NASMHPD

NASMHPD and NASDDDS Legal Divisions 2011 Joint Annual Meeting

November 15, 2011

Washington Update

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Outline

- The Budget Control Act of 2011
- Health Care Reform Implementation – Benefits and Insurance Exchanges
- Medicaid Emergency Psychiatric Demonstration – IMD Exclusion
- Dual Eligible Population
- Community Living Assistance Services and Supports (CLASS)
- Constitutionality of the Affordable Care Act

Level of SMHA Budget Reductions:

FY2009 to FY2011 Total $3.4 Billion in Cuts

Year	Average	Median	Minimum	Maximum	Total
FY 2009 *(39 States)*	$36,849,116	$13,226,000	$0	$554,003,000	$1,216,020,843
FY 2010 *(38 States)*	$29,123,575	$12,300,000	$0	$213,591,000	$1,019,325,136
FY 2011 *(37 States)*	$37,981,650	$12,000,000	$0	$523,437,000	$1,177,431,138

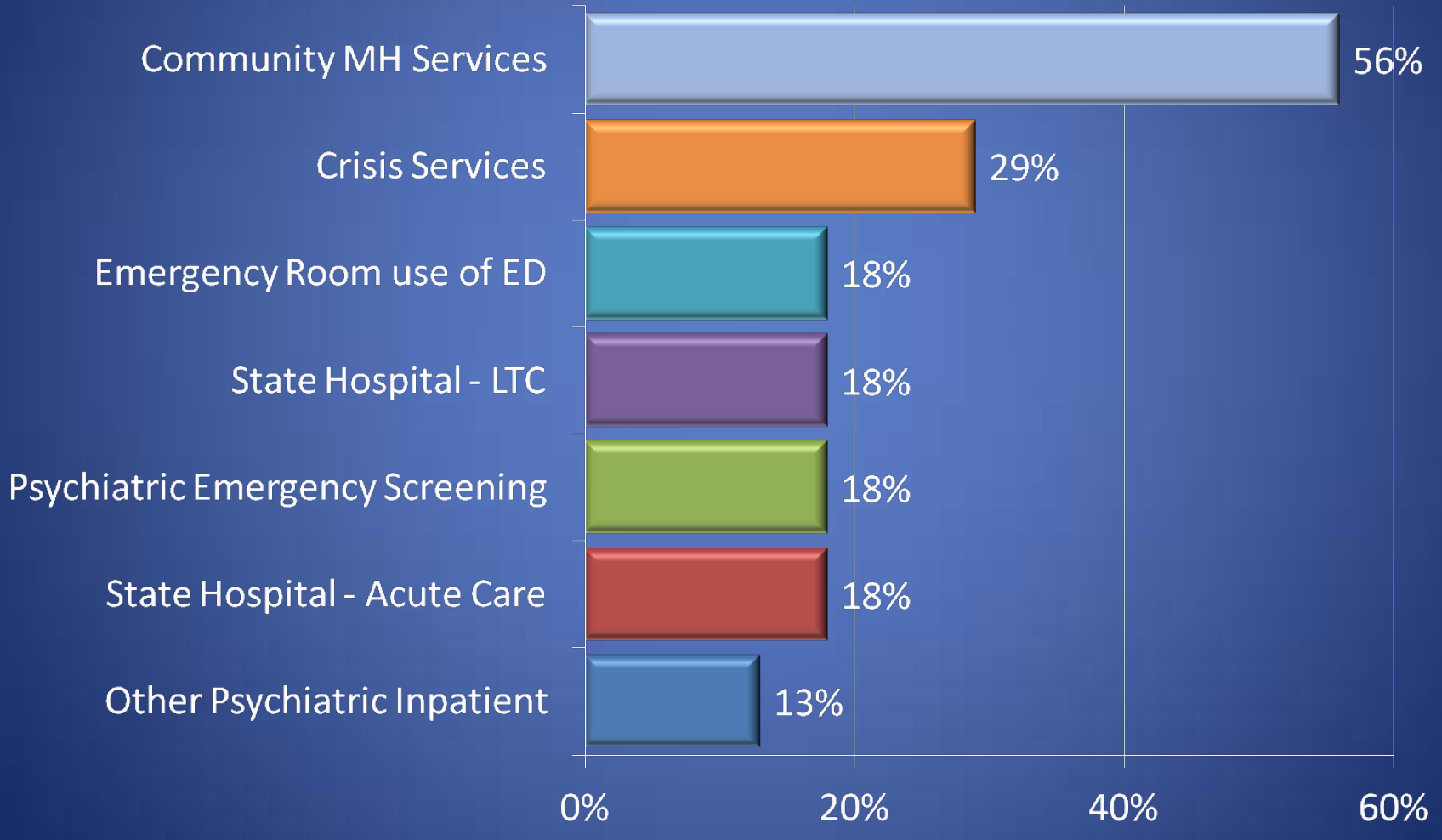
Source: NRI/NASMHPD 2010 Survey on Impact of State Budget Shortages on State Mental Health Systems: Results based on 47 SMHAs Reporting

