



**Comments on Proposed Budget to Senate Finance Health and Human Resources Subcommittee
January 17, 2011**

In the introduced budget we support

- **\$4 million to expand crisis stabilization** to help adults with serious mental illness experiencing psychiatric crisis, reduce hospitalizations, divert people from incarceration, and provide better support systems in the community for persons experiencing crises.
- **\$2.4 million for targeted community-based mental health services** to address the downsizing that has occurred at Eastern State Hospital.
- **\$5 million for regional crisis stabilization to address psychiatric crises** for individuals with intellectual disabilities and co-occurring mental health disorders
- **\$2 million to restore funds to re-open a 20-bed geriatric psychiatric unit** at Southwestern Virginia Mental Health Institute in Marion, Virginia
- **Increased capacity for DBHDS** for licensing and oversight of funding and programs

In the introduced budget we oppose

- ***Eliminating Comprehensive Services Act (CSA) funding/services for “non-mandated” populations.*** CSA serves children with mental health needs. The “mandated” populations CSA are children in special education and children in foster care. Eliminating the ability of CSA to serve “non-mandated” children will result in loss of services for about 1,400 kids with mental health needs who are served by the CSBs or juvenile justice. CSA allows communities to identify and figure out what the gaps and needs are, and how to best fill them for children in need. This proposal compromises that ability.
- ***Reclassifying “Therapeutic Foster Care” as a “Residential Service” for children and adolescents with mental health needs.*** This reclassification has the effect of increasing the local funding match rate for therapeutic foster care services. Although the proposal will save the state more dollars, it will shift the cost to the localities and create a disincentive to use therapeutic foster care for children with serious emotional disorders in need of secure and viable treatment options that are close to home. This increase in local match for therapeutic foster care will lead to an overreliance on residential treatment centers which the state has worked diligently over the past three years to avoid. Further, the savings are not reinvested to help bolster and expand children’s mental health services.

Our position on the Governor’s managed care proposal

We support health care for all persons with mental illness that is affordable, nondiscriminatory, and includes coverage for effective and appropriate treatment. The movement of state Medicaid systems to Medicaid managed care presents the possibility that managed care companies will focus on controlling health care costs at the expense and well-being of the person. We therefore maintain the following principles regarding expanding Medicaid managed care to adults with serious mental illness and children with serious emotional disorders:

1. ***Mental health/substance abuse services should be carved out.***

- “Community mental health rehab services” under the state Medicaid plan provide many of the keys to helping adults and children succeed in the community. Services under “rehab services” include crisis stabilization, psychosocial rehabilitation, intensive community treatment/PACT, substance abuse, and intensive in-home and therapeutic day treatment (kids’ services).
- Carve-out programs are more likely to include specialized benefits including rehab services, supportive and residential housing, and recovery-oriented support services that are vital.
- From experience of other states, the states that have pursued carve outs is where access tended to be good and services were provided. States that did NOT include a carve out – many problems authorizing services, seeing doctors, problems getting crisis services, problems getting medications, and other types of problems.

2. *Transparency, accountability, and choice should be ensured in any managed care proposal.*

- In the services that are available to adults with serious mental illness and children with serious emotional disorders
- In the rules and regulations about those services
- In defining “medical necessity” about the managed care company’s discretion to deny or restrict services.
- In grievance and appeals processes available to the plan-holder’s ability to appeal denials or limits to services
- Performance of managed care companies must be documented, publicly available, explicit and detailed, benchmarked, and independently validated.

Managed Care and Medical Necessity

Most MCO’s develop their own definition of “medical necessity”. The definition often provides MCO’s the broad discretion to deny or restrict access to services. For example, many MCO’s do not consider suicide attempts or suicidal ideation as a “medical necessity”.

3. *Remove as few resources as possible from the system.*

- There continues to be a shortage of high quality community-based mental health care services for adults and children in Virginia, despite gains that have been made in recent years. Efficiencies that are found from managing care should be retained and reinvested.
- Virginia should not cut its budget in anticipation of savings when implementing managed care. If there are savings to be realized from managed care those savings should be reinvested to improve services rather than revert savings to the state general fund.

Summary of NAMI Report on Consumers' Experiences with Medicaid Managed Mental Health Care

NAMI's report, *Stand and Deliver: Action Call to a Failing Industry*, observed that managed care plans failed to deliver on the following expectations:

- Publicly available and current practice guidelines,
- Easy hospital admission and flexible hospital length-of-stay,
- PACT (Programs of Assertive Community Treatment) programs,
- Immediate access to all effective medications,
- Suicide attempt viewed as a medical emergency,
- Consumer and family participation in their treatment planning and care,
- Measurement of clinical outcomes,
- Access to psychiatric rehabilitation,
- And access to secure and supportive housing.

Further, NAMI's survey of consumer and family experiences with managed care, 25 percent of respondents had positive experiences with managed care in four areas:

1. improved access to treatment,
2. emphasis on preventing crisis,
3. focus on consumer satisfaction,
4. and decreased unnecessary hospitalization.

The five areas of most negative experience with managed care were:

5. Don't know how to file an appeal (55 percent);
6. Seeing the patient's doctor (41 percent);
7. Problems getting medications (34 percent);
8. Problems getting crisis services (33 percent);
9. And problems getting admitted to a hospital (28 percent).

Filing appeals for denials and limitations of service/treatment:

- Twenty-five percent of respondents had filed an appeal with their health plan
 - Families were successful 54 percent of the time on behalf of the plan member and the individual plan-holder was successful 42 percent of the time.