal match for the rate paid by the state to the provider. The state receives no federal match for provider (or county) costs that exceed the state-approved rate. However, from a management standpoint, there is a concern that cost-based rates could reward inefficient operations. These are important issues for mental health, but are not limited to mental health. The Department is considering development of separate information and recommendations to the legislature regarding MA rates.

## Culturally Appropriate Services

The Mental Health Act (cited above) requires development of mental health services which "are sensitive to cultural differences and special needs." Stakeholders have expressed concerns about access to services that are culturally appropriate. Based on our discussions with key stakeholders, we recommend that this be dealt with as an integral part of changes in the mental health service system.

Standards will need to be written for any new services that will be covered by MA. Cultural competency and cultural appropriateness should be addressed as part of those standards. Both the content of the services provided and the qualifications of the staff providing the services need to be sensitive to cultural differences and special needs.

## Consumer-Directed, Recovery-Based Services

The Mental Health Act, which is cited above, requires development of a service delivery system which "recognizes the right of adults with mental illness to control their own lives as fully as possible" and services which "increase the level of functioning of adults with mental illness or restore them to a previously held higher level of functioning". There are some who are concerned that, if services such as community support services are covered under MA, the services will become over-professionalized and less in spirit with the concept of consumer-directed, recovery-based services. However, information from other states indicates that these services can be developed, under Medicaid, in ways that support consumer-directed, recovery-based concepts. Like the cultural issue above, this is an issue that can be addressed in the standards that will need to be written for any new covered services. The standards will need to be based on current research as to what is effective. Current research indicates that effective services include peer support and family support approaches, and extensive use of informal supports.

## Case Management Funding

In the 1998 Session, the Department proposed legislation to:

- Simplify MA billing for mental health case management from a system which required billing by the minute under seven procedure codes to a new system which would use a monthly bundled rate and two procedure codes.

- Change the rate from a flat statewide rate that equaled less than half the average cost to a rate that would be based on each county's documented costs for county-provided services, and a county-negotiated rate for contracted services.
- Allow counties to receive a full federal match for additional local spending for this service, thus resulting in about $4 million per year in additional federal revenue for expanded mental health services.

In order to accomplish the above, the Department proposed to transfer the current state share of MA for this service into grants to counties, and make counties responsible for the non-federal share. Concerns were expressed during the Session that this would inappropriately transfer responsibility for caseload growth from the state to the counties. A compromise was worked out which adopted the Department's proposal effective July 1, 1999, and required the state grant to the counties to change in future years based on caseload growth.

The law places the counties at risk for the non-federal share of increases in cost per unit of service, but puts the state at risk for increases in numbers of people served. This compromise position makes sense for a service like case management, where the county has a great deal of control over the cost per unit, but not as much control over the number of people. It also avoids a financial incentive to underserve people who need the service.

In addition, the case management law effectively requires both the state and the counties to at least maintain their current level of funding, with all new federal funds (estimated to come out to about $4 million per year for case management) being required to be used for non-residential, non-inpatient mental health services.

## Issues Specific to Adult Mental Health

As indicated above, legislation has already passed to increase federal funding for case management for both adults and children. By including the following adult mental health services under the MA fee-for-service rehab option, significant amounts of new federal funding could also be obtained:

- independent living skills training
- medication monitoring
- crisis services

These services are further defined in M.S. 245.462, subd. 6, and 245.4712, subd. 1. They are currently provided by community support programs located throughout the state and by residential treatment programs which are located in 29 counties. In the state fiscal year ending June 30, 1997, these programs received the following funding:

- Community support programs received about $40 million, of which about $6 million was federal funding, largely Medicaid funding for day treatment. The rest of the funding came from the state ($23 million) and the counties ($11 million).

- Adult residential treatment programs received about $34 million, of which $5 million was federal funding, largely Supplemental Security Income for room and board. The rest of the funding came from the state ($25 million), the counties ($2 million) and client fees for room and board ($2 million).

On average, about 80% of the people served by community support programs are eligible for MA. Aside from day treatment, which is already covered, about 50% of the services provided by community support programs could be covered if the state chose to cover the full range of mental health rehabilitative services under MA.

