

**THE TIPPING POINT
MENTAL HEALTH IN MAINE 2010
NAMI MAINE
DECEMBER 2009**

EXECUTIVE SUMMARY

Four facts are indisputable:

- (1) Mental illness and substance abuse are the **leading cause of death and disability** in Maine and rarely occur in isolation; they most often occur in conjunction with other illnesses, including physical illness;
- (2) **Mental health care in Maine is in trouble**, supports are fragmented, disconnected, and inadequate;
- (3) Maine relies almost exclusively on Medicaid to fund treatment for mental illness and substance use. Unlike other illness where the burden is shared with private payors, **cutting Medicaid disproportionately affects people with mental health needs; and**
- (4) Maine has **cut spending for mental health services by over \$48 million** in the last two years and proposes to reduce spending by an additional \$91,000,000 between 2010 and 2011. These reductions are pushing people with mental illness into the public safety system in record numbers.

The loss of \$48 million dollars to the mental health and substance abuse service system over the last four years has resulted in significant additional costs and multiple examples of poor outcomes including increased recidivism to correctional settings for children and adults, an increase in the use of high cost services (hospitals and emergency rooms), increased public safety interventions, and cost shifting to services that are funded only by the general fund (corrections).

The current fiscal crisis is serious and cuts to government are needed. However, the random reductions proposed in the current budget proposal for mental health and substance abuse services will increase health care costs, eliminate health care parity for mental illness and substance abuse, and compound the pressures on Maine's public safety system.

Experts across the nation suggest thoughtful mechanisms to address the cost of mental illness – but these have not been considered in this budget. NAMI Maine recommends:

- **Managing all of MaineCare.** Currently, behavioral health is partially managed by an Administrative Services organization. High end services and people who receive health care that is not related to mental health, are not managed. All of MaineCare should be managed.
- **Freeze and evaluate.** Continued random reductions in treatment services cost more. Freeze mental health spending at current levels and establish a special commission (like the Board of Corrections) to understand the full extent of mental health spending, overlaps and duplications, and to make rational recommendations for reform that actually save money, rather than shift costs to others.
- **Evidence-based and promising practices.** Now is the time to be aware of what services work, and which produce few outcomes. Maine's payment system should reflect incentives for treatments that follow evidence-based and promising practices. Rather than cut everyone's rates 10%, which assumes that all services produce equal outcomes, fund proven treatments adequately, and phase out ineffective practices. Assist service providers to move into desired models of care.
- **Reduce bureaucratic oversight at the same rate as service system reductions.** It is clear that community mental health services have been significantly reduced, but the bureaucracy that

oversees them has not. Commensurate consolidation is needed in order to spend the bulk of funds on service delivery.

- **Hospital beds.** It is time to consider if Maine has an adequate number of hospital beds, where they are, and if the state can afford to maintain two psychiatric centers.

MENTAL HEALTH IN MAINE 2010

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“the concept that small changes will have little or no effect on a system until a critical mass is reached. Then a further small change "tips" the system and a large effect is observed.”

Brief History of Mental Health Spending in Maine

The modern era of treatment for mental illness began in the U.S. in the 1970s when states, including Maine, began to deinstitutionalize – to discharge people from asylums to supports in their home communities. Deinstitutionalization in the 1970’s and 1980’s led to sharp decreases in the number of psychiatric beds. However, as beds closed, states put little money into community care. According to Doug Rooks, author of *From Darkness to Dawn: Maine’s Mental Health System* (MECEP, 2001) there have been many ups and downs in funding for community mental health care in Maine. Despite the 1988 consent decree designed to create a community system of care that would allow people with mental illness to thrive in their home communities, Rooks describes a number of obstacles, including changes in philosophy and focus as administrations change, difficult economic times, and cuts to services that have prevented compliance with that decree ever since.

He also describes considerable shifts in spending for mental health services. In 1988, the state budget included \$10 million for AMHI, \$17 million for BMHI, and just \$9 million for community care. At that time general fund dollars were the only source of funding for mental health; private insurance was not required to cover mental illness, and Medicaid was not in the picture. In 1992, as part of a national economic downturn many states, including Maine, shifted costs from the general fund to Medicaid, using something called “disproportionate share”. It was one of the things that helped balance the budget, as general fund dollars previously devoted to psychiatric care were shifted to other parts of the budget and mental illness was no longer strictly covered by general fund dollars. Disproportionate share also brought a federal match for every general fund dollar. The cost of psychiatric hospitalization moved to Medicaid, and Maine got two federal dollars for every one provided by Maine taxpayers. That trend has continued and contributes, along with expanded community services, to an ever expanding need for Medicaid seed (the one dollar of state general fund money that is needed to draw down two federal dollars). Today, if you have serious mental illness, it is difficult to receive needed treatment unless you are Medicaid eligible. Although parity laws that require private insurers to cover mental health conditions began to be enacted in the late 1990s (Maine’s first parity law passed in 1996 and expanded in 2003) private insurers continue to limit payments for mental health conditions because of substantial gaps in state and federal law. For example, in Maine, parity is required only in large group managed insurance plans. In the small and individual market Dirigo Health is the only product available for individuals and small groups that offers real parity. The rest continue to have significant annual and life-time limits as well as different co-pays for mental health treatment. (See an analysis of Maine’s and the newly passed federal parity law attached. Also of concern is Maine’s recent decisions to remove parity from MaineCare, and if these changes may violate federal parity laws.)

