A "SHARED STATE" OF MIND:

FINDING COMMON SOLUTIONS FOR FUNDING OF MENTAL HEALTH SERVICES IN TENNESSEE

A Report

by

NAMI Tennessee and the Campaign for the Mind of America

March 3, 2005

EXECUTIVE SUMMARY

In response to the pressing challenges facing TennCare, NAMI Tennessee and NAMI's Campaign for the Mind of America offer recommendations for cost-effective systems solutions to ensure services and supports for people living with mental illness in Tennessee.

The economic cost of failing to provide adequate care and supports for people with mental illness is devastating for individuals, families, communities and the state's economy. In a time of tough choices for Tennessee, this report offers economically sound recommendations for immediate solutions to protect services for the state's most vulnerable citizens.

Specific solutions are based upon research and the experiences of other states facing similar pressures to balance the budget while offering a system of care for individuals with mental illness. Highlights include:

- Alternatives to Restricting Access to Medication for People Living with Mental Illness:
  - Drug Utilization Management
    - The Missouri Approach – Formed in 2003, the Missouri Mental Health Medicaid Pharmacy Partnership (MHMPP) analyzes pharmacy claims data on a monthly trend basis for better behavioral pharmacy management. Missouri reports an estimated savings of nearly $9 million in the first year of the program.
  - Disease Management
    - The Texas Approach – Four pilot sites in Texas provide a continuum of care for patients by coordinating medical resources across the health care spectrum. Tennessee Commissioner Betts' proposal to implement a Disease Management approach will ensure treatment integrity and save money by diverting funds from more costly services.
- Alternative Proposals for Medicaid Cost Savings and Funding Strategies:
  - Illinois was recently successful with the support of the Illinois Hospital Association in gaining the support of the Bush administration for a hospital tax levy that will allow the state to capture $450 million in extra federal Medicaid money.
  - Michigan passed a 75 cent-a-pack increase in the state's cigarette tax to generate an additional $300 million annually for the state's Medicaid program.
  - Washington state's Department of Social and Health Services has created a "No Wrong Door" program to coordinate services across various programs, ensuring cost savings and quality of care for people with mental illness.

Given today's budgetary difficulties in Tennessee, meeting patients' needs is a challenge. Yet, the fiscal risks to the state of drastic cost containment actions for people living with mental illness will surely result in greater financial cost and will ultimately put Tennesseans at risk. NAMI Tennessee and NAMI's Campaign for the Mind of America are prepared to work with all stakeholders to develop solutions to protect care and meet the state's fiscal challenges.

THE OBJECTIVE OF NAMI TENNESSEE AND THE CAMPAIGN FOR THE MIND OF AMERICA IS TO HELP TENNCARE PARTNERS DEVELOP A COST-EFFECTIVE AND EFFICIENT SYSTEM OF COMMUNITY-BASED SERVICES FOR PEOPLE WITH SERIOUS MENTAL ILLNESS.

NAMI Tennessee and its partners are poised to work with all Tennessee policymakers and decision makers to solve health care financing and delivery issues the state must address. Within this context, NAMI recommends that core mental health services be in place for Tennesseans with severe mental illness; those who are covered by TennCare and those who are not. Essential services include: crisis response, inpatient and residential treatment, psychiatric medication, detoxification, intensive case management, psychotherapy for specified diagnoses, and support services. Eligibility for core services should be based on functional assessment so as to allocate scarce resources to the most disabled. Multiple funding streams should be crafted into a seamless system of care for this priority population, allowing for consistent service provision, quality assurance and cost-effectiveness.

NAMI Tennessee and the Campaign for the Mind of America believe, as this report shows, that the costs of failing to provide adequate care and environmental supports for persons with mental illnesses are staggering to individuals, families, communities and the state, and that these costs are frequently unnecessary. With appropriate services and supports, many people with these illnesses can be effectively treated and become productive citizens. To help the state resolve this crisis, we are prepared to work with all partners to develop a cost-effective comprehensive system of services, supports and environmental requirements for people with serious mental illness.

With these goals in mind, we have identified several cost-effective alternative strategies that other states have adopted to control the escalation in overall Medicaid costs, preserve quality and protect access to medications for vulnerable populations. We believe these alternatives should be strongly considered in place of eliminating the TennCare program. NAMI Tennessee Campaign for the Mind of America and its partners stand ready to help craft solutions to address the needs of our most vulnerable citizens.

I. INTRODUCTION

The TennCare program was launched in 1994 to expand traditional Medicaid coverage and now provides health benefits to 1.3 million low-income, uninsured and disabled people – about 22 percent of the state population. Tennessee Governor Phil Bredesen (D) announced earlier this year that the state will move to eliminate coverage for 323,000 adults in TennCare (Figure 1). The governor's plan could end coverage for about 30,000 adults with serious and persistent mental illness (SPMI). For the remaining adults with SPMI, coverage will be subject to medical and prescription-drug benefit limits similar to those found in other states' health care programs.

TennCare at a Glance (Figure 1)

On January 10, Tennessee Gov. Phil Bredesen (D) announced steep cutbacks in Tennessee's expanded health care program for the working poor. Here are the highlights:

1.33 million		Total enrollment today
$8 billion		Budget ($2.5 billion state, $5 billion federal, $500,000 other sources)
22%		Of state population covered
The changes		
323,000		Adults disenrolled, including:
		67,000 people with serious medical conditions that have made them "uninsurable" **121,000** who cannot afford private health insurance **97,000** with extremely high medical bills **38,000** who have Medicare, but need treatment covered only by TennCare.
New limits:	12	**Doctor visits** per year
	20	**Hospital days** per year
	4	**Prescriptions** per month
	10	**X-ray or lab visits** per year
Remaining in the program		
		612,000 low-income **children** **Indigent pregnant women**

Source: The Washington Post, page A3, January 18, 2005.