In the Department's discussions with the advisory group regarding mental health revenue maximization, there was general support for expanded MA coverage for the three community support program services referenced above. This is a direction that would clearly be in keeping with the Mental Health Act and the guiding principles described earlier in this report. However, there was mixed support for expanded MA coverage for residential treatment. This is a service which is already more highly developed in Minnesota than many other states. From a county staff standpoint, a residential placement may be an easier way to deal with a difficult client, as opposed to the more difficult to develop, less restrictive alternatives that would be more in keeping with the guiding principles in the Mental Health Act. By expanding the non-residential community-based services, the incentives are in a direction that supports and expands recognized best practices in the mental health area.

## Issues Specific to Children's Mental Health

Minnesota has already taken a number of steps to expand MA coverage for children's mental health services. Minnesota uses the "rehab option" for day treatment, home-based treatment, family community support services and therapeutic support of foster care for children with severe emotional disturbance. However, utilization of MA children's mental health services has been limited, partly due to restrictive definitions and requirements in state rules. These requirements were originally imposed partly due to concerns about controlling costs. However, it appears that partly due to these restrictions, actual use of these services has been far less than had been predicted.

For example, the fiscal note that accompanied the passage of MA coverage for children's home-based treatment in 1989 predicted that MA expenditures for this service would rise to $7 million per year within five years. Actual expenditures for services provided in the fiscal year ending June 30, 1996 were $1,742,570; and for the following fiscal year (FY97) $1,907,835. It is difficult to forecast costs for any new Medicaid service, since full implementation takes many years. Providers are usually cautious to expand services and therefore gear up gradually to meet requirements. Wherever the providers are counties, county boards are usually reluctant to add staff. Service recipients usually need time to learn about and utilize new service options. Since expenditures for home-based treatment did not increase significantly from FY 96 to FY 97, it appears that growth has now stabilized. Unless there is a change in the restrictions that currently apply to this service, it is clear that additional growth will not come close to the original projections.

A similar situation appears to be developing with regard to family community support services (FCSS) and therapeutic support of foster care (TSFC). Due to a combination of legislative and administrative delays, coverage of these services did not begin until November 1996. Based on bills received as of 10/1/98, utilization for these services is also considerably below projections.

Discussions with providers and advocates have identified the following issues behind the low utilization of current MA coverage for children's mental health services:

- Current rules limit providers of home-based services to those who are certified under Rule 29, outpatient hospitals, or mental health centers.
- Current rules require providers of FCSS and TSFC to be under contract with the county.
- The billing system is very complicated, involving large numbers of codes and modifiers.
- Rules limit the amount and types of combinations of services that can be provided concurrently without prior authorization, especially for people who need short-term, very intensive services.
- The complicated billing process results in rejection of claims, requiring re-billing and delay of payment.

DHS staff are meeting with a focus group of providers and advocates to identify ways in which the billing system could be improved, but still retain accountability and appropriate prohibitions against improper or unnecessary services. Resolution of technical billing issues could play a significant role in increasing utilization of these services. However, certain requirements, such as the requirement to have a county contract for certain services, may still be necessary to assure appropriate coordination and prevent service duplication.

**Children's Residential Treatment**

A number of states obtain significant federal revenues by using Medicaid for children's residential treatment. The Minnesota Department of Human Services has studied this issue a number of times over the last fifteen years and has consistently decided to limit MA for this service to two small inpatient hospital units located in the state Regional Treatment Centers. The main concern has been that coverage of this service would be an inappropriate incentive for additional out-of-home placements. The preference has been to first focus on development of non-residential alternatives.

There are two very different options under federal law which could be used to cover children's residential treatment:

- The inpatient psychiatric services benefit for individuals under age 21, also referred to as the "psych/21 benefit," which can be used to cover the cost of qualifying inpatient services.

- The general "rehab option" described earlier in this report, which can be used for specific services that may be provided as part of residential treatment that meet the criteria for the "rehab option."

On November 19, 1998, the federal Medicaid agency issued long-awaited rules clarifying that the psych/21 benefit is not limited to facilities accredited by the Joint Commission on Accreditation of Hospital Organizations, but can also apply to facilities with alternative accreditation. However, the new rules still left open a major unanswered question: the federal summary of the new rules indicates that rules defining the standards for non-hospital facilities would be issued "at a future date." Therefore, even if Minnesota wanted to use this option, it is not clear whether the current children's residential treatment facilities could comply with the new, yet-to-be issued federal standards.