During the mid 1990’s as Maine emerged from the economic downturn, there was considerable effort to comply with the AMHI Consent Decree. The Governor and Legislature committed significant revenue to community services so that class members stuck in the hospital for many years could move to the community. Spending for community treatment grew from \$9.3 million in 1988 to \$106 million in 2000. During that same time spending for children’s residential and community treatment also expanded. Years of legislative calls to bring children home from out of state group homes were answered as a community system of care for children with mental health problems was created. However, since 2003, the state has faced ongoing budget deficits, culminating in a \$500,000,000 reduction in state spending in 2009, including reductions to children’s mental health.

“Cost Shifting” as Consequence of “Cost Savings”

The “Medicaid-ization” of mental health treatment places continued pressure on *Medicaid seed – one dollar of general fund money is needed for every two dollars of federal Medicaid funding*. In addition, Maine’s costs are higher than the national average, partly because Mainer’s income is lower and their health status poorer than the rest of the country (Maine’s 2008-2009 State Health Plan, pg. 21). **While overall spending on health care in Maine rises each year, spending for community mental health services has been reduced** (cuts are described more fully later).

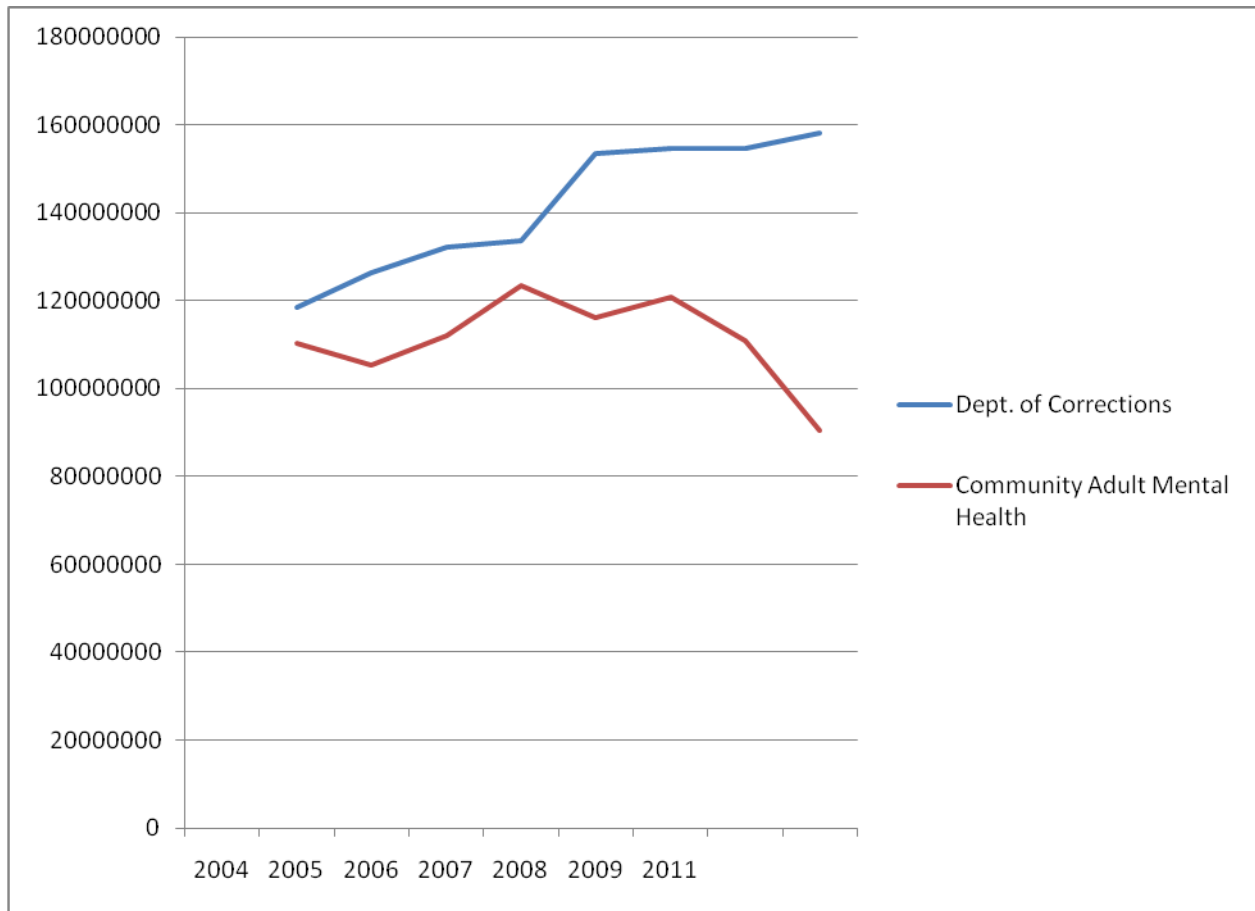
Nowhere, is the plight of people with chronic illness more sadly reflected than in the rates of incarceration of people with mental illness and substance abuse problems. Deinstitutionalization, lack of parity, changes in commitment laws, and tough stands on public safety all contribute to the problem. The story of deinstitutionalization is not complete until we examine the outcome of closing thousands of psychiatric hospital beds. The U.S. Department of Justice’s website notes: “The historical forces that led to the trans-institutionalization of the mentally ill from alms houses to state mental hospitals in the 19th and 20th centuries have now been reversed in the aftermath of recent deinstitutionalization policies. Evidence suggests that people with mental illness are now being caught up in the criminal justice system, a circumstance reminiscent of pre-asylum conditions in the early 19th century.”

The Department of Justice goes on to say that a growing body of evidence demonstrates that the criminal justice system has taken over from the public health system as the destination for many with mental illness and addictions. The deputy director of the National Institute of Mental Health (NIMH) said” With the reduction of psychiatric beds in the past years, there is only one place that can’t say “no” when you need someone kept away from society: the criminal justice system.” Though he fails to discuss the futility in terms of outcomes and cost, he and others cite statistics such as these:

- A study of the Chicago jail found that 6% of males and 12% of females entering the system had severe mental disorders, including schizophrenia, mania, and major depression;
- A 2005 study concluded that as much as 24% of the prison population has a severe mental illness; and
- The Department of Justice’s Bureau of Justice Statistics reports that more than half of all prison and jail inmates have mental health problems.

