



Minnesota Association of Community Mental Health Programs, Inc.

Improving quality through education, public policy advocacy, and member services

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Comments to Senate Staff on Rehabilitative Services

Ron Brand, Executive Director

Introduction

I'm Ron Brand, Executive Director of MN Association of Community Mental Health Programs, Inc. I have been in this role for the past 17 years in this role and previously worked for years as a psychologist and administrator in various community clinics and programs. The Association is a nonprofit comprised of nonprofit organization members who have facilities located in over 120 sites scattered statewide, urban and rural. Collectively, they provide care and services to over 125,000 persons each year. The members provide a substantial majority of the mental health services to public and private children, adults and families. Most also provide chemical dependency services. I am also here representing the National Council for Community Behavioral Health in this meeting. The information that I will provide is based on our experience in Minnesota, but I am confident that the story is very similar in other states. I want to thank the meeting organizers and sponsors for this opportunity to share our experience and perspective with you today. Our overall goals for this presentation: What are MH rehabilitation services? Who provides and who receives the services? What good is done? What happens if this benefit is restricted? We want support for stopping or slowing down CMS efforts to restrict essential services.

Services provided by MACMHP members

Our members are mostly community mental health centers. They are safety-net providers, and like others safety-net providers (urban hospitals, FQHC's, critical access hospitals) they provide services to people without regard to ability to pay. Our member organizations tend to be fairly large nonprofit corporations that provide a broad array of behavioral health services such as psychiatry, psychotherapy, medication management, residential treatment, and a variety of intensive non-residential rehabilitation services. In this presentation I want to focus on the rehabilitation services, so we will come back to that in a minute.

Often their caseloads include very high proportion of people covered by government health insurance, Medicaid, Medicare and our homegrown program called MinnesotaCare. The centers also provide services to thousands who are uninsured or underinsured, due to gaps or limitations in coverage. In addition to their key role with public/government programs, our members have become key providers for private healthplans, BCBSM, Medica, and others who have come to value their ability to provide intensive nontraditional services to very disabled, troubled children and adults.

Clients/Consumers: Who is our clientele?

So, in Minnesota, our clients are a mix of private/commercial and public sector covered persons with diagnosis of major depression, schizophrenia, bi-polar, or anxiety disorders such as post-traumatic stress disorder or severe phobias.

What are these conditions like? Have you ever had "stage fright", feeling immobilized by how others might judge you? Have you ever had jet lag where you can hardly move and your mind just cannot get going and your body aches? Ever had your thoughts race, bouncing from one thing to another? Or alone late at night cringing in fear, mistakenly seeing an intruder where it was only a tree branch in the wind? Multiple these experiences by 20 times over and you might get a feeling for what persons with anxiety disorders, severe depression, ADHD, or psychosis might experience every day, all day, week after week. So, persistent and pervasive that it becomes difficult to function, to complete everyday tasks that we take for granted. Often, clients have a combination of illnesses and disorders that complicate the situation-mental illness and diabetes, or substance abuse, or heart disease. We know

from research and experience that an array of services, or continuum of care---the combinations of treatment, medications, and rehabilitation services provided by our centers is especially important with the kids or adults living with more complex or chronic conditions. Most important is the mental illness is treatable and most people have substantial recovery to become productive in their lives and community. Managing symptoms helps children and adolescents develop stronger relationships and attain personal success. Many non-traditional services provide support and build skills important to becoming more self-sufficient and avoid serious relapses.

Examples of Community-based rehabilitation services: Note that these services are often provided in combination and coordination with other Medicaid benefits and other services.

- **Independent living skills:** A brief description includes: learning skills to improve functioning affected by mental illness and symptoms. For example, in-home living skills training, coaching on coping with and managing daily activities such as money, food and nutrition, school or work, relationships, organizing and taking medications, and personal hygiene.)
- **Illness management and recovery support** includes skills to understand disorder, manage symptoms, improve functioning of daily living affected by the disorder, deal with medications and side-effects and learning to recognize and cope with situations that are triggers for relapse such as isolation, misusing drugs, letting things slide and snowball into unmanageable problems.
- **Crisis assessment and stabilization:** These are episodic illnesses, with all too frequent relapses. Crisis services can assess the situation and mobilize intensive services to stabilize the person, avoiding hospitalization or, all too often, jail. We have mobile services that go to hospital ER's or a person's home, even work with police. Because crisis services are available, and built into the plan of care, the person can be living more independently knowing that crisis services can be brought to the situation to prevent symptoms spinning out of control.
- **Assertive Community Treatment (ACT):** "ACT" combines many elements of the above, plus other services delivered by a team of professionals whose backgrounds and training include social work, rehabilitation, counseling, nursing and psychiatry. Among the services included in ACT are: case management, initial and ongoing assessments; psychiatric services; employment and housing assistance; family support and education; substance abuse services; and other services and supports critical to an individual's ability to live successfully in the community. ACT services are available 24 hours per day, 365 days per year. The "Assertive" part of the program means that the staff goes out to the person and don't always wait for the client to come to them. This can be very important for individuals with severe mental illness who have severe functional impairments, who have avoided or not responded well to traditional outpatient mental health care and psychiatric rehabilitation services. Persons served by ACT often have co-existing problems such as homelessness, substance abuse problems, or involvement with the judicial system and/or multiple hospitalizations. ACT has been called a "hospital without walls"; it is often the last best hope for many people with serious mental illness short of long-term institutionalization or repeated hospitalization.
- **Supported housing:** Imagine an arrangement that provides for stable housing and adds to it the assistance of combining and coordinating components of the above, plus other services. This goes beyond "assisted living" in which nurses or social workers come to the person's home to help with daily living. In addition to the above services, staff might help work with landlord to better accommodate a person with disabilities, and to help with inevitable conflicts that occur in any living situation. Without this assistance an individual with serious mental illness living in independent housing could be overwhelmed by circumstances in isolated situation quickly spin out of control causing a person to lose their housing or network of friends.