AGONY

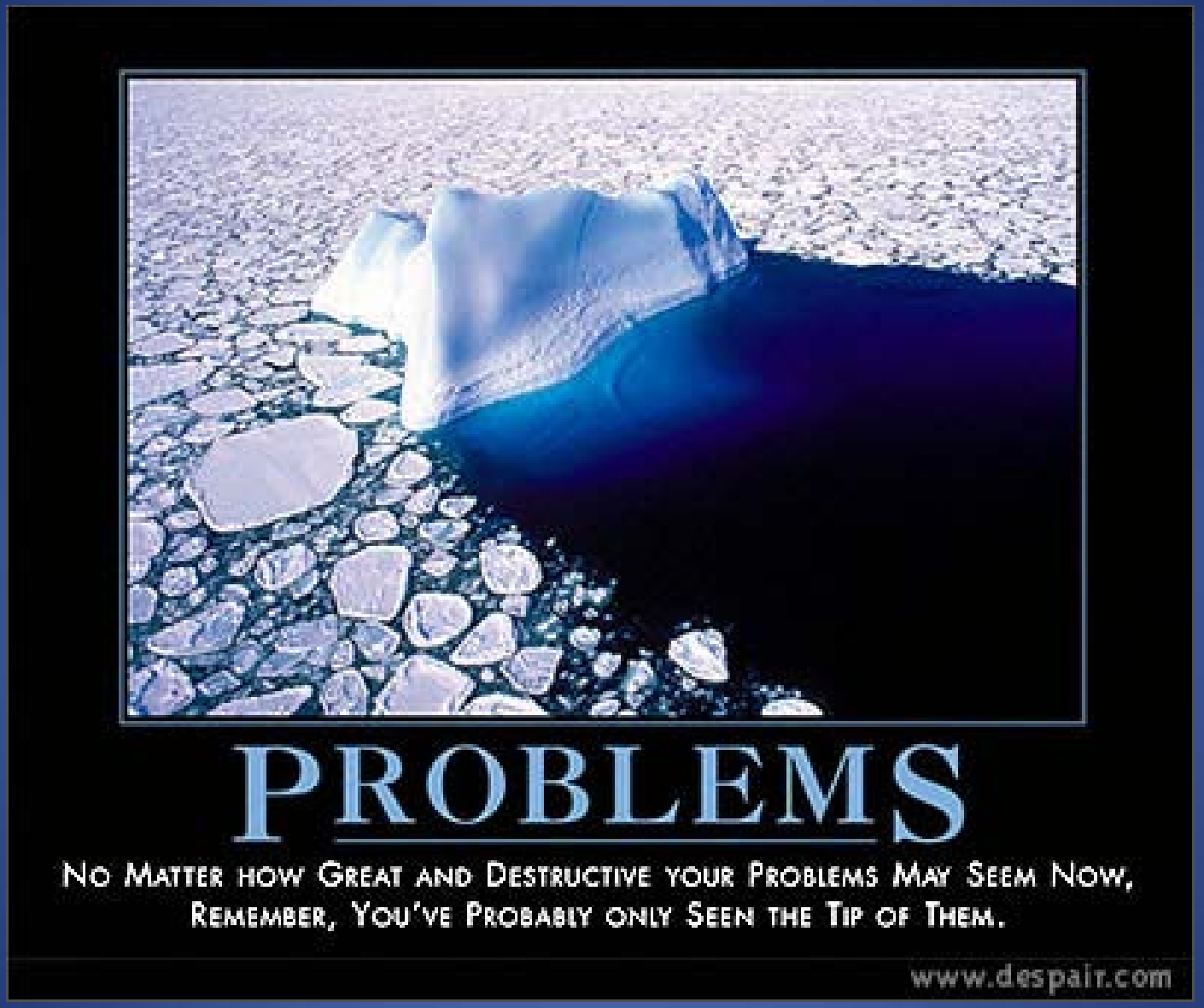
Not All Pain Is Gain.