The chart below, which shows correctional spending in Maine since 2004, shows the relationship between spending on community mental health and spending on corrections.

“Nowhere is the plight of people with chronic illness more sadly reflected than in the rates of incarceration of people with substance abuse problems.” U.S. Department of Justice website



The Incidence and Cost of Mental Illness and Substance Use Conditions

The Institute of Medicine’s landmark report: Improving the Quality of Health Care of Mental and Substance-Use Conditions (2006) reports that major depression is the second leading cause of death and disability (next to heart disease) for all ages, and the **leading cause for individuals aged 15-44**. Alcohol use ranked highest for males aged 15-44 and 5th across all ages. **Together, major depression and drug and alcohol use and dependence are the leading cause of death and disability among American women and the second highest cause of death among men.** Moreover, these illnesses seldom occur in isolation, between 15 and 43 percent of the time, they co-occur. And further, they significantly compromise the treatment outcomes for general health conditions, increase the use and cost of general health care, and have adverse consequences for workplace productivity and costs. Mental illness is a major risk factor for the development of adverse health behaviors such as smoking, overeating and a sedentary lifestyle. (pgs. 37-38). From 2001 to 2003, only 40.5 percent of people meeting a specific definition of severe mental illness received any treatment. (page 6) This was before nationwide reductions in mental health spending. Despite the overwhelming evidence that mental illness and substance abuse are the top causes of illness and disability in this nation, they remain outside of mainstream healthcare and are rarely mentioned as part of needed health care reform. This neglect contributes to the ongoing diversion of people with mental illness to non-medical public safety systems and the diversion of funds that should pay for treatment to those same systems.

Policy based on State Coverage

It is important to highlight this nation's policy on spending for mental illness and its impact on access to treatment. Since Dorothea Dix's crusade to take people with mental illness out of jails and almshouses, people with mental illness have been the responsibility of state government. State asylums were funded by the general fund as was all community treatment. For this reason, private insurance laws were allowed to exempt coverage for mental illness because state's paid for it from their general funds. As recently as 1976, federal HMO laws exempted HMOs from parity for mental health and chemical dependency treatment based on the premise that STATE GOVERNMENTS would continue to finance behavioral health care services.

In Maine, like the rest of the nation, general fund dollars supported treatment for people with mental illness until the advent of disproportionate share in the late 1980s. Faced with a serious recession, Maine and other states shifted funding of mental health services to Medicaid. First the state hospitals, then residential treatment, case management, and other community services – all eventually made the shift to Medicaid. General fund dollars that had supported treatment for people with mental illness disappeared into the deficit to support other government programs. Meanwhile, policy continued to be based on the myth that states were paying for treatment for mental illness. Policy continues to reflect this myth including prejudicial aspects of Medicaid and Medicare law and is now turning up in specialized housing voucher programs as well. The additional difficulty for people with mental illness is that they do not have eligibility for nursing facility based waivers (where income allowances are higher) though they are uniquely at risk of involuntary hospitalization and in need of specialized follow-up post hospitalization. This is particularly true as long-term hospitalization options have disappeared in Maine and most people are discharged from psychiatric hospitals shortly after they are admitted. With the advent of behavioral health managed care “carve outs”, mental health spending has become particularly vulnerable. Treatment for all other chronic, relapsing, lifelong conditions like diabetes, cancer, HIV, asthma, and cardiovascular illness are blended into the Medicaid budget and into overall health care spending. But mental illness is carved out, uniquely visible, and has become a special and targeted focus for cuts. Unfortunately, the asylums are no longer there to provide a safety net. Both the beds **and** the funding are gone.

Managed Behavioral Healthcare

Although 31 states operate managed care programs for the Medicaid population, just five exclusively enroll people with disabilities, and those five programs are voluntary. There is some evidence that managed behavioral health care does save money, but there is also evidence that it can create additional barriers for people with mental illness and their families in a system that is already fragmented and complex. The research about carving out public behavioral health care for management is consistent – it must be done carefully, with significant input from stakeholders, and, if not properly designed and monitored, can pose serious threats to the health and well being of people with disabilities. A study conducted for the health insurance industry in 2004 found that despite the millions spent on the Managed Care Organization, overall cost savings in the Medicaid program result from managing the program, particularly the more costly levels of care (i.e., hospitalization). The research also indicates that managed public behavioral health care will fail unless: (1) there is substantial consumer and family input into the development, design, oversight, and continued quality

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improvement activities of any effort to manage behavioral health; (2) a thoughtful, considered, and slow planning and implementation process; and (3) a full assessment of the existing behavioral health system, its strengths and weaknesses; and the development of a plan that addresses them. Maine's behavioral health carve out is an ASO (administrative services organization), which provides a lower level of management and excludes hospitals altogether). Savings associated with this arrangement have yet to be published. And, despite hiring an expensive firm to manage care for people with behavioral health problems, the bureaucracy that oversees the system of care has been reduced by just 2%.

Mental Health Spending Reductions in Maine 2006-2007

Changes enacted during the 2006-2007 legislative session provided some additional funding and reduced spending for community mental health as follows:

- \$513,000 was *added* for two state-wide consumer programs and one warm line.
- \$287,000 was *added* to spending for assistance to people who have lost MaineCare.
- \$200,000 was *added* for vocational assistance.
- \$1,000,000 was *added* to cover residential care for people leaving the state psychiatric hospital.
- \$477,816 was *added* for housing subsidies, and
- \$1,000,000 was *added* for substance abuse treatment for people who have lost MaineCare.
- Managed care was implemented and \$30,400,000 was *slotted to be cut* in mental health spending.
- \$700,000 was *cut* from residential care for children.