Funding residential treatment under the rehab option would be complicated administratively, since facilities would have to isolate the portion of their costs that would qualify as "rehab services" from other non-covered costs, such as room and board. Compliance with rehab option requirements would probably increase overall costs and reduce current federal funding under Title IV-E, because Title IV-E pays for a significant portion of costs for children who are IV-E eligible.

Additional administrative complexity would probably also be involved under either of the above options to address concerns about inappropriate incentives for out-of-home placement. For example, Iowa (which includes the "psych/21" benefit in its Medicaid program) has set up elaborate controls to ensure that residential placements do not escalate. Iowa's controls include limitations on the number of providers who can participate in the program.

A related issue is the federal IMD issue described earlier in this report. Under federal law, a children's facility which is funded under the "psych/21 benefit" is a type of IMD which is allowable for Medicaid reimbursement. However, if Minnesota uses the rehab option to cover certain services provided by residential facilities which are not approved under the "psych/21 benefit", those facilities with more than 16 beds would be ineligible due to the IMD exclusion.

Regardless of the legal issues in Medicaid funding for children's residential treatment, the Department of Human Services continues to be concerned about inappropriate incentives for out-of-home placement that may be created.

The Department received the following input from Chris Koyanagi, policy director at the Bazelon Center for Mental Health Law (the Bazelon Center is a nonprofit legal advocacy organization which is nationally recognized for its leadership in mental health services) :

> *The Bazelon Center's mission is to promote the rights of children and adults with mental disabilities and to guarantee their access to appropriate community-based services. We believe children should live at home with wraparound services and supports, whenever this is possible. When it is imperative to remove the child from the home for any reason, therapeutic foster care, a group home placement or other community-based residential arrangement is the appropriate alternative.*
>
> *Large residential treatment centers have no proven record of effectiveness. They separate a child from her family, neighborhood and community in order to provide therapeutic services that can just as readily be provided in a more homelike setting. Children in crisis need psychiatric hospitalization, not residential treatment. Children not in crisis can be managed in alternative settings.*

Most of the input we have received from Minnesota advocates and counties emphasizes the need to focus on development of non-residential alternatives.

## Possible Ways to Maximize Federal Funding

We found a general consensus among stakeholders and consultants that the following principles should apply to all mental health revenue maximization proposals:

- The services to be funded must be in keeping with the guiding principles in the Mental Health Act.
- If new federal funding is accessed, it should be used for additional and improved mental health services, including compliance with federal requirements regarding quality assurance and statewide access.
- Clear standards and effective monitoring procedures must be developed to assure accountability and quality services.

Within that context, the Department has identified the following options:

| Adult MH Options | Pros | Cons |
|---|---|---|
| 1. Continue current limited MA coverage under day treatment only. | • More predictable from a state budget standpoint. | • Continued reliance on county and state funding for community mental health services.<br>• Inability to develop support networks which allow people to participate in their communities, develop informal supports, and engage in productive activities such as work.<br>• Potential for longer stays in costly hospitals, due to the lack of flexible, community-based alternatives. |
| 2. Implement expanded MA rehab option including:<br>• Community support services, specifically medication monitoring and independent living skills training<br>• Innovative crisis services, such as mobile crisis response teams and crisis services in adult foster care settings. | • Increase federal funding by about $10 million per year.<br>• Use the new funds to develop support networks which promote self-sufficiency by allowing people to participate in their communities, develop informal supports, and engage in productive activities such as work.<br>• Prevent unnecessary reliance on hospitalization and other restrictive types of intervention for serious mental illness. | • Matching funds must be identified (see options A and B below).<br>• The services and funding methods will have to comply with federal restrictions. |

| Children's MH Options | Pros | Cons |
|---|---|---|
| 1. Continue to implement current MA coverage of children's mental health services without legislative changes. | • Funds are already budgeted. (About $5 million per year in additional state and federal funding is already in Minnesota's Medicaid forecast.) | • Some of the barriers to full implementation require revision of laws and rules. |
| 2. Implement expanded MA rehab option including:<br><br>• Establish reimbursement mechanisms for mobile and short term crisis intervention services delivered in multiple settings.<br>• Expand the range of providers that counties and children's mental health collaboratives may contract with to provide services.<br>• Expand family community support services to include the services of "behavioral aide," a trained paraprofessional working to achieve care plan goals.<br>• Broaden the allowable location of service delivery in a way that better supports the delivery of therapeutic services in settings like pre-schools and summer camps. | • Increase federal funding by about $3 million per year, in addition to the $5 million increase already budgeted.<br>• Use the new funds to develop services which increase child and family functioning, promote self-sufficiency and family integrity, and improve school performance.<br>• Prevent unnecessary reliance on hospitalization and other restrictive types of intervention for serious emotional disturbance. | • Matching funds must be identified (see options A and B below).<br>• The services and funding methods will have to comply with federal restrictions. |