Given the well-documented effects of untreated mental illness and the modern array of evidence-based mental health treatments, it is both humane and fiscally prudent to maintain a continuum of care to Tennesseans who, despite severe psychiatric disability, can live and work in their communities.

According to the 2000 U.S. Census, the state of Tennessee has a total population of 5,689,283; 75.4% of this population or 4,289,719 individuals are 18 years of age or older. It is estimated that 2% of the adult population has severe and persistent mental illness, or over 85,794 adults in Tennessee.

Citizens of the State of Tennessee with chronic mental illnesses still languish waiting for community based services, wander our streets homeless, fill up emergency rooms when preventive treatment should have been provided, and needlessly end up in the criminal justice system (as described in more detail in the next section). This is a human travesty that is avoidable with adequate funding and services. Treatment means the difference between hope and despair, struggle and recovery, and even life and death.

Limiting mental health treatment does not save taxpayer dollars. Instead limiting mental health treatment results in tragic unintended consequences and cost shifting. The story below is an example of this tragedy

II. UNTREATED MENTAL ILLNESS AND THE IMPACT ON TENNESSEANS – THE CASE OF OVERCROWDING IN JAILS

According to a study published in a recent issue of *Corrections Compendium*, the journal of the American Correctional Association, officers in Tennessee jails report that 19 percent of inmates suffer from mental illness. That number is at four to five times higher than rates of mental illness among the general population.

Many experts believe the numbers are higher because officers at smaller jails tend to underreport the number of mentally ill inmates.

Across the Tennessee, local jails and state prisons will bear the brunt as TennCare funds for mental health agencies are cut and more families find themselves without insurance. Funding for mental health crisis response teams has remained static since 1996, leaving police in charge of responding to mental health crisis calls.

With inadequate services, including hospital and community-based services, people with mental illnesses are left with no place to go, and very often end up in jails and prisons by default. Unfortunately, we are putting people in jail who need diagnosis and treatment. They can recover and live productive lives if they are treated. Prisoners with mental illness cost the state millions of dollars of taxpayers' money. Care for jail inmates with mental illness, must be provided with scarce county dollars**.** Few jails are able to fund sufficient treatment to stabilize mentally ill inmates. The result is that inmates with mental illness serve longer jail sentences per type of offense, have more behavioral problems and are more likely to be re-arrested and incarcerated. By regularly treating people with mental illnesses, we can prevent unnecessary incarcerations, thereby reducing overcrowding in jails and the cost to the Tennessee taxpayers.

Inmates with mental illness are typically caught in a cycle of repeated admissions to county jails, usually for minor offenses such as vagrancy, trespassing or disturbing the

peace. They are released, rearrested, held for short periods of time and returned to the community – a sort of revolving "cell door."

Everyone benefits if this population, especially those charged with misdemeanor offenses, can receive appropriate treatment rather than incarceration. Until 2004, when grant funds were no longer available, Tennessee had one Forensic Assertive Community Treatment (FACT) program for frequent users of the criminal justice system. Program data revealed a 37% reduction in arrests and 76% reduction in jail days for program participants.

To compound the problem, 53 percent of the teens held in Tennessee's juvenile justice facilities experience mental health problems (Criminal Justice/ Mental Health Advisory Committee, Tennessee Mental Health Planning and Policy Council, 2004). Minimal screening and even fewer mental health services are provided in most Tennessee juvenile justice facilities. The result is untreated youth who spiral down into a pattern of increased behavioral disruption and crime, ending in prison sentences during early adult years. These are wasted lives that could be channeled into productive adulthood if appropriate treatment and supports were available through the TennCare/Medicaid system. Juvenile justice facility staff reported lack of community resources as the biggest barrier for adjudicated youth.

The cost of treating people with mental illness in jails and prisons more than offsets any anticipated cost savings. Conservative estimates are that every inmate costs the state on average about $20,100 per year. Juvenile detention costs the state over $7,000 per month per child (New Freedom Commission on Mental Health). Based on data from a Milwaukee comprehensive youth services program, overall costs would be reduced by 40 percent through integrated care for children (New Freedom Commission on Mental Health).

III. A STATUS REPORT ON IMPLEMENTING BASIC SERVICES IN TENNESSEE

The National Substance Abuse and Mental Health Services Administration and experts in the field are promoting services and supports for people with serious mental illness from community living, including the implementation of evidence-based practices (EBPs) – proven interventions shown by research and implementation to work and promote recovery. Together with stable housing, these services really help people with SPMI. If the necessary resources are not committed to housing and community-based care, an already tenuous situation of long waiting lists for services will undoubtedly get much worse.

Tennessee must go farther in implementing EBPs. The vast majority of individuals who need these services and can benefit from them yet are not receiving them, an overview of which is provided below.

Although Tennessee has made an effort to implement evidence-based practices to assist adults with mental illness, including the 85,794 adults most severely in need of these

services, significant gaps remain between the number of programs and the needs of people with mental illness. We want to work with all stakeholders to close those gaps. The core services listed below provide a brief summary of self-reported data for FY 2004 from the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD).

