National Association of State Mental Health Program Directors (NASMHPD)

NASMHPD Policy Brief

Financing and the Public Mental Health System

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I. Background

As the State Mental Health Authorities (SMHAs), NASMHPD members have an important role to play in the implementation of the Affordable Care Act (ACA) and the Mental Health Parity and Addictions Equity Act (MHPAEA). That responsibility demands effective partnership with the U.S. Department of Health and Human Services' Centers for Medicaid and Medicare Services (CMS) and Substance Abuse and Mental Health Services Administration (SAMHSA), as well as with State Medicaid Directors and Single State Authorities (SSAs) for State Substance Abuse Systems. Despite the growth in Medicaid's role, the financing of safety net behavioral health services remains largely a state responsibility with contributions from the Federal mental health and substance abuse block grants.

Demand for care and the complexity of the conditions affecting individuals seeking treatment is growing. The National Institute of Mental Health (NIMH) estimates that 26.2 percent of Americans – or roughly 57.7 million people – are affected by mental illness in any given year (NIMH, 2010). Approximately one-fourth of Americans will have a mental disorder in a given year, and almost half (46.4 percent) will be afflicted during a lifetime (NAMI, 2009). According to the 2008 National Survey of Drug Use and Health, approximately 22.2 million – or 8.9 percent – of the American population over the age of 12 were classified as having substance abuse or dependence in the prior year (SAMHSA, 2009). Many of these persons have historically had difficulty accessing care because their insurance plans lacked sufficient coverage for mental disorders or required higher out of pocket contributions for behavioral health care. Others lacked insurance coverage all together. Health reform cannot succeed in improving access, reducing costs and improving quality without the full inclusion of behavioral health in reforms of financing mechanisms, the delivery system, and quality.

Under the ACA provisions, increased numbers of uninsured individuals who are at-risk for or who have behavioral health conditions, will now be covered for care. The Kaiser Family Foundation (KFF) estimates that 15.9 to 22.8 million more children and adults will enroll in Medicaid by 2019, depending on the success of states' outreach efforts (KFF, 2010a). In a different study, researchers estimate that approximately 5.4 million uninsured persons with mental health and substance use disorders (MH/SUD) will obtain coverage through the expansion of Medicaid, while many more will gain coverage through the health insurance exchanges (Donahue et al., 2010). In addition to the expansion of coverage found in the ACA, expectations are rising about access to care as a result of the Mental Health Parity and Addictions Equity Act (MHPAEA). MHPAEA requires most health plans to increase coverage and eliminate discriminatory rules and payments, making benefits for mental health and addictions treatment comparable to the coverage provided for all other health conditions (MHPAEA, 2008). While the implementation of parity presents challenges, the parity law improves access to services for many individuals living with behavioral health conditions.

Both the ACA and MHPAEA create an unprecedented opportunity to implement comprehensive health insurance coverage, including coverage for mental health and substance use (MH/SU) conditions, for nearly all Americans. The ACA also contains provisions that address gaps in financing to support home- and community-based services, integration of behavioral health and primary care services, and delivery system models to reduce costs and improve quality. SMHAs play a vital role in the development, delivery, financing, and evaluation of mental health services within this rapidly evolving public healthcare environment and are poised to contribute their specific knowledge and experience in meeting the needs of citizens at risk for or with behavioral health conditions, with the effort to implement the reforms promoted by federal policy, program, and legislative initiatives. SMHAs remain committed to meeting needs of the most vulnerable persons, including those who may not be eligible for federally

financed or covered services under the ACA, through preservation of safety net services. For these reasons, NASMHPD addresses below both opportunities and risks contained in several federal initiatives, including Medicaid expansion, home- and community-based services (HCBS) and health homes.