## Non-federal Matching Funds Options

Any Medicaid changes that expand coverage beyond current state laws and rules will require identification of matching funds roughly equivalent to any new federal funds. The following options are presented for both adult and children's mental health services:

| Matching Funds Options | Pros | Cons |
|---|---|---|
| A. Finance the state share with new state money. | • This is the option preferred by advocates and counties.<br>• Administratively simple.<br>• Consistent with the way most other services have been developed under Medicaid.<br>• The funds will be used for much-needed expansion of services to promote self-sufficiency. | • New state funds will be difficult to obtain. |
| B. Finance the state share with transfers from existing state grants for family and adult community support services. | • Does not require new state funding. | • It will be difficult to develop a way to transfer existing funds where everyone feels like a "winner." A few counties and providers might receive less than they get now.<br>• This could reduce the funding available for clients who are not eligible for MA.<br>• Counties will be opposed to funding future growth of MA services out of existing capped funding.<br>• This is not consistent with the financing method used for most other MA services, which rely on a direct state MA appropriation. |

## Case Management Options

The Department supports the compromise case management law enacted in the 1998 Session. We are proceeding with the administrative work necessary to achieve the July 1, 1999 effective date which is required by that law.

Some members of the revenue maximization advisory group have expressed concern that the case management financing strategy might be applied to expansion of the rehab option. We agree that the financing arrangement that was worked out for case management would not be a good policy choice for rehabilitative services. Case management is different because:

- Case management is largely a county-provided service whereas rehabilitative services are largely provided by the mental health centers and other private vendors. Counties have less control over rehab

service costs, quality and utilization.

- Since coordination of services is the essence of mental health case management, it makes sense for case management to be largely county-provided or county-controlled, given the county's role as the local mental health authority.

- Federal regulations regarding free choice of provider allow restrictions on who can participate as a case management provider which are not allowable for other services.

- Given that the county will, and should, have more control over case management than other services, it makes sense for the county to have more direct responsibility for the non-federal share.

- The 1998 law is fully in keeping with the above principles: it recognizes a state liability for caseload growth, it provides counties with full ability to get federal match for additional local spending, and it makes counties liable for the non-federal share if they choose to spend more per person.

- Case management is not a covered MA service for other populations, except for:

    - Child welfare case management, which was the model for the 1998 mental health case management legislation (but the mental health compromise added the provision of state funding for caseload growth);
    - Administrative case management, in which case counties pay the full non-federal share;
    - Case management which is provided as part of a home and community-based waiver or managed care waiver, in which case the case management is funded with funds that would otherwise have been used for institutional care.

Therefore, the financing strategy that was worked out in 1998 makes sense for mental health case management, but not for expanded rehabilitative services.

The Department gave serious consideration to other case management financing options and concluded that all other options that have been identified to date would not come close to the 1998 legislation as far as consistency with the principles in the Mental Health Act and potential for increased federal revenue.

## Appendices

Appendix A: List of Advisory Group Members
Appendix B: Medicaid Rules Regarding Comparability, Statewideness and Free Choice of Vendor
Appendix C: Information From Other States