Increased Demand for Mental Health Services During the Recession

Percentage of States Experiencing Increased Demand for Services



Preliminary Results based on 47 SMHAs Reporting


PROBLEMS
No Matter how Great and Destructive your Problems May Seem Now,
Remember, You've Probably only Seen the Tip of Them.
www.despair.com

The Budget Control Act of 2011
Five Key Provisions

- **Debt Ceiling Increased**
- **Discretionary Spending (e.g., SAMHSA's budget) Caps Enacted**
- **Special Committee Created to Identify Additional Budget Deficit Savings**
- **Enforcement Mechanism for Deficit Reduction Established**
- **Balanced-Budget Amendment Vote**

Debt Ceiling Increased

- President authorized to increase the debt limit by at least $2.1 trillion over the next 18 months, eliminating the need for further increases until 2013.
- By ensuring a debt limit increase of at least $2.1 trillion, deal removes the specter of default until after the 2012 elections.
- Law immediately increases the debt limit by $400 billion.

Debt Ceiling Increased, cont.

- Additional $500 billion increase in the debt ceiling will occur soon that will carry through February 2012.
- This action and future increases will be assured, unless rejected by 2/3 of Congress.
- $2.1 trillion figure is a benchmark in negotiations.

Discretionary Spending Caps Enacted

- Immediately enacts 10-year discretionary spending caps generating nearly $920 billion based on latest CBO projection in deficit reduction, balanced between defense and non-defense spending.

- Nearly $350 billion will be cut from the defense budget over 10 years.

- Only $21 billion will be saved in the first year (FY 2012 budget beginning in October 2011.)

Discretionary Spending Caps Enacted

- Mandatory spending funds entitlement programs like Medicaid and Medicare.
- Discretionary spending funds the rest of the government's agencies and departments.
- Discretionary spending is broken up into 12 appropriations bills, which can be passed separately or bundled together as an "omnibus" bill.

Where Things Stand – Lots of Dickering & Bickering

- Potential 8% cut to SAMHSA's budget.
- SAMHSA "PRNS" programs in jeopardy – potential 50% cut over FY 2011.
- Key programs related to suicide prevention, homelessness, consumer & family initiatives, integration of BH and PC services.
- Update on Senate and House Labor-HHS Appropriation bills.

Special Committee Created to Identify Additional Savings

- Bipartisan, bicameral Congressional Committee called the "Joint Select Committee on Deficit Reduction" required to report legislation to reduce deficit by November 23, 2011, which will receive fast-track protections.
- "Super-Committee" tasked with identifying an additional $1.2 to $1.5 trillion in deficit reduction.
- Committee can consider tax measures that increase revenue, as well as cuts in entitlements and defense.
- Congress is required to vote on the Super-Committee recommendations by December 23, 2011.