Access to the multiple services described below is frequently impeded because responsibility for providing them is vested with different providers who are administered by different systems and are subject to different funding streams and rules. Additionally, the boundaries between public and private sector services have been increasingly blurred as public sector agencies have contracted with private organizations to provide and/or manage services. We are prepared to work with all stakeholders to assure close collaboration and coordination among diverse systems and providers to achieve cost-effective and positive outcomes for the treatment of people with severe mental illnesses.

Assertive Community Treatment (ACT): ACT is defined as a multi-disciplinary clinical team approach to provide intensive community treatment, support and rehabilitation services on a time unlimited basis to individuals who experience the most intractable symptoms of severe mental illness and who often experience the greatest functional deficits. Four established ACT (also known as PACT) programs serve 431 persons in the state with an investment of $4,309,185 in FY 2004. While some progress has been made in offering intensive services to individuals in need, there is still much to be done to fully implement ACT.

NAMI Expectations: 12,869 persons should be served

Supported Employment: Supported employment programs typically assist people in obtaining competitive employment—that is, community jobs paying at least minimum wage for which any person can apply—in accord with client choices and capabilities, without requiring extended prevocational training. Twelve (12) programs are operational in FY 2004 to support adults with SPMI in securing competitive employment. TDMHDD reports that 733 persons have participated in supported employment with a state investment of $1,260,787. There is still great unmet need for supported employment services.

NAMI Expectations: 42,897 persons should be served

Medication algorithms (Schizophrenia and Bipolar Disorders): A medication algorithm translates the latest available knowledge about medications into practical pharmacotherapy suggestions and promotes the optimal recovery in the consumer population. There are two such programs in the state – one serving 1,196 individuals with schizophrenia and the other serving 1,655 individuals with bipolar disorder. The state also administers one algorithm program for 1,257 individuals with major depression. No data was provided on expenditures for these programs.

NAMI Expectations: All medication prescribers in Tennessee should utilize algorithms.

Integrated MH/SA Services: Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence,

integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. Currently, 4 programs are implemented in some parts of the state with an investment of $420,613 in FY 2004. TDMHDD was not able to estimate an amount of persons served. There is a need for great expansion across the state to appropriately serve this population.

NAMI Expectations: 42,897 persons should be served

Family Psychoeducation: Offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. One program is implemented statewide through NAMI TN—Journey of Hope. In FY 2004, the state invested $167,265 to offer this program to 213 family members. NAMI TN operates one other psychoeducational program that is supported by the state, 'Visions for Tomorrow', that served an additional 61 persons. With the current level of programs, significant numbers of families of people with severe and persistent mental illness are not able to receive this service.

NAMI Expectations: Minimum 42,897 family members should be served

Illness Self-Management: Includes a broad range of health, lifestyle, and self-assessment and treatment behaviors by the individual with mental illness, often with the assistance and support of others, so they are able to take care of themselves, manage symptoms, and learn ways to cope better with their illness. One statewide program (BRIDGES) is offered. Across the state, 3,118 persons have been served through this program at a cost of $141,575 to Tennessee. The vast majority of individuals who should receive this program are not served at the current levels of implementation.

NAMI Expectations: Accessible to all 85,794 persons with severe and persistent mental illness in the Tennessee.

Jail Diversion Programs: Jail diversion programs are specific programs through which some type of mental health intervention places people with mental illnesses in the community instead of keeping them in jail. Individuals with mental illnesses may be identified for diversion from the criminal justice system at any point, including pre-booking interventions (before formal charges are brought) and post-booking interventions (after the individuals have been arrested and jailed).

Mental health courts are adult criminal courts that have a separate docket dedicated to persons with mental illnesses, divert criminal defendants from jail into treatment programs, monitor the defendants during treatment and have the ability to impose criminal sanctions for failure to comply. In the criminal justice system, Tennessee has established one mental health court in Davidson County, but no state money has gone to support this court. Twenty-one counties administer jail diversion programs that have served 2,845 individuals, supported by a state investment of $772,000 in FY 2004.

Consumer Housing: The Department of Mental Health and Developmental Disabilities has established housing units across a continuum from round-the-clock supervised living

to home ownership, to assist more than 4,150 Tennesseans with SPMI. Included in that continuum are 24/7 supervised housing, partially supervised independent congregate housing, independent rental housing and home ownership. Since FY 2000, the state has used $2,500,000 annually of its own funds for housing development, and leveraged more than $87 million annually in other funding to operate these programs.

NAMI stands ready to work with all policymakers to design a system of efficient and effective community-based services that promote recovery and resiliency for people with severe mental illness.

We know that real-time, comprehensive programs implemented in California for people with serious mental illness decrease the number of days of hospitalization by 66 percent, decrease days of incarceration by 82 percent, and reduce days of homelessness by 80 percent (New Freedom Commission on Mental Health).

IV. CONSEQUENCES OF ELIMINATING/RESTRICTING TENNCARE BENEFITS FOR PEOPLE WITH MENTAL ILLNESS

It is important to recognize that the system of care currently available to individuals with mental illness is very fragile and is saturated with demand with very limited resources. The "safety net" that was in place for individuals prior to the creation of TennCare disappeared as those resources were blended into the TennCare program. Governor Bredesen has established a Safety Net Task Force to identify existing resources for the disenrolled, but more time is necessary to re-establish the service infrastructure for the most vulnerable TennCare enrollees, those with severe disabilities such as SPMI.

Our experience in recent years is that local government resources for services and funding to these populations have continued to diminish in scope and size. Few resources will remain in place and those providers cannot absorb the numbers of individuals that will be potentially impacted.