These changes together resulted in **cuts to community mental health spending of \$27,622,181.**

Mental Health Spending Reductions in Maine 2008 and 2009

The state budget was reduced by \$500,000,000 in 2009; additional reductions of over \$400,000,000 are currently under discussion for 2009, 2010, and 2011. The Maine Department of Health and Human Services Website described the following **key reductions** in service areas in April of 2008:

Mental Health

- *\$3.1 million in grant funded adult mental health services. This impacts programs that were not offered statewide and individuals who are not Medicaid-eligible to receive home-based services, counseling and money management assistance.*
- *\$2.1 million in grant-funded children's mental health, impacting children's cabinet, family mediation, outpatient counseling and flex funding used for "onetime need" Mental Health, MaineCare.*
- *\$1.5 million in savings because fewer children are in congregate care.*
- *\$1.2 million by eliminating Intensive Community Integration, but keeping medication management and case management.*
- *\$1 million in outpatient services by aligning reimbursement rates in mental health and substance abuse services.*
- *\$625,000 from day treatment.*
- *\$500,000 for case managers for children receiving mental health and child welfare services.*
- *\$330,000 by consolidating adult and child mental health crisis services by April 1, 2009.*

MaineCare Services

- \$4.1 million in the private Non-medical institution program, including establishing a maximum number of days a bed will be held for a person.
- \$3.5 million savings by changing the pharmacy benefit for childless adults.
- \$865,000 saved by reviewing the clinical criteria for the Katie Beckett program.
- \$555,000 by establishing premiums in the Katie Beckett program.;

Together, and including the loss of federal dollars, direct cuts to community mental health services totaled \$20,665,000. A portion of the \$27,060,000 in cuts to other MaineCare services also impact programs for people with mental illness and their families. **Over the past four years, cuts to community mental health services have totaled over \$48 million dollars.** Additional policy-based attempts to control costs removed mental health parity from the non-categorical MaineCare program – placing limits on the number of mental health visits that may be used in a year. The managed care carve out places limits on community mental health services, but does not monitor or control the higher cost hospital care. People with cancer, HIV, and heart disease receive the treatment they need to treat their illness. People with mental illness receive 12 visits – whether these treatments are adequate or not is irrelevant to the State of Maine, which is charged with their care.

Mental Health Spending Reductions in Maine 2010 and 2011

Spending reductions were also enacted for 2010 and 2011, including changes in eligibility for adult case management and reductions in residential and other programs for children. Anecdotal evidence suggests that children are now entering or recidivating to the juvenile justice system in Maine in record numbers, perhaps as a direct consequence of these reductions. In early 2009, the Chief Justice and First Lady of Maine joined the Dean of Maine’s Law School to convene a taskforce to address the needs of the growing numbers of juveniles entering the juvenile justice system. This task force has identified unmet mental health and substance abuse needs and barriers to treatment as significant contributors to the problem. Despite this and other evidence of significant cost shifting to other areas of government (corrections, public safety)¹ from cuts to community mental health services, new revenue shortfalls of \$400,000,000 have been identified and resulted in a mid-December proposal to make additional reductions to community mental health:

- \$7,909,698 in reductions to children’s community mental health, including reducing provider rates by 10%, limiting outpatient visits to just 18 per year, and eliminating funding for crisis services for children without MaineCare.
- \$100,078,834 in reductions to community services including rate reductions for providers, limiting all hospital outpatient visits to 15 per year and all other outpatient visits to 18 per year, reducing access to medications, limiting inpatient hospitalizations to just 5 per year, and eliminating all supports to families of adults (NAMI Maine). Over 19 million dollars are reductions in non-Medicaid funding for adult mental health services, including the elimination of

Over 19 million dollars are reductions in non-Medicaid funding for adult mental health services, including the elimination of NAMI Maine, Maine’s only program for families of adults with mental illness.