First Meeting of Super-Committee Setting the Stage

- Rep. Hensarling cited the rising costs of the Medicare and Medicaid programs as the main drivers of the long-term deficit issue.
- Sen. Baucus made a point of saying increased revenue must be part of the solution.
- Sens. Kerry and Portman urged the committee to go beyond the $1.5 trillion mandate and come up with a comprehensive, long-range plan to help ensure future fiscal stability.

First Meeting of Super-Committee Setting the Stage

- Sen. Jon Kyl said he might quit the committee if it considers additional cuts in military spending beyond the $400 billion already agreed to in the law.
- Rep. Clyburn said that it is plain wrong to put all the burden of debt and deficit reduction on the elderly, the middle class and the poor.
- Rep. Becerra highlighted that Democrats believe the need for new taxes is critical, particularly on the wealthy.

Where Things Stand – Getting Closer to a Deal?

- GOP intially willing to embrace higher taxes ($350 billion) as potential breakthrough; tax code revisions.
- Limit value of itemized reductions – e.g., breaks for home mortgage interest, charitable contributions; eliminate other tax breaks.
- Offered $1.2 trillion deficit-reduction package that would cut $750 billion, raise $500 billion in revenue.

Or is Time is Running Out in the Hour Glass?

- Democrats initially willing to accept reductions in federal health spending ($400 billion).
- Now calling for $1 trillion in new tax revenue and $1 trillion in spending cuts with Medicare and Medicaid taking a significant hit.
- Both spending cut initiatives could decimate the programs.
- But if the committee does reach agreement will Congress vote for the plan?
- “The Elephant in the Room”

Enforcement Mechanism for Deficit Reduction Established

- Enforcement mechanism established to force all parties to agree to "balanced" deficit reduction over 10 years.
- If Super-Committee fails to make recommendations to reduce deficit, enforcement mechanism will trigger spending reductions beginning in 2013 – split 50/50 between domestic and defense spending.
- Enforcement protects entitlements.
- "Automatic sequester" on spending programs ensures that – between the Committee and the trigger – Congress will put in place an additional $1.2 trillion in deficit reduction beginning in 2013 on top of the $920 billion discretionary spending caps.

COMMUNICATION

The only thing that keeps you from losing
the slight amount of job satisfaction you do have
is the fact that you don't really know what is going on.

Balance Budget Amendment

- A vote by both the Senate and House will be held this year on a Balanced-Budget Amendment to the Constitution.

- If approved by Congress, two-thirds of the states would have to approve the amendment in order for it to become law.

Implications for Behavioral Health Programs and Services

- It appears that immediate cuts to the Medicaid program – the major payer of publicly-funded behavioral health care services – have been avoided through the legislation.
- Super-Committee can recommend major entitlement cuts as it tries to find at least $1.2 trillion in budget deficit savings.
- Medicaid could incur major budget reductions over the next 10 years.

Implications for Behavioral Health Programs and Services

- Medicaid BH consumers could lose coverage – forcing them back into state hospitals and ERs to obtain needed care.
- States already making Medicaid cuts.
- As discretionary spending caps will increase over time, Federal agency budgets (SAMHSA?) could be subject to large cuts.

ACA & HEALTH CARE REFORM IMPLEMENTATION

Essential Health Benefits Package

- ACA mandated broad package of "essential health benefits" (EHBs) equivalent to a "typical employer plan" be offered by health plans participating in newly created state-based insurance exchanges.
- Congress directed HHS to flesh out the details. HHS, in turn, asked the Institute of Medicine (IOM) to recommend a process for defining and updating the EHB package -- but not to develop a specific list of benefits in the broad package.
- ACA stipulates that health plans must offer to individuals and small businesses who seek coverage through exchanges that packages "at least" include 10 broad benefit categories, including **MH and substance abuse disorder services, as well as "behavioral health treatment."**

Essential Health Benefits, cont.

