

# UNDER THE MICROSCOPE

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## THE CHANGING LANDSCAPE OF MEDICAID

### WHAT YOU NEED TO KNOW AND DO TO NAVIGATE, ADVOCATE, AND NEGOTIATE

**TOPIC:** As the federal government grapples with a multi-trillion dollar deficit, a combined state deficit of \$136.1 billion will be recorded from FY2010 to FY2012. Much of this state shortfall then falls on counties. Perhaps nowhere are the effects seen more clearly than in the changing landscape of the Nation's largest health insurance program and federal-state partnership, Medicaid, a critical federal funding source for counties. Serving almost 50 million low-income adults and children—a disproportionate number of whom have mental or substance use disorders or developmental disabilities—Medicaid is a significant funding source for safety-net public hospitals, clinics and other county entities, fueling local health employment and economic activity. In fact, when fully implemented, the Affordable Care Act (ACA) will widen Medicaid's vista, extending coverage to additional millions of poor and near-poor people in need of health care. Yet, despite economic uncertainty and historic levels of both poverty and unemployment, the Medicaid program is being forced to do more with less.

When it comes to county health care for people with mental illnesses, substance use disorders and developmental disabilities, the Medicaid landscape presents a mixed picture. Some proposed and implemented changes are beneficial, such as broadened access to care and beefed-up parity requirements under the ACA. Other changes—funding cuts and service changes proposed by some federal and state legislators—could damage the health of people with behavioral disorders and the capacity of counties to serve them.

This first **Under the Microscope** takes a look at Medicaid issues about which county behavioral health and developmental disability authorities should be concerned, suggesting actions for you to take today and tomorrow.

**ANALYSIS:** County behavioral health and developmental disability authorities protect the public health, providing care and support for people with serious mental or substance use disorders or developmental disabilities at public hospitals, clinics, schools, correctional facilities and other community settings. These authorities also may contribute to (or pay all of) the state match for some Medicaid services, like mental health care and case management, long-term care and administrative costs. Working on the front line of prevention, treatment, and recovery services, county behavioral health and developmental disability authorities provide a large volume of dollars and human capital to assist millions of Medicaid beneficiaries with serious mental illnesses, substance use disorders or developmental disabilities.

*What is changing?* While the ACA holds the promise of greater availability of evidence-based health care for millions now uninsured or underinsured, county behavioral health and developmental disability authorities at the same time must grapple with reductions in overall health funding, amplified by growing national joblessness and economic uncertainty.

- On June 30, 2011, FMAP's temporary increase in federal Medicaid funds provided in the stimulus package ended, effectively cutting federal Medicaid dollars to states.
- Since FY 2009, many states have cut non-Medicaid mental health funding; more cuts are on the way.
- ACA changes will make insurance available to 32 million adults who now lack coverage, half of whom will become Medicaid enrollees, of whom as many as 1/3 are likely to have a pre-existing mental illness or substance use disorder.

States and counties face difficult choices about what to do about Medicaid, whom to cut and how to cut while staying within current Medicaid law and regulation. Among the issues affecting county behavioral health and developmental disability programs and funding for good or ill are:

- Eliminating or downscaling optional Medicaid services, a list that, with the exception of EPSDT, includes most adult and child mental health services (e.g., ACT, supportive housing, intensive case management, crisis intervention, wrap-around services, and medications).
- Funding reductions that could compromise key county and other local efforts to move from community placement to community engagement for people with developmental disabilities.
- Managing a dramatic increase in Medicare beneficiaries with substance abuse problems among the 32 million being added to the rolls under the ACA since the 1998 exclusion of substance abuse as a qualifying SSI disability had excluded many with substance disorders from Medicaid.
- Moving toward a managed health care model consistent with the ACA's assumption that benefits will be managed based on quality and outcomes. Given the spotty history of both Medicare and behavioral health with managed care, emphasis should not be placed on managing costs, but rather on rewarding effective performance and positive outcomes related to implementation of best practices in prevention, early intervention, treatment and recovery.
- Growing state and federal efforts to cut funding for health promotion, illness prevention and early intervention, despite the ACA's emphasis on these key services.
- State decisions either to drop out of Medicaid altogether or to seek a federal waiver to reframe Medicaid in ways not necessarily transparent to program stakeholders at the county, local and individual levels.
- The need to consider if Medicaid beneficiaries also are Medicare eligible. One of the most difficult to care for and expensive populations, these "dual eligibles" are a key focus for CMS; they also will be one of your most significant county care challenges.