Given the current condition of local governments, it appears unlikely that they can infuse additional dollars to assist these individuals with safety net services. Further complicating the situation, most individuals with mental illness have complex medical conditions that require more frequent and more specialized treatment than a generic "free clinic" could offer. Likewise, few faith-based clinics are prepared to offer the intensive treatments and supports necessary for people with SPMI. Community mental health centers are most equipped, but will need additional state funds in order to meet the need. As it currently stands, in order to utilize federal matching dollars people with SPMI should remain on TennCare.

The Impact of Reducing Services

The consequences of eliminating coverage and significantly reducing services will be serious to the system of care, as well as to individuals. For individuals with mental illness, the outcomes are predictable and include increases in inpatient psychiatric hospitalizations, incarceration, job loss, homelessness, violence and suicide. These are not doom and gloom fantasies but realities that occur in states where similar actions have

impacted this at-risk population (Kaiser Commission on Medicaid and the Uninsured and the Center for Budget and Policy Priorities). The negative health consequences for individuals will be compounded by the economic impact on individuals and families, the mental health system, faith-based services and programs and by the state and local government programs that are left to pick up the pieces.

Limiting the number of prescriptions covered under Medicaid per month or limiting the number of physician visits would have harsh impacts on people with mental illness who will thus need more health care (Miller, JE, Restricting Access to Medications Hurts Patients, Their Families, and Their Communities, *Drug Benefit Trends*, 2003).

Efforts to limit access to medications can result in more doctor visits, trips to the emergency department, and hospitalizations, which instead increase total health care costs. Lack of appropriate care can also trigger a downward spiral that ends in homelessness or incarceration (Ingoglia, CS, Caring for Persons with Mental Illness: Making Policy Decisions that are Truly Cost-effective, *Drug Benefit Trends*, 2003).

The Impact on the State Budget

According to recent analyses, eliminating TennCare would not produce the level of savings for the state budget that the Governor is seeking (Center on Budget and Policy Priorities and McKinsey and Company).

Ending TennCare would result in a reduction of federal matching funding for hospital services and require an increase in the amount paid from the state treasury for those hospital expenditures, largely offsetting the savings from insuring fewer people (Center on Budget and Policy Priorities).

Most private hospitals operate on slim margins due to the federal Disproportionate Share Hospital (DSH) payments that supplement Medicaid. Reducing Medicaid payments will force them to close their psychiatric units. Some hospitals will go out of business all together.

The Impact on the Economy

Reductions in state expenditures associated with the switch from TennCare to Medicaid would cause the loss of almost twice as much in federal matching funding, leading to a significant reduction in business activity and employment in the state. According to state officials, reversion to the traditional Medicaid program would save at least $650 million in state funds in state fiscal year 2005-2006 (Center on Budget and Policy Priorities).

If TennCare is eliminated, it will trigger the loss of at least $1.2 billion in federal matching funds because the federal government funds nearly 65 percent of TennCare expenditures. Economic analysis, based on a model developed by the U.S. Department of Commerce, indicates that the loss of $1.2 billion in federal funds would lead to a reduction in business activity in the state of Tennessee of at least $1.6 billion and a loss of at least 14,500 jobs in fiscal year 2005-2006 (Center on Budget and Policy Priorities).

Additionally, eliminating TennCare and replacing it with a more traditional Medicaid program will lead to severe consequences for low-income Tennesseans with mental illness and other chronic conditions, health care providers, and the Tennessee economy. The proposed cuts would reduce state expenditures, but they would also lead to a reduction in federal matching funds nearly twice as large as the amount that the state would save. This would create dislocations throughout the entire Tennessee health care system.

The reduction in federal matching funds would have negative economic consequences, creating a ripple effect through the economy.

The Impact on Health Care Providers

The loss of TennCare health insurance coverage would create significant financial problems for Tennessee health care providers. The majority of people who would lose TennCare health insurance coverage will become uninsured, but would still need health care. As a result, most of these people would attempt to obtain charity care or discounted health care from hospitals, clinics and other providers across the state (Center on Budget and Policy Priorities). As a result, uncompensated care would increase significantly for providers leading to payment shortfalls. Hospitals would then turn around and shift costs to private purchasers and businesses thereby increasing the cost of care provided to privately insured individuals. This would ultimately lead to higher health insurance premiums for businesses in the state. Small employers would especially feel the brunt of this cost shifting.

Earlier studies conducted by the Urban Institute on the relationship between the lack of health insurance and uncompensated care indicate that the uncompensated care sought by Tennesseans losing coverage would amount to between roughly $230 million and $450 million a year. Such large increases in uncompensated care would lead to substantial financial losses for health care providers and result in cost shifting to private payers (*Health Affairs* Web Exclusive, February 12, 2003).

In addition to the findings referenced in this section, a February 2004 report by McKinsey and Company, a consulting firm hired by the state to examine TennCare options, indicated that Tennessee would not realize large budget savings simply by terminating TennCare and reducing the number of people covered.

The report stated, "The significant savings associated with reducing coverage would likely be largely offset with the loss of the Section 1115 waiver and the resulting changes in the federal funding formula." As stated in the report, issues related to how the state accounts for certain hospital expenses could result in substantial increases in state costs. Specifically, McKinsey noted that if the TennCare waiver were eliminated, Tennessee would have to stop using its current flexible Certified Public Expenditure approach of accounting, requiring the state to contribute a larger share of these costs from the state, rather than the federal budget.

McKinsey estimated that the resulting increase in costs to the state would offset much of the savings that Tennessee would achieve from eliminating coverage for those covered

under the TennCare waiver. The report found that replacing TennCare with a traditional Medicaid program, "would therefore require the state to contribute additional money from the state funds, largely offsetting the savings from reducing enrollment."