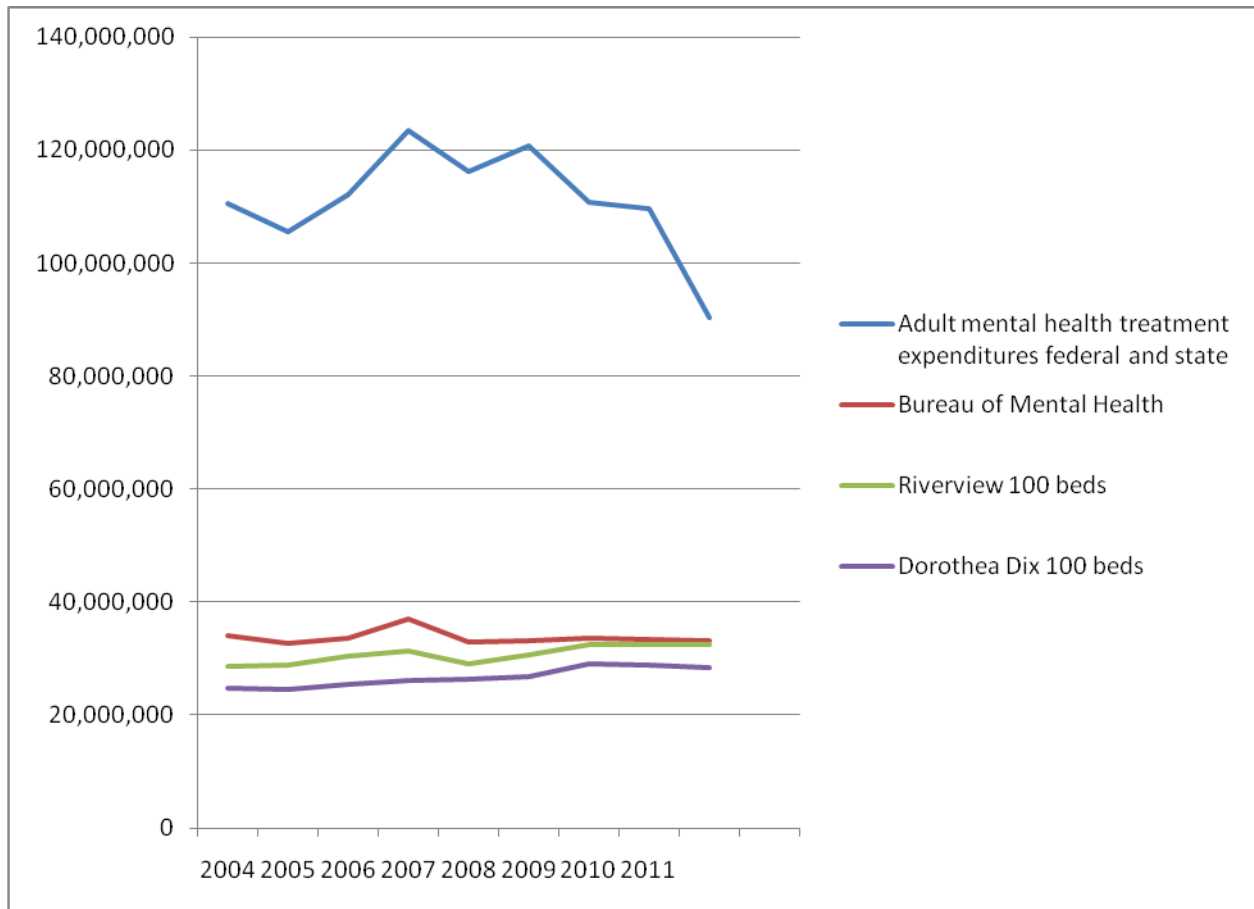
¹ Multiple media reports in late 2009 report the growing concern of the public safety community to increased incidents involving people with mental illness. The 2008 Maine Attorney General’s report on the incidence of the use of deadly force by Maine police officers provides further evidence that government leaders are aware of the outcomes of reduced mental health spending.

NAMI Maine, Maine’s only program for families of adults with mental illness. (See attached list of proposed reductions at the end of this paper.)

Together, if enacted as proposed, this will mean a total reduction of \$19,210,304 in **non-Medicaid** spending for the biennium and a total of well over \$100,000,000 for the biennium, if matching federal dollars are included.

Perhaps this is the tipping point, where community mental health cannot survive in sufficient amounts to offer even a minimal safety net that can absorb the needs of people with mental illness and their families.

The chart below summarizes adult mental health spending since 2004.



A simple and incomplete analysis of these numbers shows that spending on community mental health, the least expensive kind of treatment, has fallen 18% since 2009 while spending on Maine’s two state run psychiatric hospitals has risen 14%. Although it appears that 42% of total spending is for hospital care and 58% on community care, without knowing the cost of non-state psychiatric hospitals, no real comparison is possible. We also know that Maine spends \$60,747,034 per year for 150 psychiatric beds, at a cost of \$404,980.26/year/bed. (National studies show that an intensive outpatient program like Assertive Community Treatment costs \$10,000 per year/person.) During this same time frame, spending on the Bureau of Mental Health has remained fairly constant at just over \$33 million. These totals, as

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proposed for 2011 are: \$90,426,877 for community mental health, \$65,590,608 for both state hospitals, and \$33,155,000 for the bureau.

Impact of Spending Reductions

There is little doubt that mental health care in America is in trouble. The President's New Freedom Commission Report, released in 2002, said: "For too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic – the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities." That report also recognizes that States have relied on the Medicaid program to support their mental health systems, making Medicaid the largest payer of mental health services in the country. Unlike other illnesses, where the burden is shared with private payors, Medicaid accounts for 20% of all mental health spending and 36% of all public mental health spending in the U.S. **Thus, cuts to Medicaid spending unequally affect people with mental health needs.**(pg. 21).

The Court Master issued a report in February of 2009 assessing the impact of budget reductions on adults with mental illness in Maine who are covered by the AMHI Consent Decree. That report concluded that the budget cuts had resulted in:

- An increase in unmet needs from 4.3% to 22.1%
- An increase in **homelessness** from 6.6% to 10.3% and increased unmet housing needs from 1.6% to 26.9%
- A decline in the availability of **crisis services** from 83.3% to 75.6%
- A decrease in the availability of **vocational supports** from 62.4% to 59.7%

That report also describes:

- A 2009 report by the Attorney General documented an **increase in the frequency and seriousness of threats to public safety** because of crises involving people with mental illness and the reduction in inpatient and outpatient psychiatric resources.
- A 2008 study by the University of New England found that after the budget cuts that took effect in July of 2007, **police departments across the state saw a 26% increase in the number of mental health related calls for service** in the first quarter of fiscal year 2008.
- Statistics maintained by the Penobscot County Jail between 2007 and 2008 show that 30% of inmates are taking psychotropic medications and the number of inmates on suicide watch has nearly doubled.
- Reduced services, elimination of services, increased clinical case loads, and longer waiting lists. (One community mental health

A 2007 report...describes a 108% increase in jail spending between 1997 and 2004, with an unexpected 46.7% increase by the Department of Corrections in 2007 alone.

center in southern Maine reported reducing services for frail elderly clients with mental illness from 90 to 16, closing services for 80 families who have substantiated child abuse or neglect cases, closing case management for 56 young people with serious mental illness, eliminating consultations to nursing homes, discontinuing mental health assessments for 33 children who were removed from their homes, laying off 9 workers, eliminating or reducing health care benefits for staff, and closing two offices).

