Georgia Association of Community Service Boards, Inc.

February 29, 2012

Jerry Dubberly, PharmD, MBA
Chief, Medicaid Division
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303

RE: Comments on the Navigant Medicaid and CHIP Redesign Final Report

Dear Dr. Dubberly:

The Georgia Association of Community Service Boards (CSBs) welcomes the opportunity to comment on the Navigant Medicaid and CHIP Redesign Final Report. The Association is the voice of Georgia's public safety net behavioral health and developmental disabilities services providers. The 25 CSBs currently serve thousands of adults and children with mental illness, developmental disability, and substance use disorder in every county of the state.

A recent publication of the National Council for Community Behavioral Healthcare asserts, "States cannot achieve true integration of clinical services in managed care arrangements simply by contracting with a managed care entity. Clinical integration requires access to appropriate personnel, services, and supports that are paid for and aligned within the managed care approach."[1]

CSBs believe this is good advice, and encourages the Department of Community Health (DCH) to take all necessary steps to ensure that adults with chronic health conditions, such as serious mental illness (SMI) or substance use disorder (SUD), and children and youth with serious emotional disturbance (SED) or SUD, and adults and children with developmental disability have access to services specifically designed to meet their needs.

Impact on Settlement Agreement

[1] National Council for Community Behavioral Healthcare. July, 2011. "Increasing Access to Behavioral Healthcare: Managed Care Options and Requirements." Retrieved February 23, 2012 from http://www.thenationalcouncil.org/galleries/business-practice%20files/Increasing%20Access%20to%20Managed%20Care%20Report.pdf.

On October 29, 2010, the U.S. District Court in Atlanta approved a Settlement Agreement, as revised, between the State of Georgia and the U.S. Department of Justice related to behavioral health and developmental disabilities. The Governor, the Commissioner of Behavioral Health and Developmental Disabilities, and the Commissioner of Community Health were signatories to this agreement. The Navigant Report is silent as to how a risk-bearing managed care organization (MCO) will assure the U.S. Justice Department as well as the representatives of consumer and advocate organizations who filed an amicus brief in this case that the state's obligations and responsibilities enumerated in the Settlement Agreement will be met.

Generally, persons with severe mental illness (SMI), such as schizophrenia or bipolar disorder, require a robust set of services, many of which are currently available under the Medicaid rehabilitative services (rehab) option administered by the Department of Behavioral Health and Developmental Disabilities (DBHDD). What assurances can be given by DCH if the rehab option and behavioral health services for the aged, blind, and disabled are contracted to either an MCO or a behavioral health MCO (BH-MCO) that the unique needs of this population will be met?

Regardless of any changes in the Medicaid benefits plan, DBHDD will continue to serve uninsured individuals as well as provide services that fall outside Medicaid benefits to both Medicaid and non-Medicaid beneficiaries. The Navigant Report is silent as to how coordination with services offered by DBHDD will be reflected in the new Medicaid benefits plan.

Conditions in state-operated psychiatric hospitals and developmental disabilities facilities were the driving forces that led to the Settlement Agreement. While Georgia's Money Follows the Person (MFP) Medicaid demonstration targets persons with developmental disability in state facilities, there is no similar program for residents of state hospitals who have psychiatric conditions. The Kaiser Commission on Medicaid and the Uninsured[2] reports that Georgia is developing a Medicaid state plan amendment that will allow individuals with SMI to be added to the MFP Medicaid demonstration. Is this true? Again, the Navigant Report is silent as to any expected linkage between state psychiatric hospitals and community-based behavioral health services that facilitates movement into the community.

Consumers, advocates, and providers of community-based behavioral health services will remain skeptical of any proposed Medicaid redesign, whether carve-in or carve-out, that does not significantly expand on the Navigant Report by describing how persons with SMI and other behavioral health challenges will benefit from inclusion of expanded behavioral health services in such plan. While cost-saving arguments are important considerations, the appropriateness of the behavioral health services offered to persons with SMI is of equal, if not greater, importance.

Essential Medicaid Redesign Tenets

[2] Kaiser Commission on Medicaid and the Uninsured. December, 2011. "Case Study: Georgia Follows the Person Demonstration. Retrieved February 26, 2012 from http://www.kff.org/medicaid/upload/8262.pdf.

CSBs offer the following tenets which we believe are essential to any redesign, and which we believe will protect the population we serve. These tenets are equally applicable in a model where behavioral health services are carved-in or carved-out in the overall Medicaid redesign.

CSBs believe that the approach to care should be recovery-based rather than based on a strict medical model. CSBs believe that a recovery-based model can be supported in both carve-in and carve-out models.

Georgia's Medicaid redesign must cover all of the important components of a recovery-focused behavioral health service delivery system, including peer support, supported employment, and supported living services. SMI can lead to high levels of impairment in functioning, requiring a special approach to integrated services. Typical acute episodic care models cannot provide for the care coordination and care management that is needed to improve health and reduce expenditures for persons with this chronic condition.