II. Recommended Policies and Action Steps for Federal Entities and NASMHPD: Program and Financing Opportunities to Promote and Support Integration of Prevention, Treatment and Rehabilitation

The ACA and the MHPAEA present a new opportunity to implement coverage, financing and delivery structures that will assure access, promote clinical and system integration, deliver comprehensive care, and achieve resiliency for all Americans and recovery for persons with disabilities. In the spirit of the Supreme Court *Olmstead vs. L.C.* decision, NASMHPD is eager to help realize the opportunities in the ACA to strengthen home- and community-based services and to fully integrate medical and behavioral health. There are several discrete provisions that hold great promise for achievement of these objectives. However, the contours of the opportunities and anticipated results depend heavily on rules yet to be written and implementation frameworks yet to be devised. NASMHPD members offer initial input on selected coverage and financing provisions as follows:

Benchmark Benefits. The ACA improves access to and affordability of behavioral health benefits by including them as part of the "essential health benefits" package for health plans. These benefits are to be included in plans supported by Medicaid in the expansion population, as well as those plans promoted through the state health insurance exchanges. If we are to avoid the gaps in insurance coverage, inequities in care limits, and disparities in reimbursement that characterize behavioral health benefits, as well as bring an end to the cost and patient shifting that characterize our care delivery systems, we must forge consensus across payers and plans on a core behavioral health benefit. In addition, NASMHPD recommends consideration of the adoption of a universal definition of *medical necessity* that includes rehabilitation, habilitation, prevention, recovery programs and long term care services. This will provide clear guidance to States and providers that would promote consistency in the supports and services provided for mental health and substance use, utilization management and most importantly, quality assurance across the Medicaid program.

The findings of the NASMHPD Medical Directors Council report *"Morbidity and Mortality in People with Serious Mental Illness"*, that people with SMI die, on average, 25 years earlier than the general population, makes the case that the people served in the public mental health system are indeed a health disparities population. Among persons with SMI, the "natural causes" of death include preventable and treatable conditions such cardiovascular disease, diabetes, respiratory disease and infectious disease. Close to half of all cigarettes smoked in the U.S. are smoked by individuals reporting a mental disorder. NASMHPD affirms the recommendation included in the Medical Directors Council report that persons with serious mental illness and substance use disorders be designated a health disparities group and that resources be applied to close the disparity gap.

To provide coverage for behavioral health conditions that is comparable to other health conditions, the benchmark benefit must include not only acute care and outpatient behavioral health services, but also more intensive rehabilitation services analogous to those provided in cardiac, neurological or orthopedic rehabilitation following an acute illness or inpatient procedure. The benchmark benefit will of necessity be a continuum of behavioral health benefits.

Behavioral health conditions are under-diagnosed and under-treated in the US despite their high prevalence in the population and solid research pointing to the fact that treatment works, prevention is possible, and recovery is achievable (WHO, 2001; CSEH, 2008). Behavioral health conditions

commonly co-occur with other chronic health conditions in adults and yet services are rarely delivered in concert (Kessler et al., 2005; Parks et al., 2006). These findings suggest the importance of having screening, evaluation and diagnostic services available at multiple access points in primary care and behavioral health care networks. We applaud the requirements in Affordable Care Act to include coverage for preventive and wellness services, including in Qualified Health Plans offered on the exchanges, and to provide coverage for preventive services without cost-sharing. We urge HHS to include mental health and substance abuse preventive and wellness services in those packages. Early intervention when symptoms of mood and anxiety disorders and other mental disorders first appear will have enormous payoff in reducing the impact of behavioral health disorders and improving general overall health. NASMHPD strongly supports the nurse home visitation program included in the ACA and urges HHS to address the inclusion of individuals at risk for mental health as well as substance use disorders.

Benchmark benefits should be designed to support:

- Utilization of skilled specialists to perform comprehensive assessments to determine the differential diagnoses that inform successful treatment and care planning for mental health and substance use conditions. Accurate diagnosis by skilled experts is fundamental to crafting a care plan which may have primary and specialty care elements in much the same manner as other health conditions.
- Evidence-based treatment services including medication combined to optimize client outcomes, providing the right treatment at the right time in the right amount; and
- Acute, intensive treatment services designed to rapidly respond to emergent situations, resolve crises, and treat acute episodes of illness in home- and community-based settings, to complement inpatient care in order to prevent repeated acute exacerbations of illness and associated disability.

Benchmark benefits should also include rehabilitation services that facilitate the process of recovery and restoration of function following onset or acute exacerbation of illness. Given the life domains that are impacted by behavioral health conditions, rehabilitation may have multiple components. As SAMHSA states in its vision of its proposed services continuum for a modern behavioral health care system, recovery support is essential to "promote social integration and optimal health and productivity" (O'Brien, 2010). Rehabilitation and recovery support for persons with acute and/or serious, disabling conditions includes a scope of services analogous to those provided for other health conditions, subject to comparable clinical and medical necessity standards, including but not limited to:

- prevention and wellness services,
- home-based habilitative services,
- psychosocial rehabilitation and supported employment,
- supported and recovery housing, and
- peer supports.