## Appendix A: List of Advisory Group Members

| | Representing | | Representing |
|---|---|---|---|
| Ron Brand<br>Bob Steele | Mental Health Centers | Sandy Holmstoen<br>Donna McDonald | Children's Subcommittee of State Advisory Council on Mental Health |
| Pat Bugenstein<br>Barbara Flanigan | League of Women Voters | Tom Johnson<br>Pat Koppa | Alliance for Mentally Ill |
| Roberto Aviña | Communities of Color | Darrin Helt | Psycho-social Rehab Programs |
| Pat Conley<br>Patrice Battaglia | County Commissioners | Mary Regan<br>Jim Fischer | Children's Residential Treatment Facilities |
| Claire Courtney | State Advisory Council on Mental Health | Pat Siebert<br>Kathy Kosnoff | Disability Law Center |
| Pat Carlson<br>Sarah Maxwell<br>Dave Sayler | County Social Services | Tom Eberhart | State Regional Treatment Centers |
| Jane Funk<br>Diane Ollendick-Wright | Adult MH Residential Facilities | Tom Witheridge<br>Bill Conley | Mental Health Association |
| Cindy Wall | PACER | Bill Wyss<br>Boyd Brown, Jr. | Ombudsman for MH-MR |

**Equality of Medical Care**

Under the regulation requiring "comparability of services for groups" [Reg. Sec. 440.240], a state's Medicaid plan must provide that services available to any categorically needy individual are not less in amount, duration, and scope than services available to a medically needy individual. The plan must also provide that services available to any individual in the following groups are equal in amount, duration, and scope for all individuals within the group: (1) the categorically needy and (2) a covered medically needy group. See the *State Medicaid Manual* guidelines at .37, below, and at ¶14,513.21. The following limits are provided [under Reg. Sec. 440.250] with respect to comparability of services:

(1) Skilled nursing facility (SNF) services [Reg. Sec. 440.40(b)] may be limited to persons 21 or older (see ¶14,545).

(2) Early and periodic screening, diagnosis and treatment [Reg. Sec. 440.40(b)], as provided in Sec. 1905(a)(4)(B) of the Social Security Act, must be limited to individuals under 21 (see ¶14,551).

(3) Family planning services and supplies must be limited to individuals of child bearing age (including minors who can be considered sexually active and who desire such services and supplies (see ¶14,553)).

(4) Services to persons in institutions for mental diseases [Reg. Sec. 440.140] must be limited to persons 65 or older (see ¶14,361, ¶14,601).

(5) Inpatient psychiatric facility services [Reg. Sec. 440.160], as provided in Sec. 1905(a)(16) of the Social Security Act, must be limited to individuals under age 22 as specified in Reg. Sec. 441.151(c) (see ¶14,604).

(6) Benefits under Medicare Part B made available to individuals through a "buy-in" agreement (see ¶14,945) or payment of the premiums, or the payment of part or all of the deductibles, cost sharing, or similar charges under Part B, may be limited to such individuals who are covered by the agreement or payment.

(7) Care and services that are additional to those offered under the state Medicaid plan and that are made available under a contract between the state (or political subdivision thereof) and an organization providing comprehensive health services may be limited to individuals who reside in the geographic area served by the contracting organization and who elect to obtain care and services from it. (See also ¶14,513.)

(8) Ambulatory services for the medically needy [Reg. Sec. 440.220(a)(2)] may be limited to individuals under 18 and groups of individuals entitled to institutional services.

(9) Services provided under exceptions to state plan requirements allowed under Reg. Sec. 431.54 (see ¶14,513) may be limited in accordance with those exceptions.

(10) Services provided under an approved waiver of Medicaid program requirements (see ¶14,625) may be limited as provided by the waiver.

(11) If the Medicaid agency has been granted a waiver of the requirements of Reg. Sec. 440.240 (comparability of services) in order to provide home or community-based services under Reg. Secs. 440.180 or 440.181, the services provided under the waiver need not be comparable for all individuals within a group.

(12) An agency that imposes Medicaid cost-sharing requirements on recipients in accordance with Reg. Sec. 447.53 must not impose them on recipients who are federally exempt from cost sharing, *i.e.*, children under 18, pregnant women when the services are related to pregnancy, institutionalized individuals, certain health maintenance organization (HMO) enrollees, and individuals receiving family planning or emergency services.

(13) Eligible legalized aliens who are not in exempt groups [see Secs. 435.406(a) and 436.406(a)] and considered categorically needy or medically needy must be furnished only emergency services as defined in Reg. Sec. 440.255, and services for pregnant women as defined in Sec. 1916(a)(2)(B) of the Social Security Act for five years from the date the alien is granted lawful temporary resident status.

