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CULTIVATING LEADERS FOSTERING INNOVATION

ACMHA ARM CHAIR REFLECTIONS
Financing – 2001 Summit

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In 2001 the topic of the ACMHA Summit in Santa Fe was financing – the money and incentives involved in the purchase of mental health and substance abuse services. In keeping with the "financing" theme, a "marketplace of ideas" was created in which Summit participants traveled from table to table where thought leaders were "selling" their ideas about issues of financing behavioral health services. Roving reporters observed this exchange and reported on their observations.

After the Summit concluded, a group of participants produced a white paper entitled *"Financing Results and Value in Behavioral Health Services"* in which ACMHA called for the following:

1. Conducting a "fearless inventory" of what is bought, how it is bought, and how value for those dollars is measured;
2. Tying reimbursement schedules to the use of evidence-based practices;
3. Implementing different purchasing methods, specifically network purchasing in which all providers and payers are held accountable for person-centered outcomes; and
4. Funding demonstration projects that use new financial strategies to produce better outcomes, results, and value.

The Summit also resulted in a call for at least five percent of community behavioral health money being spent for consumer and family-operated services by 2005 (dubbed 5 by 5), a goal that has yet to be achieved and that has fallen by the wayside in terms of pressure to achieve it and tracking what gains have been made.

Now, nine years later, it is clear that money, systems, and leadership still matter in producing results and value in behavioral health services. Gains have been made in viewing and using financing differently, but much remains to be accomplished and, in some cases, financing changes have made producing results and value even more difficult. High level reflections about the current state of behavioral health financing are presented below, along with recommendations about financing going forward.

<u>Money Still Matters</u>

Over the years, numerous writers have made the point that money matters in seeking behavioral health results and value. The amount of money, the type of money, and the use of available money still drive what is achieved in behavioral health delivery systems.

Amount of Money
While spending more money on a problem does not necessarily solve it or make it better and while more could be done with available money, it is clear that behavioral health care in America is still inadequately funded. This reality is getting worse. Despite increased Medicaid spending on behavioral health and despite parity requirements at the federal level and in many states, the amount and proportion of public funding for behavioral health has not increased substantially as a proportion of either total health care expenditures or gross domestic product (GDP). Public funding increases are often targeted for new services or facilities rather than for existing infrastructure or essential community-based services, leaving safety net services scrambling to deal with rising costs of salaries and benefits and uncovered costs such as transportation and professional development.

Limited new dollars are often spent for behavioral health care for growing adult prison and juvenile justice populations while basic community-based provider rates in many states have been frozen for 10 years or more. The CMHS Mental Health Block Grant receives four percent less in constant dollars than it did in 2003[1], and most state and local government fund increases have been allocated to support growing match requirements in Medicaid or growing needs of populations for which those jurisdictions are directly responsible – in jails, juvenile detention or juvenile justice centers, adult prisons, or state hospital facilities. Without infrastructure investment, community mental health and substance abuse services programs are struggling just to stay afloat and to address increasingly complex billing and compliance requirements.

Despite the current emphasis on healthcare reform[2] there is no expectation that provisions of a final bill will dramatically alter the overall behavioral health financing status, certainly in the short term. The expectation is that there will be increased pressure toward formal integration of behavioral health with general health, which could induce competition for limited dollars rather than synergy that yields improved outcomes.

Type of Money
Medicaid continues to be the primary source of funding increases with the proportion of total behavioral health spending that is Medicaid growing nationally and in individual states and localities.[3] Medicaid is a crucial source of funding for individuals with lower-incomes and/or severe disabilities. It is also a 'medical assistance program' using fee-for-service or encounter-based claims payments in small (typically 15-minute) time increments that reward production of multiple services rather than appropriate outcomes. Medicaid as a payment source encourages episodic, short-term acute care. Medicaid does not yet effectively treat persons with severe and persistent behavioral health needs either as persons with disabilities (e.g. persons who are developmentally disabled) or as persons in need of a specialty health service. Nor does Medicaid have reimbursement mechanisms that foster integrated interventions for people with complex, co-morbid conditions. Medicaid does not have a way to compensate for the start up costs of implementing a new evidence-based practice in behavioral health, and does not yet have a way to pay for performance in the behavioral health arena.[4] In addition, Medicaid exclusions of