- IOM recommended the initial EHB package offered by health plans participating in insurance exchanges be equivalent in scope to what could be purchased by the average premium a small business would pay on behalf of an individual employee.

- IOM said the EHB package should be adjusted so that the expected national average premium for a "silver plan" (second-lowest-price offered by plans) is actuarially equivalent to the average premium small employers will likely pay in 2014 for a typical benefit plan.

- Pegging small employer plans as the typical health plan that HHS should consider in determining the minimal EHB package, could serve to lessen the overall scope of BH benefits offered in the exchanges.

HEALTH CARE REFORM IMPLEMENTATION

Health Insurance Exchanges

- HHS and Treasury have taken steps to establish Exchanges, under the ACA .
- Exchanges are state-based competitive marketplaces where individuals and small businesses will be able to purchase private insurance beginning in 2014.
- States are already working to establish Exchanges and over half of all states have taken actions to build an Exchange.

Health Insurance Exchanges, cont.

- Proposed rules provide guidance determining whether individuals are eligible for coverage through the Exchanges, for premium tax credits to assist in the purchase of private insurance, or for Medicaid or CHIP.
- HHS and Treasury will conduct outreach campaign and solicit public comment on the proposed rules from state leaders, employers, consumers, health care providers, health insurers, and the public.
- Another rule includes several important provisions related to BH and access to care for those with BH needs.
- ACA requires exchanges to consult with certain groups of stakeholders as they establish their programs and throughout ongoing operations, and the specific requirement that exchanges consult with advocates for individuals with BH service needs, both as Exchanges are developed and ongoing.

Implications for Behavioral Health

- All health plans participating in the Exchanges will be required to offer health coverage to people with BH conditions and any individual with a pre-existing condition(s).
- BH benefits must be included in the benefit packages offered by health plans.
- As Exchanges are developed, SBHAs need to be involved in design and implementation of Exchanges to ensure that needs of BH consumers are represented.
- States required to solicit BH consumer input /representation during the planning and operation of Exchanges.

Health Care Reform – Quality Measures

ACA provision -- *Psychiatric hospitals and psychiatric units shall submit data on quality measures in "a form and manner and at a time specified by the Secretary."*

- ACA requires CMS to establish a quality reporting program, otherwise known as the "Pay-for-Reporting Program", for inpatient psychiatric hospitals for fiscal year 2014 and each subsequent year.

- There is a 2.0% payment linked to reporting quality data for Inpatient Psychiatric Facilities. CMS required to publish measures by October 1, 2012.

Quality of Care Measures, cont.

- Goal is to develop measures that will promote better health for the BH population, better care for individuals and lower cost through improvement in the delivery of care.

- Quality Measures will try to provide a reliable assessment of care that is both safe and is linked to improvement in important patient outcomes.

Quality of Care Measures, cont.

- In an effort to align this program with the other CMS quality reporting and value-based purchasing programs, CMS's aims are to include mix of standards, process, outcomes and patient experience of care.

- Goal -- Key alignment across Medicare and Medicaid programs, minimize burden, and seek national endorsement.

Quality of Care Measures, cont.

NCQA has developed "candidate measures" of medical care provided to people with schizophrenia for HHS. Measures focus on treatment of schizophrenia in outpatient settings, use of claims/encounter data, and are intended for reporting by state Medicaid programs. Measures address pharmacologic/physical health needs of individuals with schizophrenia.

Candidate measures are:

- Use and Continuity of Antipsychotic Medications;
- Cardiovascular Health and Diabetes Screening;
- Cardiovascular Health and Diabetes Monitoring;
- Follow-Up After Hospitalization for Schizophrenia; and
- Emergency Department Utilization.