- Failure to discharge patients residing at Riverview Psychiatric Center because there is no funding for community treatment in the community.

A 2007 report funded by the Maine Health Access Foundation for Cumberland County, *Corrections at a Crossroads*, describes a 108% increase in jail spending between 1997 and 2004 and an unexpected 46.7% increase in spending at the Department of Corrections, with a \$20.7 million dollar increase in 2007 alone. There is a definite connection between these increases and the shift of mental health care from psychiatric hospitals to the jail and prison system. In late 2009, the number of civic hospital beds available at Riverview Psychiatric Center was compromised by the increase in the need for forensic beds. This resulted in the opening of a 16 bed unit at Dorothea Dix Psychiatric Hospital to address some of these forensic needs. A 2009 agreement by the State to create the Correctional Advisory Board and consolidate corrections across Maine may begin to address the needs of inmates with mental health and substance abuse needs, including re-entry and diversion policies designed to send people to treatment and not to jail. Although it is more cost effective to treat people in the community where two of every treatment dollars comes from the federal government, reductions in funding for community care may thwart efforts to more effectively address the health care needs of inmates if the service community cannot meet their needs. In addition, we must prepare for the mental health and substance abuse needs of returning veterans, who will also need scarce mental health and substance abuse resources in the next ten years. According to the U.S. Department of Veterans Affairs, there were 145,419 veterans in Maine in 2003 (Maine's 2008-2009 State Health Plan, pg 53), ranking Maine the state with the highest percentage of veterans in the nation. As soldiers return from Iraq and Afghanistan, the issue of improving local access to care for veterans will be highlighted. The signature needs for these new veterans are substance abuse, trauma related mental health conditions, and traumatic brain injury.

A December 2009 report on the use of Maine's statewide warm line show significant differences in access to services since budget cuts began in 2006. In 2006, 60.4% of callers reported having case managers; in 2009, this number had fallen to 34.4%. In 2006, 83% of callers reported having a primary care physician, in 2009 this had fallen to 36.7%. In 2006, 73% of callers had psychiatrists; in 2009 only 48% had psychiatrists. In 2006, only 2.9% of callers reported they had no mental health services. In 2009, 16.4% reported they had no services. During these same years, participants also report increased use of emergency departments (up from 14.5% in 2006 to 32.8% in 2009)

Conclusions and Recommendations

Conclusions. Mental Illness and substance use conditions are the leading causes of death and disability for Mainers between the ages of 15 and 44, and the second leading cause for all ages. Depression is a complicating factor in the treatment of most general medical conditions. Multiple reports suggest that the system of care for mental illness and substance abuse conditions lags behind the rest of medical care and that jails and prisons have become the primary providers of care for people with mental illness. The needs of returning veterans with mental health and substance use conditions will further complicate the picture for Maine. Nonetheless, Maine's economic crisis has led to the removal of over \$48 million dollars in direct community supports for people with mental illness and substance use conditions and a proposal to cut another \$100 million between 2009 and 2010. Cuts already enacted have resulted in increased rates of homelessness for people with mental illness, an increase in the number of

public safety-related contacts with people experiencing psychiatric crisis, and a continued reliance on jails and prisons as the treatment option for people with mental illness and substance use conditions. There can be little doubt that cutting spending on community mental health leads to increased spending in corrections (where the entire cost is borne by the general fund), in hospitals (the most expensive level of care), and in public safety programs (funded with property tax dollars and general fund dollars). **Forcing non-health care providers to care for people with mental illness produces poor outcomes and higher cost.** It is foolish to save one general fund dollar in the mental health system, lose two federal Medicaid dollars, only to spend that same general fund dollar on mental health services in public safety settings. Exacerbating this waste is the fact that people will need more mental health services in settings that exacerbate the symptoms of their illness. They will stay longer, recidivate more often, and cost more.

Recommendations. Many reports recommend strategies to improve how we address the needs of people with mental illness and substance use conditions, but none suggest that a wholesale reduction in spending produces good outcomes. Instead, studies² offer numerous recommendations including:

- Better coordination of mental and physical healthcare;
- Early identification, screening, assessment, and treatment including expanded school mental health programs and programs across the lifespan;
- Address mental health with the same urgency as physical health;
- Advance evidence-based and promising practices and measure results;
- Build a system of care that uses the preferences and abilities of people with mental and substance conditions to drive treatment; and
- Widespread adoption of integrated electronic health records.

Any of the following would produce better outcomes than the wholesale reduction of mental health services that has been initiated and will only be exacerbated by this new budget. Consider the following:

- Managed care. Currently, mental illness and substance abuse treatment are partially managed by a private contract with an administrative services organization. High cost MaineCare patients are assisted by another company, with an eye toward better coordinating their care. Treating all MaineCare recipients the same, and specifically, treating behavioral health like any other chronic illness, would produce cost savings. **All of MaineCare should be managed.** Treatment of ALL illness, including services provided in hospitals, should be managed by a single managed care organization, rather than multiple costly management contracts.
- Evidence-based and promising practices. Now is the time to be aware of what services work, and which produce few outcomes. Maine's payment system should reflect incentives for treatments that have been shown to work. And, those that follow evidence-based models must be funded at levels that allow fidelity to that model. Rather than cut everyone's rates 10%, which assumes that all services operate equally, fund proven treatments adequately, phasing out ineffective practices via rate reductions. To assure there is adequate access to these promising and evidence-based treatments, assist service providers to move into desired kinds of practice and phase out treatments that do not produce results.
- Streamline and consolidate. Review and understand what the state is currently funding. Eliminate duplications, particularly those where there is a private contract and state employees doing the same thing. For example, in response to a severe budget crisis can the state afford the following:

² Improving the Quality of Health Care for Mental and Substance Use Conditions, the Institute of Medicine, 2006; The President's New Freedom Commission 2003, Mental Health: A Report of The Surgeon General, 1999; Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders, 2003

- Two psychiatric centers – Dorothea Dix and Riverview. Can community hospital psychiatric beds meet the need?
 - Multiple contract agents to manage and oversee complex need MaineCare members?
 - Consent decree coordinators, independent case managers in the community, and contracted entities to manage care?
 - The same number of internal administrators who used to oversee the system of care now that there is an independent contracted managed care organization that oversees the system of care?
 - Child resource coordinators and multiple information and referral organizations in the community?
 - Internal consumer advisors and two independent community-based consumer groups?
- Special Review. Create a special commission, like the Board of Corrections, to review all mental health spending across the system, including the cost of the state bureaucratic functions, to recommend and live within a consolidated budget. *Freeze community mental health spending, but do not cut it further, until this group can convene and report.*
 - Block grants. Use block grant dollars to support peer and family supports, a practice common in other states and one which leaves these programs open to all and not dependent on Medicaid funds or general funds..

Attachment One: PARITY LAWS

Federal Parity Law 2008	Maine Parity Law 2003
<p>Groups of 50 or more employees (or coverage offered in connection with such a plan) that provides medical, surgical, behavioral health must:</p> <ul style="list-style-type: none"> • No special restrictions may apply to mental health and substance abuse including deductibles, copayments, coinsurance, out of pocket, annual and lifetime limits • Treatment limitations applicable to mental health/substance abuse must not be more restrictive, including limits on frequency of treatment or scope or duration of treatment. • Out of network and in-network coverage must be the same. • A group may manage benefits but it must make medical necessity and denial information available to participants. • Plans with less than 50 employees are exempt, as are plans which incur increases of more than 2% during the first plan year or which exceed 1% of actual total plan costs each year after. State and local government self insured plans may seek exemption. • Stronger state laws trump this one. • ERISA plans, state licensed health insurance organizations, and public health service act are all covered by this parity law. 	<p>Individual and small groups must provide parity for 7 listed illnesses (schizophrenia, bipolar, autism and PDD, paranoia, panic disorder, OCD, depression).</p> <p>Group policies with 20 or more must:</p> <ul style="list-style-type: none"> • Have no special restrictions for mental health and substance abuse; • Cover inpatient, day treatment, outpatient, and home health services; • Cover 11 categories of illness including psychotic disorders, dissociative disorders, mood disorders, anxiety disorders, personality disorders, paraphilias, ADD and disruptive disorders, PDD, Tic disorders, eating disorders, and substance disorders; • No special restrictions may apply to mental health and substance abuse including deductibles, copayments, coinsurance, out of pocket, annual and lifetime limits • Treatment limitations applicable to mental health/substance abuse must not be more restrictive, including limits on frequency of treatment or scope or duration of treatment. • Medication management visits must be covered the same for physical and behavioral health and may not be counted in the calculation of any maximum outpatient treatment visit limits.

Attachment Two:

PROPOSED BUDGET CUTS 2009-2011

Savings Proposals

Public Benefits

	<u>SFY 2011</u>	<u>Biennium</u>
LIHEAP	(500,000)	(500,000)
Changing the disability determination cut-off from 45 days to 90 days.	(1,000,000)	(1,000,000)
Asset transfers and annuities	(5,075,200)	(5,075,200)
	<u>(6,575,200)</u>	<u>(6,575,200)</u>

Hospitals

Hospitals - CAH to 101%	(1,614,712)	(2,018,390)
Hospitals - APCs at 86% of Medicare rates.	(1,000,000)	(1,000,000)
Hospitals - hospital tax base year from 2006 to 2008.	(10,770,945)	(10,770,945)
Hospitals - Lower DRG reimbursement	(1,237,200)	(1,237,200)
Reimb Psych Hospitals at \$500 less per discharge	(386,875)	(386,875)
Limit Hospital Admissions to 5 per year	(641,018)	(641,018)
Limit Outpatient Hospital Procedures	(1,480,214)	(1,480,214)
	<u>(17,130,964)</u>	<u>(17,534,642)</u>

Pharmacy

Pharmacy - Reduce wrap benefits for DEL	(1,800,000)	(1,800,000)
Pharmacy - Reduces funding for the pharmacy incentive payment.	(165,000)	(165,000)
Rx limits	(1,000,000)	(1,000,000)
	<u>(2,965,000)</u>	<u>(2,965,000)</u>

Additional Medicaid Reductions

Retro-active FMAP Change	-	(7,464,470)
10% Rate Reduction (excl hospitals, pharmacy, physicians & dental)	(32,573,104)	(32,573,104)
Program Integrity (net of adding 2 staff)	(1,124,891)	(1,124,891)
Limit Lab & X-ray	(169,000)	(169,000)
Modify the physician fee schedule to mirror Medicare	(1,547,500)	(1,547,500)
	<u>(35,414,495)</u>	<u>(42,878,965)</u>

Public Health

CDC reduction to funds not used for federal match	(500,000)	(500,000)
Maternal and Child Health	(100,000)	(500,000)
	<u>(600,000)</u>	<u>(1,000,000)</u>

