



# NAMI Connecticut

6402

Testimony before the Human Services Committee  
February 17, 2009  
Support for HB 6402

Good morning, Senator Doyle, Representative Walker, and members of the Human Services Committee. My name is Alicia Woodsby, and I am the Public Policy Director for the National Alliance on Mental Illness in CT. I am here to testify in support of HB 6402 AN ACT CONCERNING MAXIMIZATION OF MEDICAID REIMBURSEMENT FOR THE STATE OF CONNECTICUT AND FEDERAL MEDICAL ASSISTANCE PERCENTAGES (FMAP). Since the Governor's Blue Ribbon Commission (BRC) Report was issued in July, 2000, Connecticut has pursued initiatives to replace an institutionally-biased, crisis-oriented and fragmented approach to mental health care with a more cost-effective, community-based, person and family focused system. While some progress has been made, the state's current fiscal dilemma challenges us to review recommendations and consider measures that could be implemented both immediately and longer term to improve the state's efficiency and outcomes while preserving vital housing and services. One way to do this is to maximize federal revenue while strengthening the community system of housing and supports.

Both DCF and DMHAS have already collaborated with DSS to increase federal reimbursements under Medicaid by expanding the services covered under the state plan for the low income individuals they serve. This is particularly significant given the expected increase in the federal Medicaid reimbursement rate under the stimulus package. However, there may be more services for children that could be covered under HUSKY or the Behavioral Health Partnership, and there are many DMHAS services currently state grant funded that could be covered as optional<sup>1</sup> rehabilitation services under Medicaid<sup>2</sup> (please see attached).

An actuarial study conducted by the Mercer Consulting Group for the Department of Social Services (DSS) identified in their February 2004 published study the following *new federal revenue for these existing DMHAS services as Medicaid rehabilitation services*:

Assertive Community Treatment Teams (ACT)	\$10,554,692
Supervised Housing (services only)	11,141,684
Supported Housing (services only)	7,074,768
Mobile Crisis	<u>6,167,272</u>
Total estimated	\$34,938,416 <sup>3</sup>
Targeted Case Mgt. current revenues	<u>7,000,000</u>
<b>NET NEW FEDERAL FUNDS</b>	<b>\$27,938,416<sup>4</sup></b>

Due to concerns about expanding an entitlement and disrupting the community providers, OPM and DMHAS have moved cautiously on Medicaid coverage for adult mental health services, only covering

<sup>1</sup> The state can also expand Medicaid under the 1915(i) state plan option, which enables states to provide a prescribed set of home and community based services to individuals that earn less than 150% of the Federal Poverty Level and require less than institutional levels of care.

<sup>2</sup> The federal Medicaid program has both mandatory and optional services.

<sup>3</sup> Group homes are excluded since DMHAS and DCF are already proceeding with coverage of their services under the Rehab Option.

<sup>4</sup> Mercer Government Consulting Group, *Estimate of the Budget Neutrality of the Connecticut Behavioral Health Partnership, Technical Appendix*, Feb. 2004, Appendix J.5.

rehabilitation services at group homes thus far. However, since that study was issued, the state has allocated funds to build the capacity of community providers to comply with Medicaid requirements.

In addition, the state has received federal approval to operate a home and community based services waiver for persons with mental illness who can be diverted or discharged from nursing homes which will start April 1<sup>st</sup>.

In the course of developing this waiver, DSS and DMHAS have developed service definitions and a rate-setting methodology for services to be covered under the waiver. Two of these, assertive community treatment and community support services (included as ACT in the Mercer study), could be covered by the Medicaid state plan expanding the population served and increasing federal revenue, possibly during SFY 2010. The capacity building required to bill for services in supervised and supported housing requires further investigation.

**In order for the Medicaid maximization of community mental health services to work long-term, DMHAS must retain grant funds for the transition costs into Medicaid fee-for service, non-medical services (social support), and non-Medicaid eligible clients. In addition, the rate-setting structure must cover the cost of providing services, and funds must be targeted to expand housing options and services for individuals with complex needs.** The impact of these measures must be monitored to report the outcomes on inappropriate institutional and emergency room care.

The state can also maximize federal revenue by increasing the number of persons with mental illness to be served under its Medicaid waiver. Currently the waiver allows Connecticut to serve 72 persons in each year of the waiver, for a total of 216 persons. However, in 2006, DMHAS estimated that 420 individuals with mental illness in nursing homes had "high discharge potential." In addition, the State has lost an estimated \$7.5 million in Medicaid reimbursement because the number of persons with mental illness in some nursing homes has exceeded the federal limit. During the past two years DMHAS and DSS have developed their infrastructure to pursue nursing home discharges, and this should support an expanded waiver population.

Thank you for your time and attention.

## Medicaid and Mental Health Services

ACT services are not covered under Medicaid, outpatient services are. Group homes are the only service area, outside of traditional outpatient, partial hospital and inpatient, for which providers bill Medicaid. Services such as ACT will be billed under Medicaid on a limited basis under the new federal mental illness waiver, which is available only to 216 people.

Additional Medicaid billable services for CT could include:

- Assertive Community Treatment
- Community Support Programs
- Illness Self-Management and Recovery
- Family Psychoeducation
- Supported and Supervised Housing – support services only
- Mobile Crisis Services
- Supported employment- support services only (outside of workplace)
- Supported education – support services only
- Peer specialist services
- Telemedicine/Telemental health

**Please note:** Some of these services are covered as components of intermediate care programs provided under the hospital benefit or clinic option. These services (e.g. Illness Self Management and Family Psychoeducation) are billable by mental health service providers in the general community or DMHAS system, but it is not clear that providers are currently billing for them. Also, no provider is directly reimbursed for Targeted Case Management (TCM). The provider must report data to DMHAS and they do a single billing, so Medicaid funds aren't paid to the provider.

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