Complex behavioral problems, co-occurring medical problems, limited family resources, and difficult living conditions of adults with SMI and/or SUD and children with SED and/or SUD require strategic decisions by DCH to ensure that these individuals have access to well coordinated and effective behavioral health and medical care. Such access means including in any MCO or BH-MCO panel of providers specialty behavioral health provider organizations or agencies, such as CSBs, that offer a broad array of services. Such inclusion should make sure the methods for credentialing these providers as an organization are streamlined, allowing all their clinicians to serve a Medicaid plan's members.

CSBs believe that emphasizing the integration of physical and behavioral health care is vital to outcomes improvement and cost savings.

The integration of clinical care and services is an important goal for improving Medicaid delivery systems. Integrated health care delivery can improve care and reduce costs by ensuring that individuals with chronic conditions have ready access to both primary and behavioral health that are closely coordinated, as is the case in the Missouri Medicaid Health Home Program.

Georgia's Medicaid redesign should include health homes for persons with SMI and SUD that have the capacity to address their medical and behavioral health needs in an integrated way. This would entail (1) the expansion of co-located primary care in behavioral health settings, (2) the expansion of co-located behavioral health care in primary care settings, (3) training for primary care practices to work with adults who have SMI and/or SUD and children who have SED and/or SUD, (4) shared information systems, and (4) care coordination.

CSBs believe that the use of evidence-based best practices should be encouraged and financially incentivized in whatever approach is adopted.

Any expansion of Georgia's Medicaid program to include the Aged, Blind, and Disabled (ABD) populations should promote high quality behavioral health services. Any Medicaid redesign should promote the use of evidence-based practices (EBPs). While there is a shortage of EBPs in behavioral health service delivery, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a website that contains information about specific available EBPs.

Psychotropic medications are an integral part of any service delivery system for adults with SMI and children and youth with SED. Georgia's Medicaid redesign should require formularies to

include an effective array of psychotropic medications needed by people with SMI or SED. Access to such medications should be no more restrictive than medications for other Medicaid-eligible populations. Georgia's Medicaid program should have a policy that ensures that any required co-pays and authorizations are not barriers to access these medications.

CSBs believe that the inclusion of substance use disorder coverage for Medicaid beneficiaries is an important component to clinical integration.

The inclusion of SUD coverage in services available to Medicaid beneficiaries as provided in the federal Patient Protection and Affordable Care Act (PPACA) is an important step toward integrating such services into both physical health and mental health delivery systems. Georgia's Medicaid redesign should incorporate treatment for substance use disorders. Since most SUD providers are not currently linked to the Medicaid program, it will be important for DCH to help these providers with this transition.

CSBs believe that more funding is required to reverse a trend of reduced capacity in Georgia that could affect the state's ability to extend coverage to additional Medicaid beneficiaries.

The Center for Health Care Strategies reports that two-thirds of children and youth with SED in the Medicaid population are involved with the child welfare and/or juvenile justice system. Some states have Medicaid-funded customized care management services that target this population and coordinate care among and across schools, child serving health and social services agencies, and families. The Navigant study argues for carving-in children in foster care. By almost any measure of child well-being, Georgia ranks poorly among the states. The Medicaid redesign must improve the lives of children and youth with SED by including a full array of clinical and wrap-around supportive services.

CSBs believe that funding and resources need to be allocated to improve outreach to Medicaid beneficiaries in general, but especially to newly eligible populations.

Newly-eligible individuals with SMI, SUD, and SED will need a broad range of specialized services, such as counseling, pharmacotherapy, psychosocial rehabilitation, residential services, mobile crisis services, or assertive community treatment. Adults with SMI often require additional non-medical services, such as income support, vocational training, or housing assistance, to help them manage day-to-day activities. Some people with SMI face complex problems including homelessness, poverty, or criminal justice system involvement. In addition, individuals with mental disorders are more likely than those without to have physical health problems or substance use disorders. Thus, they also rely on non-mental health services and have a high need for care coordination across the health system.

CSBs believe that outreach to engage the homeless population is crucial in order to effectively manage costs and outcomes improvement for this population.

The homeless population has high rates of SMI, and most are uninsured adults who will become eligible for Medicaid under the PPACA. Homeless individuals with mental illness have very complex health and social services needs. There will be challenges in enrolling and serving the homeless population in Medicaid. Many individuals in this population have experienced tenuous or negative interactions with public programs. This reluctance coupled with the lack of a

permanent address will complicate Medicaid enrollment. Homeless individuals are often in an age cohort (mid 50s) where health problems are beginning to manifest.

Comment on Medicaid Managed Care and Persons with Developmental Disability

The Navigant Report is unclear with respect to its intended impact on persons with developmental disability. Currently, DCH contracts with DBHDD to manage community-based services for adults with developmental disability under the NOW (New Option Waiver) and COMP (Comprehensive Supports Waiver) Medicaid programs. DCH administers the MFP demonstration program, which is a Medicaid initiative designed to reduce reliance on institutional services and develop community-based long-term services and support options. MFP transitions adults with developmental disability out of Medicaid-funded Intermediate Care Facility–Mental Retardation (ICF-MR) programs into community-based services funded by the NOW and COMP waivers.