[1] Unpublished report from NASMHPD.
[2] This paper is being finalized in January, 2010 when no final bill has emerged from the Congress.
[3] "Within State Mental Health budgets, Medicaid accounted for 42% of revenue in 2005 and nearly two thirds of all new spending from 2001to 2005." Buck, Jeffrey A. ***Recent Changes in Medicaid Policy and Their Possible Effects on Mental Health Services*** Psychiatric Services 60:11 November 2009
[4] This is true for fee-for-service Medicaid reimbursements. However, several managed behavioral health care programs under Medicaid waivers have developed mechanisms incentivize providers for attaining defined performance targets.

payment for individuals in jail, prison, detention centers, state hospitals, and some residential settings results in a perverse incentive with no financial risks or penalties if enrolled clients end up homeless or involved with the justice system. Likewise, Medicaid does not typically provide positive incentives designed to encourage providers to seek out and serve people with the highest risk and most complex conditions.

Medicaid covers children and very low income families more than it does childless adults. While proposed provisions in federal health care legislation may expand eligibility, it may be for a limited set of behavioral health benefits as defined in "benchmark plans." Yet, since Medicaid is the only source of funding that is growing consistently, relying on this funding source leaves those individuals and services that are not Medicaid eligible increasingly vulnerable. In addition, as states face shrinking resources, Medicaid authorities are weighing options to reduce or eliminate optional services that cover flexible community supports and evidence-based treatment.

Similarly, to the extent the population is aging and increasingly dependent on Medicare, the limitations in coverage for behavioral health services from that fund source are adding to the problem. While the prescription drug program within Medicare has been helpful for many, persons dually eligible for Medicare and Medicaid now have to manage two complex funding streams to have psychiatric or substance abuse medications covered (many of the latter which are not yet covered by either source).

Use of Money

Most behavioral health fund sources still reward production of more units of service or continuation of existing programs rather than innovation, new service approaches, or production of outcomes. While some systems are working to align financial incentives with policy and performance goals (King County, WA for example) and many systems are now exploring this approach, much remains to be done to use financial incentives to encourage or purchase stable housing, success in jobs or school, reduction in suicides or DWIs, reduction in interaction with court and justice systems, achievements in individuals' life goals, and encouraging successful transition out of high intensity services (e.g., residential treatment, ACT teams) and towards self-sufficiency. Much also remains to be done to reward systems and providers for delivering the right kind of services and supports rather than simply paying for a unit of service whether or not that service is demonstrated to make a difference to the person served.

Facilities with fixed costs continue to be funded first. State hospital admissions and daily censuses are growing again for the first time in decades. In many states, a growing industry of group homes and board and care facilities is commandeering most of the income people receive from SSI or SSDI without creating real home atmospheres supportive of dignity and growth as human beings. Substance abuse treatment facilities are also experiencing an increase in utilization and lengths of stay. Treatment in the community is not always readily available for individuals who no longer need a higher level of care. Substance abuse treatment facilities are also being created to deal with methamphetamine and other insidious drugs, especially for those ordered into treatment from courts without clear planning for who will pay for those ongoing treatment and support needs once individual's leave costly facilities and are back in the community.

Performance measures and incentives are increasingly incorporated into public contracts, but they are often based on process indicators or on service efficiencies rather than on real outcomes for real people in their everyday lives. Pay for performance has not been implemented in most behavioral health care systems. Desired outcomes, despite ACMHA's early work after its first Summit and despite some work by SAMHSA for its block grant programs, have still not been accepted or adopted across jurisdictions and certainly not across funding streams or service modalities.

Likewise, despite the gains in understanding the importance of integrated substance abuse and mental health services for persons with co-occurring disorders, data and reporting systems for Medicaid and many state-level claims payment systems still disaggregate mental illness and substance abuse diagnoses, requiring a "primary" and a "secondary" diagnosis rather than allowing for a co-occurring diagnosis as *the* single diagnosis to be entered into the data system. This, along with continued lack of understanding about the need to acknowledge and address the co-occurrence of these disorders, plus the ongoing separation of service delivery systems for substance abuse and mental health, is an evident failure of financing systems.

Today, financially strapped providers must emphasize increased billing productivity or improved billing processes for services that have been historically reimbursed rather than assuring that staff is competent to provide the *right* kind of services and supports for the type of person, diagnosis, or situation that is in front of them. Funding for installing new evidence-based practices is almost non-existent; that is, funding streams rarely pay for the "non-productive" hours spent training staff on new approaches or implementing those approaches. An earlier ACMHA Summit (2000) focused on workforce issues and made the explicit connection between the competence of individuals AND the competence of systems in which they provide services, but resources have not been available to invest in workforce development strategies. Peer supports are now included in several states' Medicaid plans, but peer workers are rarely integrated into community services and programs.