(14) Aliens who are not lawful permanent residents, permanently residing in the United States under color of law or granted lawful status under Secs. 245A, 210, or 210A of the Immigration and Nationality Act, who, otherwise meet the eligibility requirements of the state Medicaid plan (except for receipt of Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or a State Supplementary payment) must be furnished only those services

necessary to treat an emergency medical condition of the alien as defined in Reg. Sec. 440.255(c).

(15) If the state Medicaid agency makes respiratory care services available under Reg. Sec. 440.185, the services need not be made available in equal amount, duration, and scope to any individual not eligible for coverage under that section. However, the services must be made available in equal amount, duration, and scope to all individuals eligible for coverage under that section. ( ventilator dependent)

(16) A state may provide a greater amount, duration, or scope of services to pregnant women than it provides under its plan to other individuals who are eligible for Medicaid. These services, however, must be pregnancy-related or related to any other condition which may complicate pregnancy [see Reg. Sec. 440.210(a)(2)]. These services must be provided in equal amount, duration, and scope to all pregnant women covered under the state Medicaid plan.

As explained at ¶14,604C, states may provide case management services without regard to comparability-of-services requirements.

**Statewide Administration**

The plan [under Sec. 1902(a)(1) of the Social Security Act and Reg. Sec. 431.50] must be in operation statewide through a system of local offices under equitable standards for assistance and administration that are mandatory throughout the state, except that the statewideness requirement does preclude the Medicaid agency from contracting with a comprehensive health care organization (such as a health maintenance organization (HMO) or a rural health clinic). Other allowable exceptions and waivers, as set forth in Reg. Secs. 431.54 and 431.55 include the following:

*Additional services under a prepayment system.*--If the Medicaid agency contracts on a prepayment basis with an organization that provides services additional to those offered under the state plan, the agency may restrict the provision of the additional services to recipients who live in the area served by the organization and wish to obtain services from it.

*Special procedures for purchase of medical devices and laboratory and X-ray tests.*--The Medicaid agency may establish special procedures for the purchase of medical devices or laboratory and X-ray tests [see Reg. Sec. 440.30] through a competitive bidding process or other means.

*Lock-in of recipients who overutilize Medicaid services.*--If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only.

*Lock-out of providers.*--If a Medicaid agency finds that a Medicaid provider has abused the Medicaid program, the agency may restrict the provider, through suspension or otherwise, from participating in the program for a reasonable period of time.

*Waiver of Medicaid requirements.*--Section 1915(b) of the Social Security Act (*i.e.*, freedom of choice waivers) authorizes the Secretary to waive the requirements of Sec. 1902 of the Social Security Act to the extent that the proposed improvements or specified practices in the provision of Medicaid services are found to be cost-effective, efficient, and consistent with the objectives of the Medicaid program.

*Case-management system.*--Waivers of appropriate requirements of Sec. 1902 of the Social Security Act may be authorized for a state to implement a primary care case-management system or specialty physician services system. [See ¶14,604C.]

*Locality as central broker.*--Waivers of appropriate requirements of Sec. 1902 of the Social Security Act may be authorized for a state to allow a locality to act as a central broker to assist recipients in selecting among competing health care plans. States must ensure that access to medically necessary services of adequate quality is not substantially impaired.

*Sharing of cost savings.* Waivers of appropriate requirements of Sec. 1902 of the Social Security Act may be authorized for a state to share with recipients the cost savings resulting from the recipients' use of more cost-effective medical care.

*Restriction of freedom of choice.*--Waiver of appropriate requirements of Sec. 1902 of the Social Security Act may be authorized for states to restrict recipients to obtaining services from (or through) qualified providers or practitioners that meet, accept, and comply with the state reimbursement, quality, and utilization standards specified in the state's waiver request.

**Free Choice of Medical Vendor**

A state's Medicaid plan must provide that any individual who is eligible for and needs services (including drugs) that are available under the plan may obtain such services from any qualified institution, community pharmacy, practitioner, or agency, including an organization that provides such services or arranges for their availability on a prepayment basis. This freedom-of-choice requirement does not apply to Puerto Rico, the Virgin Islands, and Guam. [Sec. 1902(a)(23) of the Social Security Act; Reg. Sec. 431.51.] Details and exceptions are explained in HCFA's *State Medicaid Manual* at .15, below, and at ¶14,513.21. See also ¶14,625, concerning waiver of the freedom-of-choice requirement [Sec. 1915(b) of the Social Security Act]. Freedom of choice waivers allow states to enroll Medicaid recipients in managed care programs.