Dual Eligible Population

- Coordination Office formed under ACA to ensure that dual eligible individuals have full access to the services they are entitled to; improve coordination between the federal government and the states, and develop innovative care coordination and integration models.
- Proposals that improve the care of the estimated nine million beneficiaries eligible to participate in both Medicare and Medicaid; states allowed to receive share of savings that result in improving the quality of care.
- Thirty-seven states have submitted letters of intent to CMS proposing Medicare-Medicaid demonstration projects to improve health outcomes for dual-eligible beneficiaries, according to federal officials.
- Kaiser Family Foundation and Urban Institute estimate that health care-associated costs for dual enrollees will exceed $315 billion in 2011, with Medicare paying about 55% of the total. In each program, these enrollees account for about one sixth of enrollment but almost 40 % of spending.

Medicaid Emergency Psychiatric Demonstration – IMD Exclusion

Section 2707 of the Affordable Care Act authorizes a 3-year Demonstration project under which psychiatric hospitals that are not publicly owned, or operated would receive Medicaid payment, to the extent of a state specific allotment, for providing emergency services required, pursuant to the EMTALA, for Medicaid recipients aged 21 to 64.

- State Medicaid agencies were invited by CMS to apply for participation in the Medicaid Emergency Psychiatric effort.

IMD Demonstration, cont.

- Demonstration is designed to assess whether the expansion of Medicaid coverage to include emergency services provided in **private** inpatient psychiatric hospitals improves access to, and the quality of, medically necessary care.

- Demonstration defines psychiatric emergencies as expressions of suicidal or homicidal thoughts or gestures resulting in a determination that the patient is dangerous to himself/others.

- Demonstration tests whether expanded coverage reduces burden on general acute care hospital ED's.

IMD Demonstration, cont.

- Tests whether and how differences in BH delivery systems -- including the availability of various types of beds in the state and level and types of investments in community-based BH services by the state -- affect the impact of IMD policy changes on cost, quality, and access to behavioral health care.

- Payments to participating States will be an amount each quarter equal to the Federal medical assistance percentage of expenditures for services provided under this Demonstration.

IMD Demonstration, cont.

- $75 million in Federal matching funds has been appropriated
- Funding limits determined for participating states based on yearly estimates of the number of individuals eligible for the Demonstration and cost of inpatient services provided.
- States selected will be very limited to ensure sufficient funds are available.

Implications for SBHAs and State Public Hospitals

- Applicants are limited to Medicaid agencies, but there are roles that SBHAs/State hospitals can play.
- Engage Medicaid Directors and alert them to the effort .
- Begin to evaluate whether your hospital would benefit if a private hospital in the area received one of the grants.
- Begin dialogue with state entities to develop innovative proposals, and reach out to private institutions that provide inpatient emergency psychiatric treatment – and other stakeholders – for potential collaboration.

CLASS Program Suspended

- Obama administration has suspended the long-term care program called Community Living Assistance Services and Supports **(CLASS)** – part of the ACA when it passed in 2010. Was to be financed by the premiums paid by enrollees; seemed unlikely to remain financially solvent.
- CLASS provision was supposed to provide cash payments to help people unable to perform basic living tasks to remain in their homes by hiring aides to assist them. And pay nursing home bills if higher levels of support were required.
- Critics raised concerns that the revenues brought in would not pay for the lifetime benefits and that the federal government would end up picking up the tab.

Constitutionality of the Affordable Care Act

- ACA has been under attack in the federal courts for the entire 18 months of its existence.
- Approximately 30 lawsuits have been filed challenging the law, and review by the Supreme Court by June 2012 now appears likely, given the Obama Administration and government's petition for such a review.
- Most cases brought through the judicial system claim that Congress exceeded its constitutional authority in enacting the ACA, especially in regard to the individual mandate. All the litigants want a definitive ruling on the question of whether Congress constitutionally adopted the individual health insurance requirement.

“We’re Lost – But We are Making Good Time.”

Yogi Berra

For Follow-up Questions and Further Information, Please Contact:

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