The work of the Centers for Medicare and Medicaid Services (CMS) on the design of core benefits will heavily influence the shape of these benefits and terms of plan administration. CMS is in a strong position to draw on historical utilization and cost data in identifying the characteristics and needs of currently covered populations. State behavioral health agencies are eager to collaborate with CMS and other state and federal agencies to determine the needs of the Medicaid expansion population, within which are a significant number of individuals with historical dependence on the state mental health and substance abuse agencies. The states have strong experience in collaboration with their state Medicaid programs, CMS and SAMHSA to demonstrate a range of effective financing and reimbursement mechanisms worthy of broader implementation.

Health Homes. The call to eliminate clinical and administrative redundancies, embrace integration as a quality improvement initiative, and establish integrated medical homes is growing louder (Milbank Memorial Fund, 2010). In 2008, NASMHPD called for the creation of a "patient-centered medical home" for individuals who have mental illnesses, as these individuals so often have co-morbid substance use and other serious medical conditions. The call is contained in a report, "*Measurement of Health Status for People with Serious Mental Illnesses*." The report describes the medical home as a platform for bringing together a primary care/physical health provider and specialty behavioral health services practitioners to provide collaborative care using disease management strategies based on the chronic care model (Parks et al., 2008).

Under the ACA (Section 2702), a state plan option under Medicaid is created to provide health homes for persons with multiple chronic conditions (MCC). Importantly, two of the six chronic conditions defined in the law are a serious mental health condition and a substance use disorder. Some argue that health homes may be established in primary care settings or specialty care settings, depending on the resources available in those settings, the consumers' needs, and established relationships with caregivers (Alakeson et al., 2010). Others are concerned that specialty behavioral health settings have been unable to deliver primary and specialty healthcare and may find it a challenge to do so effectively in the future (Druss and Maurer, 2010; Hogan, 2010).

NASMHPD recommends that health homes be established to align with consumer needs and consumer preferences. Financing mechanisms must align with these objectives and promote a single, integrated point of clinical responsibility for the individual, moving away from fragmented, fee-for-service reimbursement. This concept of a single point of clinical responsibility has long been a foundation of sound community mental health care systems, although the execution has been challenging given the fragmentation in financing for care. Services provided in health homes must be coordinated, including patient and family support, transition from the hospital, use of health information technology and provision of referral to community and social services. The full inclusion of behavioral health prevention and treatment services must be an essential part of all health homes.

NASMHPD recommends that state mental health authorities work closely with state Medicaid offices to ensure that behavioral health is included in health homes created under Section 2702 of the ACA for all chronic conditions and to carefully evaluate the potential for health homes for individuals with serious and persistent mental health conditions.

Home- and Community-Based Services 1915(i). The ACA (Section 2420) includes changes to Section 1915(i) Medicaid State Plan Option amendment that are intended to remove barriers to providing robust home- and community-based services (HCBS) to Medicaid recipients. One change is that HCBS Option must apply to the Medicaid eligible population statewide, creating a uniform benefit for those who meet the requirements of the target population. The Act increases eligibility to include individuals up to 300% of federal poverty level (FPL) from 150% and broadens the definition of allowable services. While providing a broader array of services statewide may be seen as having great value, the current state fiscal crisis may limit the number of states that apply for this option because funds to cover required state match are in short supply. CMS is encouraged to work with states to develop strategies to both expand HCBS and manage costs.

The ACA creates or extends other HCBS that offer a full continuum of services through organized and coordinated delivery system structures, such as Special Needs Plans (SNPs) and Accountable Care Organizations (ACOs). If designed appropriately to address the behavioral health needs of people with MH/SU disorders, NASMHPD believes that structures such as SNPs and ACOs have great potential to improve quality and reduce health care costs.

NASMHPD urges CMS to work with states to reduce barriers that may exist to apply for 1915(i) state plan amendments and increase the viability of this option.