Since the 1970s, DCH and its predecessor agencies have contracted with DBHDD and its predecessor agency, the Department of Human Resources, for the operation of ICF-MR programs in state-operated hospitals and residential facilities serving persons with developmental disability. There is also one private developmental center in Georgia that operates as an ICF-MR program.

Is it the intent of the DCH to move persons with developmental disability off of waivers and into a risk-bearing managed care program? Will risk-bearing MCOs manage care in ICF-MR programs in Georgia? While MCO management of physical health and behavioral health services for persons with developmental disability may serve a useful purpose, converting waivers to risk-bearing managed care may disrupt a specialty service delivery system with wide-spread political support.

Further, the PPACA includes an expansion of home and community-based Medicaid waivers that, if implemented in Georgia, will have a positive impact on persons with developmental disability. For example, the Community First Option will give individuals with functional limitations a choice between receiving care in an institutional setting or in their own homes or community, and is designed to assist individuals with activities of daily living as well as health-related tasks.

CSBs are not sure that transferring individuals with developmental disability from existing waivers to a risk-bearing MCO will have any beneficial effect. However, managed care for physical health and behavioral health services needed by persons with developmental disability may result in improved health outcomes for these individuals.

If DCH decides to transfer the care of persons with developmental disability from the NOW and COMP waivers to a risk-bearing MCO, then the contract between DCH and the MCO must contain a time table to eliminate the need for the waiting list for these services.[3] Also, any such

[3] Jacox, David. May 17, 2006. "Supporting People with Developmental Disabilities: Recommendations for Medicaid Reform." Baltimore, MD: Lutheran Services in America. Retrieved February 26, 2012, from http://aspe.hhs.gov/medicaid/may/Dr.DavidJacox.pdf .

contract must, at a minimum, contain all of the provisions in the NOW and COMP waivers and the MFP demonstration related to consumer choice, inclusion, community integration, flexibility of benefits, availability of skilled support staff, housing, and transportation. Determination of individual needs should be based on an assessment that is consistent and equitable.

Principles to Guide Medicaid and CHIP Redesign

On February 22, 2012, our Association's Board of Directors adopted the following principles that we believe should inform any redesign of Georgia's Medicaid and CHIP programs:

1. ACCESS

While payer source and insurance dictate one type of access for people with Serious Mental Illness (SMI) or youth with Serious Emotional Disturbance (SED), there are additional access considerations for the population, which include geographic access, and timeliness of service. In addition, the concept of "engagement" is critical for the SMI/SED population and the ability to conduct ongoing and meaningful outreach is essential for success.

2. BENEFITS PACKAGE

Benefits packages should be grounded in a public health model of disease management, which looks beyond a narrow "medical necessity" criteria to recognize that SMI/SED populations are best served by plans that address long term health and rehabilitation needs and manage the linkage between recovery and community stabilization services, support services, employment, housing, social integration, and productivity.

3. COORDINATION

A high level of expertise for individuals with complex and serious needs is needed for effective treatment planning and coordination with the SMI/SED population. The ability to incorporate appropriate utilization of specialty services and evidence-based treatments along with needs across life domains is necessary for desired outcomes.

4. PEER SUPPORT AND WELLNESS

Integrating peer support, an evidence-based practice recognized by SAMHSA, is critical to the fulfillment of a recovery-based, person-centered model of healthcare.

5. FLEXIBILITY

Early implementation of managed care models for youth with SED in Georgia have been characterized by inflexibility and limited understanding of youth interaction across child-serving systems. Authorization mechanisms that incentivize appropriate utilization of services and supports for SMI and SED populations require flexibility and sophisticated knowledge of clinical and rehabilitative needs, and cross-agency communication.

6. INTEGRATION

The integration of physical and behavioral healthcare is a pillar of healthcare reform strategies. While integration can be straightforward for healthy populations, the SMI population in particular requires intensive attention. Serious and persistent health problems (obesity, heart-related problems, asthma, etc.) for this population have been well documented. Systems that reach this population where they live and receive treatment are positioned for positive results.

7. OUTCOMES

While cost outcomes often drive the initiation of managed care strategies, the ability to pair cost outcomes with quality health outcomes and system outcomes will have a greater impact on the SMI/SED population. Experienced knowledge of the SMI/SED population should be incorporated into the development of quality and cost outcomes to enhance the development of a cost-effective program with a long term view of success.

A Standing Offer

CSBs are willing to participate in any constructive way in the Medicaid redesign. CSBs bring a high level of expertise derived from providing professional and support services to persons with SMI, SED, SUD, and developmental disability over many years.

If you have any questions, or wish to discuss further any of the issues raised in this letter, please contact Robyn Garrett-Gunnoe, our Association's executive director, at (912) 312-3205.

Sincerely,

Ralph Herndon
President

cc: Frank E. Shelp, MD, MPH
Commissioner of Behavioral Health and Developmental Disabilities

David A. Cook
Commissioner of Community Health