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## Appendix C: Information From Other States

| STATE | MH services covered under rehab option | Specifics of the Service | Issues |
|---|---|---|---|
| Illinois | - Intensive therapeutic intervention for children under age 21 | - Provide in home, school, or community<br>- one to one counseling<br>- psycho social rehab<br>- behavioral management<br>- counseling for caregivers and assistance in household management | They specified in State plan that all treatment is focused on the Medicaid eligible client. Any consultation or treatment involving families or others is solely for the purpose of addressing the mental health needs of the Medicaid client. |
| | - Client-centered consultation | - Professional communication with others who are involved with the treatment process, including staff of other agencies, schools, family members or others | |
| | - Psycho social rehabilitation day programming | - Structured program of daily activities provided in an environment which permits maximum participation of the individual | Variety of options: assertive community treatment, club houses, day programs, consumer-directed services, etc. |
| | - Psychiatric treatment | - Psychotherapy, mental health counseling, medication administration | - State had to deal with free choice of provider and EPSDT |
| | - Crisis intervention (not residential) | - Crisis assessment, short term intervention and referral | - Difficult issues<br>- Eventually dropped |

| STATE | MH services covered under rehab option | Specifics of the Service | Issues |
|---|---|---|---|
| Vermont | Rehabilitative Services<br>- specialized rehabilitative services<br><br>- basic living skills<br><br>- social skills<br><br>- supportive counseling<br><br>- collateral contacts<br><br>- group specialized rehabilitative services<br><br>- targeted case management | <br>- designed to assist individuals in restoring, retaining, or improving skills<br><br><br><br><br>- either face to face or telephone<br><br>- counseling, training, or consultation to family or significant others<br><br><br>- all of the above on left side can be provided in a group setting<br>- emphasis placed on assisting clients to access services which are non-Medicaid in nature | Vermont has used this category to cover some of the therapeutic options for children in this area - such as therapeutic camps and respite. |

| STATE | MH services covered under rehab option | Specifics of the Service | Issues |
|---|---|---|---|
| Wisconsin | Children<br>- Wrap around services (1915) (b)<br>- Managed Care<br>no more FFS<br><br>Adults<br>- CSP services<br><br>- Crisis services<br>- Supportive psychotherapy<br>- Medication management<br>- Case management | Best example of truly blended funding - including local, state, and federal, and from diff. parts of the system, such as school, social services, etc.<br><br>- Will not reimburse for both CSP and other out- patient services concurrently<br>- Crisis services to CSP recipients must be coordinated with CSP<br>-assertive community treatment | Children<br>- They advised against Medicaid for residential treatment - felt it provided incentives to institutionalize<br><br>- Now considering a version of less intensive CSP services for those who are not as seriously ill |
| Michigan | - now has a 1915(b) waiver<br>- Managed Care<br>- has Medicaid home-based services<br>- shifted $20 million into that with much more technical assistance and training in order to have the mental health centers be able to provide these services<br>- every community mental health center has an extensive home-based program<br>- they are pursuing a IVE waiver<br>- they have also used Kid Care to expand capacity for the mental health services through the community mental health centers | - identification and diagnosis<br>- prevention<br>- crisis stabilization and response<br>- case management<br>- clinic services<br>- socialization<br>- skill training<br>- health and rehabilitation services<br>- transitional non-crisis shelter<br>- transportation<br>- advocacy/legal protection<br>- child therapy<br>- family therapy<br>- assertive community treatment | - Medicaid staff advised against Medicaid for residential treatment<br><br>- interagency collaboration required among local service agencies which include community mental health, education, and family independence agencies<br><br>- individual plan of service |

| STATE | MH services covered under rehab option | Specifics of the Service | Issues |
|---|---|---|---|
| California | - inpatient<br>- outpatient<br>- case management<br>- day treatment<br>- Assertive Community Treatment (ACT)<br>- consumer run services | | - money will be on a capitated amount for each county<br>- defined target population by what was medically necessary not by diagnosis<br>- established minimum array of services<br>- used definition of medical necessity<br>- stabilized county funding<br>- expanded capacity<br>- expanded array of services<br>- role of state mental health staff changed from monitors/regulators to technical assistance |