Money Follows the Person (MFP) Demonstration. This Demonstration, extended to the year 2016 under the ACA, has important implications for people of all ages with behavioral health disorders who are seeking to leave institutions and return to the community. While the IMD exclusion has prevented using the grant to deinstitutionalize non-elderly adults, there are large and growing numbers of people with behavioral health disorders in nursing facilities who can benefit from this Demonstration. CMS needs to continue to encourage and promote more state projects under the MFP Demonstration which integrate evidence-based behavioral health services and supports into home- and community-based service systems. Innovations developed under these projects should be disseminated nationally with technical assistance to states to enable them to incorporate the innovations in their state Medicaid programs.

Co-Location to Serve the Target Client Population. The need for clinical integration and services coordination may be most obvious for those individuals with multiple conditions, but modern system goals for health promotion and prevention in the broader population are dependent upon greater efforts to integrate and coordinate behavioral health services in primary care and specialty care settings. Research into the co-location of primary care services within mental health or substance use settings indicates positive outcomes in the form of improved health status (Druss et al. 2001, Weisner et al. 2001, Boardman 2006, Kwan et al. 2008). In several settings, the use of nurse care managers provided effective support for individuals with serious mental illnesses (Druss et al. 2010). Early research on substance use in the Kaiser Northern California population documents savings in overall healthcare costs as well as improved outcomes (Weisner, 2010).

The ACA expands by $50 million an existing SAMHSA grant program to co-locate primary care services in specialty MH settings. The 13 initial awards to 11 states provide community mental health organizations with funding to provide primary care services and wellness and prevention services to their clients, either directly or via partnerships with agencies. NASMHPD strongly supports the continued investment in co-location of primary care services in MH settings and the robust evaluation of these programs and their ability to improve health status, especially those with SMI.

Disproportionate Share Hospital Payments (DSH) and Emergency Services/IMD Demonstration. The Disproportionate Share Hospital (DSH) payment reduction, cutting supplemental Medicaid payments to hospitals with high proportions of publicly insured and uninsured patients on the theory that expansions in health insurance will lower uncompensated care costs in safety net facilities, will create perhaps an unintended risk to the behavioral health safety net system. Because the law does not eliminate Medicaid's prohibition on reimbursing institutions for mental disease (IMDs) or state psychiatric hospitals for care provided to recipients between 21 and 64 years of age, these institutions will not be able to collect Medicaid reimbursement for care to currently eligible or newly eligible beneficiaries. NASMHPD members have substantial concerns about the fragility of inpatient psychiatric and residential care. A number of SMHAs depend on Disproportionate Share Hospital (DSH) Payments as a significant source of Medicaid funding for state psychiatric hospitals, totaling approximately $3 billion in 2007, of which approximately $1.73 billion were federal dollars (Draper et al., 2003; NASMHPD, 2010). These dollars represent a sizeable share of the $36.7 billion under the direction of SMHAs, and losses of this magnitude will further erode resources available to individuals in state hospitals and community based safety net programs. In those states that use DSH payments to fund home- and community-based waiver programs, there will be larger constraints on the ability to meet Olmstead objectives. These concerns are exacerbated by recent losses sustained in state funding to mental health programs, approaching $2 billion across three fiscal years in 45 states (NRI, 2010).

The law directs the Secretary of HHS to develop a methodology to distribute DSH reductions that consider several factors: the percentage of uninsured in a state; the rate at which states target DSH payments to hospitals with high volumes of uncompensated care; low-DSH states; and the portion of DSH that finances Section 1115 waivers. The law is, however, silent on IMDs as a factor. NASMHPD asks the HHS Secretary to consider the impact of a disproportionate loss of DSH revenue on the further erosion of safety net behavioral health services at a time when the states are facing continued reductions in state revenues. Since state psychiatric hospitals will not benefit from the increased Medicaid expansion under the ACA because of the IMD exclusion, we urge the Secretary to consider the time that states will need to develop community-based alternatives to hospitalization and to secure other funding to support inpatient services for individuals who require these services. As the Secretary develops a methodology to distribute DSH reductions, NASMHPD urges consideration of these unique circumstances and the differential impact of cuts on states.