V. THE NEED FOR BASIC COMMUNITY-BASED SERVICES FOR PEOPLE WITH SERIOUS MENTAL ILLNESS

NAMI recommends core community-based mental health services for Tennesseans with severe mental illness—including those who are covered by TennCare and those who are not. Essential services include: crisis response, inpatient and residential treatment, psychiatric medication, detoxification, intensive case management, psychotherapy for specified diagnoses, and support services.

Eligibility for core services should be based on functional assessment, so as to allocate scarce resources to the most disabled. Multiple funding streams should be crafted into a seamless system of care for this priority population, allowing for consistent service provision, quality assurance and cost-effectiveness.

These basic investments could yield huge savings by preventing unnecessary incarcerations, chronic homelessness, overcrowding in emergency departments and reliance on social services, and most importantly help people with serious mental illness live independent lives and contribute to their communities.

Crisis Response

Community based crisis response services prevent suicide, unwarranted criminalization and costly hospitalization of people with mental illness. To realize these savings, Tennessee must maintain round the clock psychiatric crisis response teams for telephone and face-to-face intervention in every county. Where insufficient mobile crisis teams exist we recommend psychiatric triage centers that operate on a walk-in basis. On-site security would allow law enforcement officers to transport consumers for evaluation and then return to protecting their communities.

Inpatient and Residential Treatment

When people with mental illness need acute inpatient care, NAMI prefers small, local facilities. Regional Mental Health Institutes should be the fall-back strategy for individuals with complex needs, not the first line of intervention. This strategy would maintain Medicaid funding for hospitals under the Institutions for Mental Disease (IMD) exclusion, and would also be better for the patient. We are gravely concerned that proposed TennCare changes regarding hospitalization will collide with the demise of the IMD exclusion waiver beginning July of this year. Unless people with severe mental illness can get rapid crisis response and short term local inpatient care, they will end up in the Regional Mental Health Institutes at state expense, or in jail, on the street or in the morgue.

Residential treatment for co-occurring mental illness and substance abuse should be available along with inpatient and outpatient detoxification services. Strong evidence

supports the use of integrated treatment to promote and sustain recovery for people with chemical dependency and mental illness.

Psychiatric Medication
To reduce the number of psychiatric prescriptions, NAMI recommends using evidence-based medication algorithms, drug utilization review and physician-to-physician education. We are gravely concerned that people with co-existing psychiatric and medical conditions may need more than four prescriptions per month, and therefore request a process to appeal medication limits for people with complex conditions. When general medical physicians prescribe psychiatric medications, the provision of psychiatric consultation will help physicians prescribe in a more effective and frugal manner.

Case Management
Consumers who are severely disabled require intensive case management to organize the resources necessary to support recovery. Since public dollars must be prioritized, NAMI recommends focusing case management on those who need it most, rather than providing a little service to many people as we do now. Over 30 years of research has proven Assertive Community Treatment (ACT) to be the most effective method for stabilizing people who are extremely disabled in the community, thus avoiding long-term, costly hospitalization. Tennessee only has four ACT programs in Tennessee at the present time; we need more.

Psychotherapy
Research shows that specific types of psychotherapy are the treatment of choice for disorders such as clinical depression, personality disorders, co-occurring mental illness and substance abuse and post-traumatic stress disorder (U.S. Surgeon General Report). Individuals with these disorders benefit from specific types of time-limited psychotherapy to help them re-establish healthy patterns of thinking, feeling and behavior. Medication alone is not sufficient.

Psychosocial Rehabilitation
While standard methods of vocational rehabilitation have not generally been effective for people with severe mental illness, psychosocial rehabilitation has a proven track record of 40 years. Twelve psychosocial clubhouses across Tennessee provide pre-vocational training, transitional employment and supports to help people with serious mental illness get a job and keep a job. Tennessee also has a nationally recognized housing initiative administered by the Department of Mental Health and Developmental Disabilities that brings in millions of federal dollars to develop housing for people with serious mental illness.

Additionally, Tennessee has a well-developed system of consumer operated peer centers where people with serious mental illness are employed to offer support, education and assistance to their peers. Peer Centers will need increased funding and further staff training and supervision to accommodate increased service demand as those whose benefits are cut or limited will seek information and support.

Consumer and Family Education
An essential component of disease management is education of the patient and family about disease states and preventive strategies. NAMI Tennessee and the Tennessee Mental Health Consumers' Association offer courses to mental health consumers and their families at no cost to the participants and minimal cost to the state. As stated in the PORT study released in 1995 by the National Institute of Mental Health, family education programs reduce patient relapses by more than 50%, and family psychoeducation is cited as one of the two non-medication approaches most likely to succeed.

There is widespread agreement in the mental health field that close collaboration and coordination among diverse systems and providers is essential to achieving good outcomes in the treatment of people with severe mental illnesses. NAMI Tennessee is prepared to work with all parties to weave these core services into a tapestry that addresses the needs of vulnerable people with serious mental illness. Community based supports are cost-effective and not only support patient recovery but also ensure that people with serious mental illness can have the opportunity to become productive, tax-paying citizens of our state.

VI. ALTERNATIVES TO RESTRICTIONS TO ACCESS TO MEDICATIONS

Pharmaceutical costs are the major inflationary factor in TennCare behavioral health services. Other service expenditures have consistently run $70 million per year under projections, as demonstrated in the charts shown in Appendix 1 (TDMHDD, Forum on the Future of Mental Health Services in Tennessee, 2003). NAMI Tennessee and the Campaign for the Mind of America offers solutions that have demonstrated value in containing pharmaceutical cost while not creating barriers to appropriate medication for persons with SPMI.