Adult Mental Health

Adult Mental Health - Non-Medicaid funding is reduced		
Involuntary Hospitalization	(670,000)	\$ (1,020,000)
Assertive Community Treatment (ACT)	(585,000)	\$ (731,000)
Daily Living Supports Services (DLSS)	(152,000)	\$ (190,000)
Community Intervention	(200,000)	\$ (473,000)
In-home Counseling Services	(270,000)	\$ (340,000)
NAMI	(220,000)	\$ (275,000)
Maine Center on Deafness & Maine Coalition Against Sexual Assault (Warm Line)	(137,723)	\$ (172,153)
Outreach	(79,000)	\$ (97,000)
Court Master	-	\$ (125,000)
Consolidate Warm Line	(72,000)	\$ (90,000)
QIC	(5,000)	\$ (5,000)
Professional Services	(108,246)	\$ (163,930)
Portland Identification and Early Referral (PIER)	(35,000)	\$ (43,750)
CSSP Training	(113,000)	\$ (113,000)
Center for Learning/Muskie School	(300,000)	\$ (450,000)
Mobile Crisis Services Consolidation	(1,350,000)	\$ (1,350,000)

Transportation	(282,500)	\$ (282,500)
Reduces funding for DDPC due to increased revenues.	(500,000)	(500,000)
Transfers mental health funding for contracted vocational services to DOL for match purposes.		
	(304,000)	(304,000)
Limit Mental Health Outpatient Therapy to 18 visits per year	(742,498)	(742,498)
Reimburse MH OP hospital services consistent with MaineCare non-hospital policy	(780,360)	(780,360)
	<u>(6,906,327)</u>	<u>(8,248,191)</u>
<u>Children's Mental Health</u>		
Reduces funding for non-MaineCare children's services.		(310,000)
Crisis Services	(840,000)	(840,000)
Reduces funding for PNIMs to reflect the savings associated with the creation of a children's waiver.	(979,560)	(979,560)
Limit Mental Health Outpatient Therapy to 18 visits per year	(684,727)	(684,727)
	<u>(2,504,287)</u>	<u>(2,814,287)</u>
<u>Other Children's Services</u>		
Reduces funding for contracted services for a variety of community supports.		(150,000)
Domestic Violence	(42,129)	(42,129)
Victim Assault	(37,907)	(37,907)
Family Planning	(281,599)	(281,599)
Shaw House	(34,000)	(34,000)
Crossroads for Women	(23,416)	(23,416)
Maine Children's Trust	(130,949)	(130,949)
Reduces funding by streamlining adoptive family recruitment using technology.	(450,000)	(562,500)
	<u>(1,000,000)</u>	<u>(1,262,500)</u>
<u>Substance Abuse</u>		
DEEP Deappropriation	(250,000)	(500,000)
Reimburse SA OP hospital services consistent with MaineCare non-hospital policy	(234,577)	(234,577)
	<u>(484,577)</u>	<u>(734,577)</u>
<u>Developmental Disabilities (MR)</u>		
Reduces funding by decreasing room and board subsidies.	(1,022,207)	(1,830,463)
Reduces funding by centralizing the administration of shared living services. (net)	(2,100,000)	(2,100,000)
Limit separate reimbursement for Day Hab Services in ICF/MRs	(743,573)	(743,573)
Eliminate additional administrative and program related costs in portions of high cost budgets in MR Services for individuals whose costs exceed \$200k per year	(707,770)	(707,770)
	<u>(4,573,550)</u>	<u>(5,381,806)</u>
<u>Adults with Disabilities</u>		
Reduces funding from the Consumer Directed Services program.	(500,000)	(625,000)
	<u>(500,000)</u>	<u>(625,000)</u>
<u>Elder Services</u>		
Reduces funding by managing utilization of the homemakers program.	(750,000)	(937,500)
Reduces funding for non-MaineCare adult day services and other supportive and administrative services.		(250,000)
Eliminate existing adult day services for 30 people effective July 1, 2010	(321,426)	(321,426)
Eliminate 6 contracted Adult Protective Services case aides	(276,336)	(276,336)
Reduce funding for occupational therapy consultation	(37,561)	(37,561)
Reduce funding for administrative efficiencies	(164,280)	(164,280)
Efficiency in management, reduce travel, copying, printing and supplies	(28,397)	(28,397)
Reduce contract to Goold for assessments	(172,000)	(172,000)
	<u>(1,750,000)</u>	<u>(2,187,500)</u>
<u>Other</u>		
Administrative Changes: Position Actions, Object Code changes	(356,424)	(799,482)
Eliminates 6.5 positions from General Fund accounts departmentwide.	(843,028)	(843,028)
	<u>(843,028)</u>	<u>(843,028)</u>

	(1,199,452)	(1,642,510)
Total Reductions	(81,603,852)	(93,850,178)
Appropriation Requests	\$ 1,890,077	\$ 20,315,081
Unappropriated Surplus Request - CAP Funding	<u>\$ -</u>	<u>\$ 5,813,927</u>
Net Reduction (tied to Governor's Press Release)	\$ (79,713,775)	\$ (67,721,170)
Add back: FY11 Cycle Push Reduction	\$ (17,928,000)	\$ (17,928,000)
Add back: CAP Unappropriated Surplus (not a general fund appropriation request)	<u>\$ -</u>	<u>\$ (5,813,927)</u>
Net DHHS Reductions (Ties to Budget Summary Report)	\$ (97,641,775)	\$ (91,463,097)
	-	-

Notes

There could be some double counting of the 10% rate reduction in the reductions to Non-Cats, Parents Expansion and the cycle push

The 10% rate reduction does take into account current budget initiatives. MR Waiver residential providers would have an additional 4% reduction.

Various FMAP Changes

Maintain enhanced ARRA FMAP (based on current appropriations - hold harmless)

Maintain enhanced ARRA FMAP (based on current appropriations - new base in FFY11)

FMAP to 66% after ARRA ends

FMAP

SFY10 Q1

SFY10 Q2
SFY10 Q3
SFY10 Q4
Blended SFY10 State Share