The proposed rehabilitation regulations will undermine these essential, life-giving services. The three-legged stool of therapy, rehabilitation and medications will not stand with one leg shortened. A significant portion of psychiatric rehabilitation is seriously threatened by these regulations and related efforts to restrict services to the very citizens for whom they are intended. Tens of thousands of kids and adults will be affected.

Among the specific concerns in the proposed regulation that I want highlight:

The “intrinsic element” test introduces a completely new concept, without statutory or regulatory precedent. Essentially, this rule says that services that are an intrinsic element of another program funded by another federal, state, or local source cannot be paid through the rehabilitation option.

While there are certainly examples of wholesale “refinancing” of social service activities that shift cost to the Medicaid program, this new provision would seriously harm the important efforts by workers in every state and community nationwide to combine and coordinate housing with rehabilitative supports, prepare persons to be socially and psychologically ready to work or to deal with workplace stresses, or package a combination of covered services into an efficient coherent program. In each of these examples we would want clients to receive services from multiple programs, often made possible through inter-agency collaboration and funding agreements. In fact, in treatment for other diseases, such as congestive heart failure, diabetes, and others, CMS is actively promoting use of bundled, coordinated comprehensive service packages.

This provision will be very difficult to administer and will likely result in many un-intended and unwarranted restrictions and denials. For example, states receive Mental Health Block Grants and Social Services grants based on an archaic formula. It is a limited fund that can be used for services that might be covered by rehab. option, it funds certain programs, but is in no way an entitlement for individuals. Could an overzealous auditor interpret the intrinsic element test to mean that rehab. services cannot be covered because the block grant must be a primary payer for the service? It is possible to define allowable Medicaid services and encourage efficient packaging or bundling without resorting to the “intrinsic element” test or adding a burdensome administrative requirement that each specific service component be billed in 15minute units.

In my home state, Minnesota, last year a proposal to further improve the covered services was progressing through our Legislature. I was asked, more like begged by our state agency to pull the proposal from the Finance committee because they feared that if we submitted a state plan amendment, that our whole rehabilitative service package would be scrutinized. That in seeking to take two steps forward, we would be pushed four steps back. In addition, the bundled rate-setting method used for ACT services was already rejected by CMS, before these regs are even effective. The matter is under appeal and will be heard soon in administrative court.

Restorative services. The rules state that rehab. services must be “restorative”, not “habilitative”. This is a huge issue for our providers, depending on how the regulations are implemented. Remember, mental illness is typically a chronic, episodic illness in which recovery progress is cyclical, not linear. Providing the right combination of services to someone that helps maintain him independently in his/her home for a year is a success. Failure to provide the services would result in an all to predictable results: homelessness, yes; and jail certainly. But also hospital ER’s, or placement in treatment or nursing homes very costly expenses that fall onto the Medicare and Medicaid program.

It is important that the regulations and implementation by CMS recognize that the services may be necessary to maintain functioning and maintain the rehabilitative progress, but may not be able to document steady, step-wise progress toward restoring functioning that may never had be attained because of the nature of the disorder. Certainly, we agree that the client must have the cognitive capability or capacity to learn the new skills and work toward the rehabilitative goals, but it is completely unreal to require that all services “restore” a person to a previous level of functioning. When our members talk about the impact of the new regulations, this is the area that the direct care staff and supervisors fear the most.

Thank you for this opportunity to discuss Medicaid rehabilitation services with you. In our opinion, the proposed regulation would seriously undermine essential, life giving services and unnecessarily thwart the progress toward recovery of tens of thousands of adults with serious mental illness and kids with serious emotional disturbance. I would be glad to respond to questions and to be a resource to you as the Senate works on these issues in the days ahead.