The State of Tennessee Comptroller of the Treasury Report on *TennCare Prescription Drug Costs*, *December 2002*, evaluates strategies implemented by Tennessee to control TennCare prescription drug costs in light of initiatives in other states and the private sector. The report also recommended changes in the TennCare prescription drug benefit to make the program more cost-effective. NAMI Tennessee and the partners believe that restricting medications is bad public policy and that cost-effective approaches exist for controlling the rate of escalation in prescription drug costs and preserving quality of care.

Additionally, pharmaceutical costs have been controlled compared to other costs when examining behavioral health inflation since the inception of TennCare Partners in 1996 (Appendix 1)

Why is Restricting Medications Bad Policy?

Limiting access to necessary medications negatively impacts productivity and the economy. With appropriate treatment, many people with mental illness are able to work

and contribute as tax-paying members of society. The denial of appropriate treatment impairs the ability of people with these disorders to maintain employment and fosters dependency on publicly funded benefits such as Supplemental Security Income and Medicaid. Restricting access is "risky business" for states.

It is critically important to maintain choice in order to find an effective treatment as quickly as possible, thus achieving the best possible clinical outcome and avoiding much higher health care costs downstream in the form of emergency department visits, hospital stays and crisis management, as well as avoiding additional budget costs due to increased homelessness and involvement with criminal justice systems.

What are the Positive Effects of Access to Medications?

The effects are enormous!

Enhanced productivity – With appropriate treatment, most people with serious mental illness are capable of working and contributing to the American tax base. In fact, a recent survey found that the majority of the costs of treating depression are offset by the increased productivity of the individuals who received treatment (Ronald Kessler).

Decreased public expenditures for hospital based services – The provision of appropriate treatment for these disorders decreases the necessity of crisis-oriented psychiatric services in inpatient treatment settings, the costs of which are frequently financed by publicly funded programs such as Medicaid and state mental health funds.

Lower burdens on law enforcement, courts and corrections – Police have become front line responders to people experiencing psychiatric crises and U.S. correctional facilities have become the largest de-facto psychiatric treatment facilities. The availability of timely and appropriate treatment for people with mental disorders will significantly lessen the considerable financial and human resource burdens associated with the overuse of the criminal justice system for mental health purposes. And, while people with serious mental illnesses are generally no more violent than the rest of society, the availability of appropriate treatment will also have a positive impact on public safety.

Healthier and more productive families – The availability of appropriate medications for people with these disorders decreases burdens on family members to provide constant care, and thereby allows family members to work and contribute more meaningfully to society.

NAMI Tennessee believes there are many cost saving alternatives to restricting access to medications. The following are several different options for reducing expenditures on Medicaid prescription drugs. These options save states prescription pharmaceutical costs without compromising quality of care for patients.

Drug Utilization Management

This approach implements utilization management strategies to promote and improve the quality of patient care for individuals with mental health disorders while seeking containment and reduction of pharmaceutical costs to state Medicaid and other public health programs. Several states have implemented these programs. Some examples are:

The Missouri Approach

Missouri formed the Missouri Mental Health Medicaid Pharmacy Partnership (MHMPP) in March of 2003. MHMPP retained the services of Comprehensive Neuroscience, Inc. (CNS) to evaluate mental health medication prescribing practices through a focus on improving patient care by educating doctors on best practice standards of mental health medications and reviewing, identifying and analyzing problematic prescribing patterns of physicians who frequently deviate from those guidelines (Alternatives to Restricting Access to Mediations).

This program analyzes pharmacy claims data on a monthly trend basis for better behavioral pharmacy management, identifies prescriber outliers based on deviations from nationally recognized best practice guidelines, engages outlier prescribers through targeted educational messages, benchmarking and peer review consultations, tracks changes in outlier prescribing practice over time, tracks high-risk patients' failure to refill antipsychotic medications and reports this to physicians, and identifies patients receiving current same-class medications from multiple prescribers and alerts all involved prescribers.

It is estimated that Missouri saved nearly $9 million under the first year of the program.

The Texas Approach

The Texas Medication Algorithm Project (TMAP) is a collaborative effort that has led to the development of evidence-based treatment guidelines for three major psychiatric disorders—schizophrenia, major depressive disorder, and bipolar disorder. The goals of TMAP are to improve the quality of care and achieve best possible patient outcomes for resources expended, and to develop and continuously update treatment algorithms and use them to reduce the immediate and long-term emotional, physical, and financial burdens of mental disorders for clients, their families, and their health care system.

The components include evidence-based, consensually agreed upon medication treatment algorithms, clinical and technical support necessary to allow clinicians to implement the algorithms, patient and family education programs that allow the patient to be an active partner in care, and uniform documentation of care provided and resulting patient outcomes. The TMAP model uses algorithms (or step-by-step procedures) in the form of flow charts to help physicians deliver quality of care based on making the best choice of medications and an assessment of their effectiveness.

The Massachusetts Approach

The state of Massachusetts has developed a clinical work group to address the issues of polypharmacy (the use of two or more medications to treat the same condition, use of two

or more drugs of the same chemical class, or use of two or more drugs with the same or similar pharmacologic action to treat different conditions).

The work group in Massachusetts includes psychopharmacologists, members of the Massachusetts Psychiatric Society, and representatives of the Department of Mental Health, the Division of Medical Assistance, the state Pharmacy Program and the state Alliance for the Mentally Ill.