Finally, the vast majority of research dollars are spent on determining how the brain works - to improve diagnoses and to improve the efficacy of new medications. While such basic brain research is extremely important, relatively little money is spent on research into how people's lives function and can improve with better and more targeted human interventions and supports in the communities in which they live. In addition, the science of dissemination has advanced dramatically since the 2001 Summit, yet the field is not using that science to broadly ensure adoption of service modalities that we now know really work.

Systems Still Matter

In addition to money, systems and how they are structured still matter a great deal. Despite the promise and call to action of the President's New Freedom Commission on Mental Health, fragmentation, duplication, and inconsistencies of goals and approaches still abound. Additionally, despite the focus of specific grants from SAMHSA, transformation in systems has really not occurred, although a few places are experimenting with major system changes.

Fragmentation and Misaligned System Values and Goals

Behavioral health issues are still driven out of multiple systems with multiple goals. Depending on which system (justice, public health,or traditional behavioral health), the belief about what works is still driven by the goal that system is trying to achieve. For example, reduction in

recidivism, reduction in traffic fatalities caused by drinking while driving, and reduction in incidents resulting in bodily harm in encounters between police and persons with untreated mental illness or substance abuse all drive toward mandatory approaches to interventions and treatment. On the other hand, goals related to self-determination, recovery, and use of natural supports in the community motivate service strategies based on engagement, provision of choice, and increasing the attractiveness of services themselves so that consumers and their families see their value.

Duplication

Considerable duplication of effort remains, with multiple activities addressing the same problem. Boutique or pilot projects are launched to address the most recent incident or identified problem as described by the most recently engaged constituency without consideration of how to judge whether the pilot worked, whether it is in fact the solution, and whether or how to integrate and sustain it with mainstream resources to take it to scale. Multiple task forces and advisory groups are formed to work on similar problems because it is easier to say that voices are needed around the table than it is to make decisions about necessary systems changes and/or to commit the funding and effort needed to truly solve the problem.

Inconsistencies and Inefficiencies

With fragmented systems and continuing duplication of effort, inconsistencies in service definitions, goals and desired outcomes, and reimbursement methodologies remain in force. There remains a maze of eligibility, administrative, program, funding, and reporting requirements and a maze of different service taxonomies for the same population or program approach driven by different jurisdictional levels, different systems, and different funding streams. This results in continued inefficiencies in use of limited dollars, with funds becoming even more categorical over the past decade.

Leadership Still Matters

Financing cannot change – and therefore the results and value of those dollars spent cannot change – without leadership at the federal, state, and local levels. Ultimately, it becomes necessary to address the politics of change. This is not the partisan politics of Congress, statehouses, and city and county councils around the country, but rather is politics related to the allocation of scarce resources that determine who gets what services, for what purpose, and with what priority.

Federal Leadership

SAMHSA is the leading voice for substance abuse and mental health service issues at the federal level. In the past, SAMHSA's voice was primarily relegated to the limited federal dollars it oversees. Block grants and special grants are either *the* primary funding stream for some efforts (e.g., community-based substance abuse services) or are isolated from mainstream resources in other arenas. In the past SAMHSA was less effective asserting leadership related to evidence-based practices or desired outcomes in other systems or in other funding streams such as Medicaid and Medicare under the Centers for Medicare and Medicaid Services (CMS). New leadership now provides significant opportunities for SAMHSA to directly influence the implementation of national health reform, other Medicaid and Medicare policy changes, federal research priorities, supportive housing, veteran's services, and health/behavioral health integration efforts. SAMHSA also has the opportunity to provide tools to state and local mental health and substance abuse authorities to assist them with data analysis and financial modeling

to support their participation in system improvement efforts and their efforts to sustain SAMHSA funding through mainstream funding sources.

State/Local Leadership
Although the federal government can and should provide greater leadership than has been evidenced in the past, most initiatives to overcome systemic barriers to serving the highest need consumers and the implementation of best practices must be designed and delivered at the state/local level. The state and local level is where the politics of resource allocation decisions are carried out on a daily basis. Federal leadership and creative financing ideas will not get much traction unless state and local leaders have the will and the wherewithal to carry them out. For many reasons – including the ascendency of Medicaid as the prime funding source, attention to criminal justice issues, and state efforts to save funds through reorganizations – mental health and substance abuse authority leaders have been disempowered and/or have a more complex interorganizational field in which to navigate. Mental health and substance abuse authorities also suffer from the "wrong pocket problem" – that is, if they do a good job the financial payoff frequently benefits agencies other than the mental health or substance abuse authority. Reducing homelessness and incarceration of people with serious behavioral health needs costs behavioral health authorities a lot of money, but success in these endeavors rarely saves these same authorities much money. For all these reasons state and local leadership often must take the form of inter-system advocacy and coordination in addition to the direct management of down-the-system service improvements.