As a result of state-related funding and service changes, clearly, counties behavioral health and developmental disability programs will face difficult choices related to downsizing or eliminating staff, programs or contracts.

*What else is under consideration?* State Medicaid cuts and changes are only the tip of the iceberg for the county behavioral health and developmental disability enterprise. A number of potential federal changes to Medicaid also are being discussed, among them:

- Converting Medicaid to a state block grant, indexed to inflation and population growth. Federal budgeteers suggest it could save some \$750 billion over 10 years. Since such a proposal could put counties, states and Medicaid service providers at risk, counties may well experience a second round of major cost-cutting.
- Repealing current Maintenance of Effort requirements. Such a change could result in draconian limitations on Medicaid eligibility for low-income children, parents, seniors, and/or people with serious disabilities — the principal groups covered by Medicaid.
- Establishing a federal "blended" matching rate for Medicaid, the net impact of which would be a reduction of federal Medicaid money. The result could give rise to reduced state benefits or enrollment, particularly among "optional" populations, such as single adults and childless couples, a large proportion of whom suffer from behavioral disorders or developmental disabilities.

Ironically, the effects of most of these cuts for county behavioral health and developmental disability authorities might well be to cost more than they save. At the very least, costs will rise, not only due to later diagnoses and treatment of sicker people, but also due to the shift in care and financial responsibility to emergency rooms, law enforcement, correctional facilities and homeless shelters.

**ACTION STEPS:** Taking action begins with the understanding that *all health care is local care and that all local care for behavioral health and developmental disabilities is individualized, coordinated and supported*. Thus, in a changing economic environment, it is critical for county behavioral health agencies to develop the agility not just to *adapt* to change, but also to *make change happen* in ways that best benefit the people we serve. That means doing better than living with a patchwork of underfunded programs. It means working smarter, knowing the questions to ask and partnerships to pursue, and taking a rightful place at the policy table before decisions are made. For example:

- When it comes to the loss of the FMAP supplement, how are you adapting? Are you picking up a greater share of Medicaid? Are you supplementing Medicaid funds with other local funds?
- What are you doing to safeguard the maintenance-of-effort (MOE) requirements critical for people with behavioral and developmental disabilities? It is key to ensure that, consistent with the ACA, these and other at-risk populations still have access to Medicaid benefits such as EPSDT, transportation and other wraparound services.

- When it comes to replacing lost revenues, are you looking to pool resources? What are you doing to collaborate on promotion and prevention efforts with county public health agencies? What are you doing with the criminal justice system to collaborate both inside and with diversion programs, parolee and release programs? What are you doing with schools and child and family welfare programs to maintain and/or strengthen wraparound services? What about housing and transportation programs?
- With the move toward managed care, what are you doing to assure that quality, not cost, is being managed? How are you responding to proposals to “manage” services by excluding or limiting certain practices?
- Medicaid costs are driven up by patients with multiple chronic conditions that being managed in a coordinated way, among them many people with behavioral or developmental disabilities with other, often untreated or undertreated co-morbid disorders. What are *you* doing to explore integrated care, such as the “medical home,” as a means of providing coordinated care and holding down costs? Are you looking at models that either move primary care into behavioral health/developmental disability settings or the reverse? Remember, integrated care also can leverage limited resources by pooling infrastructure and administrative costs.
- With the move to managed Medicaid, some states are looking to manage prescribing medications to cut costs. What are you doing about this potential? Are you prepared to cope with a limit on the number of prescriptions an individual can get filled? Are you prepared to manage with plans that curb known-effective, but expensive second-generation psychotropic meds?
- Are you seeking other sources of funding to meet the needs of people with behavioral or developmental disabilities living in your county? For example (and there are others at the local, regional and national levels), you may want to consider the Prevention and Public Health Fund (PPHF) that is providing \$15 billion in dedicated funds for state and local prevention and public health activities over 10 years.

In an era of instant communications, you can't wait to be invited to the table as a participant. Invite yourself as a significant player. Then sit down and start negotiating.

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