Disease Management

Disease Management (also called illness management) is a broad set of strategies designed to help individuals with chronic diseases such as severe mental illness collaborate with health care providers, reduce their susceptibility to the illness, and cope effectively with their symptoms.

Disease Management (DM) coordinates medical resources for patients across the entire spectrum of care. A critical distinction between DM and other approaches to traditional care is a shift in focus from treating patients during discrete episodes of care to the provision of high-quality care across the continuum. A core philosophy of DM is continuous quality improvement.

Texas is introducing disease management for serious mental illness through four pilot sites. We applaud the proposal from Commissioner Betts to implement a Disease Management approach for serious mental illnesses such as schizophrenia, depression and bipolar disorder.

We do not believe that the approach taken by the Oregon Center for Evidence-Based Policy in regard to assessments of medications is good public policy.

In the Oregon Center's approach there is no mechanism for ensuring open access to all therapies within a drug class if existing evidence is not conclusive as to which medication is "best", if there is insufficient evidence base to make such a determination, or if the evidence is disputed. In fact, if such findings are inconclusive, the recommendation immediately defaults to cost (i.e., cheapest therapies will be preferred therapies). The Center's approach completely ignores practice guidelines and patient characteristics in developing recommendations on the efficacy of medications.

TennCare and Dual Eligibles – Will They Fall Through the Cracks?

Cutting off people with mental illnesses from TennCare prior to 2006 will have a disastrous effect on continuity of care and services.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 establishes a new "Part D" in Medicare that gives people access to a private Medicare prescription drug plan. The new Medicare law has particular relevance for low-income Medicare beneficiaries – often referred to as "dual eligibles." Dual eligibles will automatically be enrolled in the program, however, the Medicare prescription drug

benefit does not go into effect until January 1, 2006. These beneficiaries often face serious health challenges such as a severe mental illness. But dual eligibles will be dropped from the TennCare program on June 1, 2005, leaving these individuals with no prescription drug coverage. More than 12,000 dual eligibles in the state will lose coverage creating a seven-month gap in prescription benefits. Protections must be put in place to continue coverage until January 2006 when Medicare coverage begins.

The impact will be immediate if dual eligibles with mental illness lose their health care coverage. With no access to medications and services, people with serious mental illness will rapidly decompensate and will become very sick. Many will seek emergency department care and will be re-hospitalized for their conditions. Eliminating coverage is shortsighted as costs will balloon in other areas of the state budget, but more importantly, many people will suffer, and some will die.

VII. ALTERNATIVE PROPOSALS FOR MEDICAID COST SAVINGS AND FUNDING STRATEGIES – IDEAS THAT DO NOT INVOLVE DRASTIC REDUCTIONS IN ELIGIBILITY OR MEDICAL SERVICES.

NAMI Tennessee believes that the core, community-based services described in the previous section are critically important so that people who have serious mental illness are able to live and become productive members of their communities. Funding these services and programs involves implementing new approaches to control the rate of escalation in health care spending while at the same time ensuring quality of care for consumers.

The National Association of State Budget Officers in a recent report found that Medicaid spending continues to significantly impact state budgets. All fifty states reporting that they have been forced to take aggressive measures to contain Medicaid expenditures. States have looked at variety of approaches to cut costs while seeking to protect the health and mental health of their citizens.

The National Conference of State Legislatures (NCSL) also reports that all 50 states and the District of Columbia have worked to control the rate of escalation in Medicaid spending over the past three years. However, NCSL warns that restricting eligibility, reducing benefits and increasing co-payments, while having a short-term impact can negatively impact vulnerable populations and substantially increase costs to a state's Medicaid budget and other budget areas.

To avoid that pitfall, states are employing other strategies. The TennCare Coalition has identified new approaches to save the state money without reducing eligibility and services. NAMI Tennessee and the Campaign for the Mind of America and its partners stand ready to assist the state in finding those strategies that meet the needs of the state and its citizens. These strategies have contained costs without cutting essential services for severely disabled people. We believe these approaches and examples will inform all parties on trends and provide for a dialogue on a range of approaches implemented by other states.

The February 2004 report by McKinsey and Company also identified strategies that could be implemented to save states money without cutting eligibility and services.

Illinois
Illinois was recently successful with the support of the Illinois Hospital Association in getting the Bush administration to sign off on a hospital tax levy that will allow the state to secure $450 million in extra federal Medicaid money. The hospital tax will bring an additional $560 million to the state of Illinois. The state will then use these funds to boost Illinois' share of federal matching dollars for Medicaid. Much of this will then be returned to hospitals through increased payments for treating Medicaid patients.

Michigan
A 75 cent-a-pack increase has been added to the state's cigarette tax to generate an additional $300 million annually for the state's Medicaid program. There is a bill before the Tennessee General Assembly to levy a tax on cigarettes in order to support TennCare (SB 54 and HB 703 were introduced on February 16, 2005, http:www.legislature.state.tn.us.)

Louisiana
A 22-page "plan for immediate action" by the Department of Health and Hospitals calls for a change in nursing home funding mechanisms under Medicaid. They advocate for one long-term Medicaid unit to oversee all services and programs for the elderly, disabled, nursing home residents and individuals under waivers who want home and community-based care. Home and community-based care services and programs are currently handled by separate agencies with separate budgets.

The state currently collects a health care provider tax from nursing homes based on the number of patients they serve. Proposals have been made to charge a tax on the number of beds, rather than the number of patients, as an incentive for nursing homes to reduce the number of beds and to encourage nursing homes to get in the business of providing community-based services.