In addition, we urge the Secretary of HHS to take a broader look at the impact of the IMD Exclusion on health care delivery for populations served by the public mental health system. One opportunity is Medicaid Emergency Psychiatric Demonstration Project created in ACA to evaluate the impact of reimbursement of services provided by IMDs albeit limited to stabilization of medical emergency situations. In selecting participating institutions and developing evaluation criteria, NASMHPD urges HHS to include an assessment of the impact on state psychiatric hospitals even though they are not eligible for direct funding. We recommend that at least one institution in the demonstration be located in a service area where there is also a public institution that could be impacted by the new funding stream. This would allow for an assessment of new funding on access to inpatient services, emergency room visits, continuity of care and other factors across public and private institutions.

Medicare Advantage Plans / Special Needs Plans (SNPs). Special Needs Plan (SNP) can serve as a platform for enrollment of individuals with co-morbid behavioral and physical health conditions in a health home and delivery of recovery oriented home- and community-based services. Special Needs Plans (SNPs) have been used as a model for care delivery to vulnerable populations in Medicare demonstrations and more recently in Medicare Advantage (MA) plans. One feature that is directly applicable to the disabled behavioral health population with multiple chronic conditions is the capacity to coordinate Medicare and Medicaid benefits and services for dually eligible beneficiaries through contractual relationships with state Medicaid plans (Grabowski, 2009). Given the complexity of needs found among the consumer population described, NASMHPD recommends that care plans for SNP members should be driven by comprehensive diagnostic and functional assessments.

Changes in Financing and Payment Policies

Financing mechanisms must align with these objectives and promote a single, integrated point of clinical responsibility for the individual, moving away from fragmented fee-for-service reimbursement. The ACA contains several provisions with the potential to promote integration of care and incentivize providers to provide timeless access, better quality and more efficient services to individuals with behavioral health and other medical conditions. As described in another NASMHPD policy brief on Health Information Technology, the ACA relies heavily on the use of Electronic Health Records (EHRs) and Health Information Exchanges (HIE) to improve healthcare. An integrated medical record that includes mental health and substance use will do much to integrate services and improve outcomes when co-location of services in a brick and mortar settings is not practical. NASMHPD urges the inclusion of behavioral health information in EHRs and HIE in order to reach the goal of reducing fragmentation and providing integrated services.

Efforts to test payment models and aligned payment incentives are underway in the health care system and include: creation of incentive pools; direct payments to patients; provider bonus and incentives;

grants and seed money; bundled payments; and case rates (Jarvis, 2010). Payment methodology changes influence provider behavior and shape delivery structures. In order to meet ACA reform objectives to address medical complexity in the population, the U.S. healthcare system needs to migrate from fragmentation to a financing framework that aligns benefit design with quality measures and reimbursement mechanisms. SAMHSA could make a major contribution to the design and implementation of financing for benchmark benefits tied to a defined measurement system. The defined measures/measurement system must address: utilization, cost, quality and outcomes. A brief review follows on several initiatives and policies with potential to advance objectives to strengthen access, quality and cost performance of behavioral health programs.

Accountable Care Organizations. The reform law provides for the delivery of care to Medicare fee-for-service beneficiaries through Accountable Care Organizations (ACOs). ACOs are comprehensive, vertically and horizontally integrated care systems designed to manage and coordinate care, with strong parallels to public mental health system constructs for a single point of clinical and financial accountability and comprehensive home- and community-based services systems.

The ACO structural design will utilize new models of organizing provider organizations to improve quality and manage cost, based on emerging Accountable Care Organization models. The structural model should include, at a minimum, primary care and behavioral health care. A preferred model will also include major medical specialists and hospitals, which aligns with emerging descriptions of a "Level 3" ACO (How to Create Accountable Care Organizations, Center for Healthcare Quality and Payment Reform, 2009).

ACOs will be eligible for enhanced payments based on shared savings if they meet quality performance standards including the adoption of electronic prescribing and heath records. This provision underscores the importance of behavioral health records integration, enabling behavioral health providers and care networks to play as full partners in ACOs. NASMHPD urges the full inclusion of behavioral health in ACOs, including behavioral health records integration.

Bundled Payments for Evidence Based Practices (EBPs): Several evidence based practices in the behavioral health field are complex, multiple component interventions. In some state Medicaid programs, reimbursement is structured around separate components, while in others a more comprehensive bundled payment has been established. For example, a number of states now employ bundled payments for Assertive Community Treatment (ACT), and others cover supported housing. NASMHPD has collaborated with the state Medicaid directors to promote broader adoption of evidence based practices, recognizing that integrated and adequate reimbursement is essential to ensuring not only widespread adoption, but also implementation of practices with fidelity to the evidence standards. NASMHPD urges CMS to examine the role of financing mechanisms such as bundled services in expanding the use of EBPs in the core services provided in the rehabilitation and clinic options.