Recommendations
With some adjustments for progress made and lessons learned in the past nine years, the financing recommendations of the 2001 ACMHA Summit are still valid and important. These are reiterated and summarized below.

1. ***Fearless inventory – just do it***. This includes a practice that Dr. Richard Frank (a health economist formerly at Harvard and now deputy to the Assistant Secretary for Planning and Evaluation at HHS) refers to as "exnovation." By this he means no longer doing things that we know don't work. The inventory should address not only what services are being reimbursed/financed now, but also who is getting those services. In addition, the inventory needs to address gaps in the system – gaps in best practices, provider capacity and workforce competencies, geographic and physical access, and service competencies related to special populations. Purchasers/payers such as state and county behavioral health authorities and the state Medicaid program should be asking: "To what degree can we assure that the right consumers receive the right services at the right time in the right amount with the right consumer outcomes?" Providers, who of necessity must respond to market forces driven by purchasers/payers, should be asking: "What would we have to do to assure we can deliver the right services to the right people with the right outcomes if the system starts to purchase services that way?" Providers might also ask: "How can we assure through collaboration and information sharing that purchasers and payers are providing the correct financial incentives to convert from whatever is being delivered today into services that are known to work for the highest priority target populations?"

2. ***Prudent purchasing of best practices and positive outcomes***. Prudent purchasing is one important mechanism for turning the results of the fearless inventory into effective strategies for change. Payers/purchasers need to think of themselves as creating market

forces (such as competition) and market incentives (such as performance payments) that reinforce movement towards desired service modalities, consumer outcomes, and system performance. Prudent purchasing results in resource re-deployment away from less desired service modalities and settings and toward more desired and efficacious modalities and settings. To be successful, this intention to re-deploy resources should be explicit. Providers have typically done what the system has paid them to do. Communities and other local entities (e.g., police, general hospitals, schools, and homeless shelters) have learned to function in the context of what has been paid for in the past. Families have fought long and hard to get the services they have for family members (even if it's not what they really wanted.) In all cases all stakeholders need to understand the objective basis for the redeployment of resources. In particular, providers need to understand how they can "win at this new game."

3. ***New financing demonstrations***. Key federal agencies[5] should jointly and collaboratively develop rigorous and replicable demonstration projects that seek to coordinate, integrate, or blend funding. Their efforts should ensure that these projects purchase a set of services that are evidence-based (or promising practices), include pay for performance strategies, and include recovery-oriented and consumer-operated services. These projects should also include the basic concepts of health care reform including clinical home and use of technology to deliver services and share information.

4. ***Federal state and local leadership and advocacy.*** Leaders at all levels need to concentrate on financing as the major driver of system transformation and implementation of best practices. Dissemination of knowledge, staff training, and special-purpose demonstration projects are positive, but can never effectuate the desired system improvements without the proper financial incentives and rewards for success. System and service delivery changes will also remain limited and idiosyncratic unless leaders find ways to invest in the change process itself. In almost all cases, the desired improvements in best practice services and targeting resources to the highest priority consumers cannot happen within current financing silos. Thus, leadership must have a cross-system and collaborative vision and implementation strategy for the change process.

A Call to Action

New leadership at the federal level provides the opportunity for rethinking how we purchase mental health and addiction services. Many federal appointees have managed state and local agencies that were responsible for purchasing billions of dollars in behavioral health services. They understand and have experienced significant frustration with the limitations of current purchasing practices and the federal/state barriers that thwart innovation. They understand that historical "purchaser silos" also contribute to static thinking regarding purchasing. These new leaders should be challenged to develop collaborative strategies that will lay the foundation for new and more effective approaches and strategies for purchasing best practice cost effective services for people with the greatest need for services and supports to attain recovery, resiliency, and self-sufficiency in the community.

[5] These include The Centers for Medicare and Medicaid Services (CMS), Office of National Drug Control Policy (ONDCP), Assistant Secretary for Planning and Evaluation (ASPE), Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), the Department of Housing and Urban Development (HUD) the Department of defense (DoD) and the Veterans Administration (VA).