Elimination of Same Day Billing Barriers. A number of state Medicaid programs place limitations or exclusions on payments for a mental health and a physical health service visit delivered on the same day, known as "same day billing." This exclusion places burdens on providers who are being encouraged to deliver integrated care and in some cases serve individuals who have difficulty scheduling appointments and securing transportation for multiple visits. In other cases, Medicaid disallows reimbursement when primary care practitioners (PCPs) list only a mental health diagnosis and the corresponding treatment, deeming these providers not certified to provide the mental health service.

The National Correct Coding Initiative (NCCI), which was applied to Medicare carriers in recent years, precludes same day billing. Section 6507 of the Affordable Care Act requires CMS to implement NCCI methodologies in the Medicaid program. Implementation is pending CMS development of a Medicaid

NCCI Manual. NASMHPD urges CMS to consider providing flexibility in implementing NCCI in Medicaid and requests CMS guidance to states that same day billing is allowable under the terms of Medicaid law. Providing general medical and behavioral health care in the same location is often the most effective way to deliver high-quality, cost-effective health care. NASMHPD strongly encourages the co-location of primary care and behavioral health services and the removal of barriers such as prohibitions against same day billing to encourage integrated care.

PCP Reimbursement. While the ACA addresses low payments to Primary Care Practitioners (PCPs), it does not address payments to other classes of primary care practitioners (nurses or other physician-extenders) or to medical specialists, including behavioral health practitioners or psychiatrists. Given the current shortages in primary care practitioners and the planned growth in the Medicaid population, one of the most significant ACA initiatives is to reimburse PCPs who serve Medicaid recipients at 100% of Medicare rates. Medicaid reimbursement rates were estimated to be 72% of Medicare rates across all services in 2008 (Zuckerman et al., 2009). Improving access to PCPs is an important development in the reform law. However, some PCPs are ill-equipped to meet the complex needs of individuals with serious behavioral health conditions and co-morbid health conditions (Stein et al., 2004). Recent research indicates that there is also a serious shortage (45,000 practitioners) of psychiatrists (Carlat, 2010). PCPs cite problem gaining access for their patients to specialty mental health settings (Cunningham, 2009). One study found that fewer than 20% of mental health practitioners in Washington DC participate in Medicaid because of low rates, which were 57%, 46%, and 58% of private insurance fees, respectively for social workers, psychologists, and psychiatrists (Regier et al., 2007).

NASMHPD urges the HHS Secretary and CMS to address these disparities to improve access to all needed disciplines. The increasing disparity in payment structures and reimbursement levels puts community behavioral health providers and centers at risk for loss of staff to better reimbursed FQHCs and limits their ability to attract primary care staff to provide more integrated services to consumers with multiple chronic conditions.

Continuation of Block Grants to Address Gaps in Medicaid Coverage. The Community Mental Health Services Performance Partnership Block Grant is the principal federal discretionary program supporting community-based mental health services for adults and children. Many essential elements of effective community-based care – such as housing – are non-medical in nature and are not reimbursable under Medicaid. Health care reform will provide basic health services to the population served by the block grant but the need for wrap-around services will remain and services will be needed for those who remain uninsured. It is important to note that while changes in the structure of these grants may be necessary to compliment the ACA and MHPAEA, states will need adequate time to adjust their current programs and processes and educate providers before changes can be successfully implemented. The rules governing the block grant must recognize the difference among the states in incidence and prevalence of behavioral health disorders, system development, and success in accessing other funding sources.

The Mental Health Block Grant is a major source of federal funding designed to support community-based services for people with mental illnesses. At the same time as demand is increasing and expectations are rising, public dollars invested in mental health care have declined. This decline has occurred due to adverse economic conditions; however, there is considerable public cost to failing to treat or under-treating behavioral health conditions. The block grants give states critical support to: (1) fund services that are tailored to meet the unique needs and priorities of consumers of the public mental health system in that state; (2) hold providers accountable for access and the quality of services provided; and (3) coordinate services and blend funding streams to help finance the broad range of supports – medical and social services – that individuals with mental illnesses need to live safely and effectively in the community.

NASMHPD strongly recommends a $100 million increase in the mental health block grant for FY 2012. We agree that the MH and SA block grants should target services not provided by traditional Medicaid, providing services to those who remain uninsured, and stabilizing safety net programs.

Summary of NASMHPD Recommendations

The recommendations of the National Association of State Mental Health Program Directors (NASMHPD) contained in this paper are summarized below.

NASMHPD:

- recommends that persons with serious mental illnesses and substance use disorders be designated a health disparities group and that resources be applied to close the disparity gap.

- recommends consideration of the adoption of a universal definition of *medical necessity* that includes rehabilitation, habilitation, prevention, recovery programs and long term care services in order to ensure an appropriate continuum of services in benchmark plans.

- urges HHS to include mental health and substance abuse preventive and wellness services in the benefit packages offered on the exchange and for the Medicaid expansion population and to address the inclusion of individuals at risk for mental health as well as substance use disorders in the nurse home visitation program.

- recommends that state mental health authorities work closely with state Medicaid offices to ensure that behavioral health is included in health homes created under Section 2702 of the ACA for all chronic conditions and to carefully evaluate the potential of the health home option for individuals with serious and persistent mental health conditions.

- urges CMS to work with states to remove barriers that may exist to apply for the 1915(i) state plan amendments and increase the viability of this option.

- urges CMS to continue encouraging and promoting more state projects under the MFP Demonstration that integrate evidence-based behavioral health services and supports into home- and community-based service systems.

- urges Congress to continue the investment in co-location of primary care services in MH settings and the robust evaluation of these programs and their ability to improve health status, especially those with SMI.

- urges the Secretary of HHS to develop a methodology to distribute DSH reductions that takes into consideration the time that states will need to develop community-based alternatives to hospitalization in state psychiatric hospitals and to secure other funding to support inpatient services for individuals who require these services.

- urges HHS to include in the Medicaid Emergency Psychiatric Demonstration Project created in ACA an assessment of the impact on state psychiatric hospitals even though they are not eligible for direct funding. We recommend that at least one institution in the demonstration be located in

a service area where there is also a public institution that could be impacted by the new funding stream.

— recommends that care plans for Special Needs Plans members be driven by comprehensive diagnostic and functional assessments due to the complexity of needs found among this population.

— urges the inclusion of behavioral health information in EHRs and HIE to reach the goal of reducing fragmentation and providing integrated services.

— urges the full inclusion of behavioral health in ACOs, including behavioral health records integration.

— urges CMS to examine the role of financing mechanisms, such as bundled services, to expand the use of EBPs in the core services provided in the rehabilitation and clinic options.

— urges CMS to consider providing flexibility in implementing National Correct Coding Initiative (NCCI) in Medicaid and requests CMS guidance to states that same day billing is allowable under the terms of Medicaid law.

— encourages the co-location of primary care and behavioral health services and the removal of barriers to encourage integrated care, such as prohibitions against same day billing.

— urges the HHS Secretary and CMS to address the increasing disparity in payment structures and reimbursement levels for community behavioral health providers and centers.

— recommends a $100 million increase in the mental health block grant for FY 2012 to address the ongoing budget crisis in the states and the orientation of the MH and SA block grants to target services not provided by traditional Medicaid, provide services to those who remain uninsured, and stabilize safety net programs.

Conclusion

The ACA and the MHPAEA present a new opportunity to implement coverage, financing and delivery structures that will assure access, promote clinical and system integration, deliver comprehensive care, and achieve resiliency for all Americans and recovery for persons with disabilities. NASMHPD is eager to help realize the full potential of these reforms and to continue its work to strengthen the core Medicaid services provided in the clinic and rehabilitation options. Achieving quality care in the Medicaid program requires the adoption of SAMHSA-supported evidence-based practices that support team- and community-based services delivered on a continuous basis by the appropriate providers in the right setting. A collaborative partnership between CMS and SAMHSA and between the SMHAs and the Medicaid agencies is key to reaching this goal. Improvements are needed in achieving a degree of consistency across CMS offices in the application and interpretation of Medicaid rules, in streamlining and improving the state plan amendment process and in understanding how to target and customize Medicaid services for the populations served in the public mental health system.