Vermont
About two-thirds of Vermont's Medicaid spending is financed from their Health Access Trust Fund (HATF). Revenues for the trust fund come from tobacco (taxes as well as part of the settlement from cigarette companies), provider taxes on hospitals, nursing homes and home health agencies, and an annual fund transfer from the General Fund.

New York
The Health Care Reform Working group proposed reducing Medicaid reimbursements to hospitals on certain costly, complicated treatments like transplants and cardiac care, thereby transferring these savings to more basic services like emergency room care and treatment for asthma.

Washington State
The state's Department of Social and Health Services has created a "No Wrong Door" program to coordinate services across various programs. Three specific groups were

recognized as key targets for program coordination: people with multiple disabilities including mental illness; troubled youth and their families; and long-term welfare recipients, many of whom were dealing with chemical dependency or mental illness.

VIII. CONCLUSION

NAMI recognizes that the state government continues to face acute financial pressures. But caring for people with mental illnesses is also a critical responsibility as articulated in Tennessee's Mental Health Code §33-6-103 which states that adults with SPMI and children with SED are a priority population for the Department's mental health services and supports. Understanding mental illness, patient needs, and how services are currently provided are important steps in determining what actions the state of Tennessee can take to improve access to quality treatment and services. Because of the nature of mental illness, individuals often require a multi-faceted approach to care. Meeting the needs of people with mental illness means addressing their "total care" needs, and that includes job training, access to medications and other services described as part of our "core services" strategy.

Given today's budgetary difficulties in Tennessee, ensuring that patient needs are met through an array of services can appear challenging. Yet, the fiscal risks to the state of drastic cost containment actions, or inaction, i.e., not addressing the medical and social needs of people with mental illness – can result in greater financial costs, but most notably, can ultimately put individuals at risk.

NAMI Tennessee and the Campaign for the Mind of America are prepared to work with all stakeholders to develop common goals and solutions to ensure that systems of care and social supports are designed efficiently and effectively and aid recovery and life in the community for people with mental illness.

These elements include: crisis response, inpatient and residential treatment, psychiatric medication, detoxification, intensive case management, psychotherapy for specified diagnoses, and support services.

We have highlighted several strategies that states have adopted or are considering in order to enhance revenue streams through hospital tax levies, financing reforms and additional "sin" taxes. Additionally, we have identified several strategies that preserve access to medications while protecting quality that have been adopted by states around the country. Restricting access to medications will not result in real cost savings – just cost shifting that will ultimately affect other state budget silos in a negative way.

It is incumbent that all concerned with the welfare of Medicaid recipients, and especially those with mental illness, develop strategies to provide quality health care that is both medically sound and cost-effective. Working together we can improve patient outcomes and save money in the short and long run.

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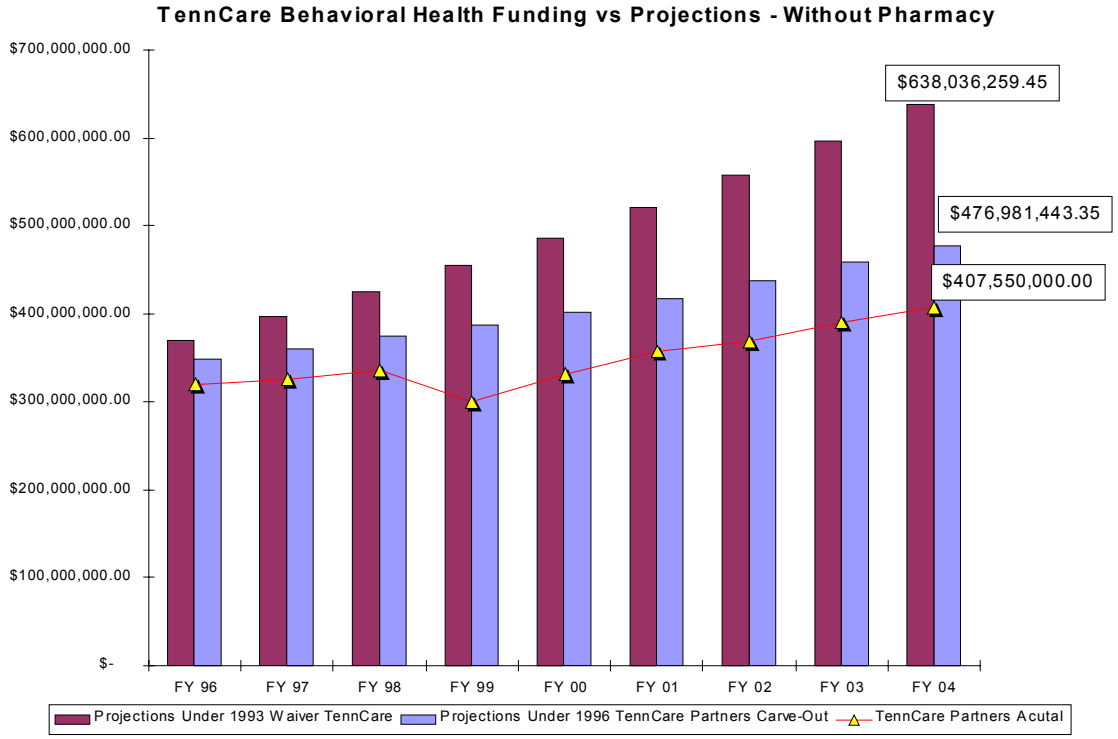
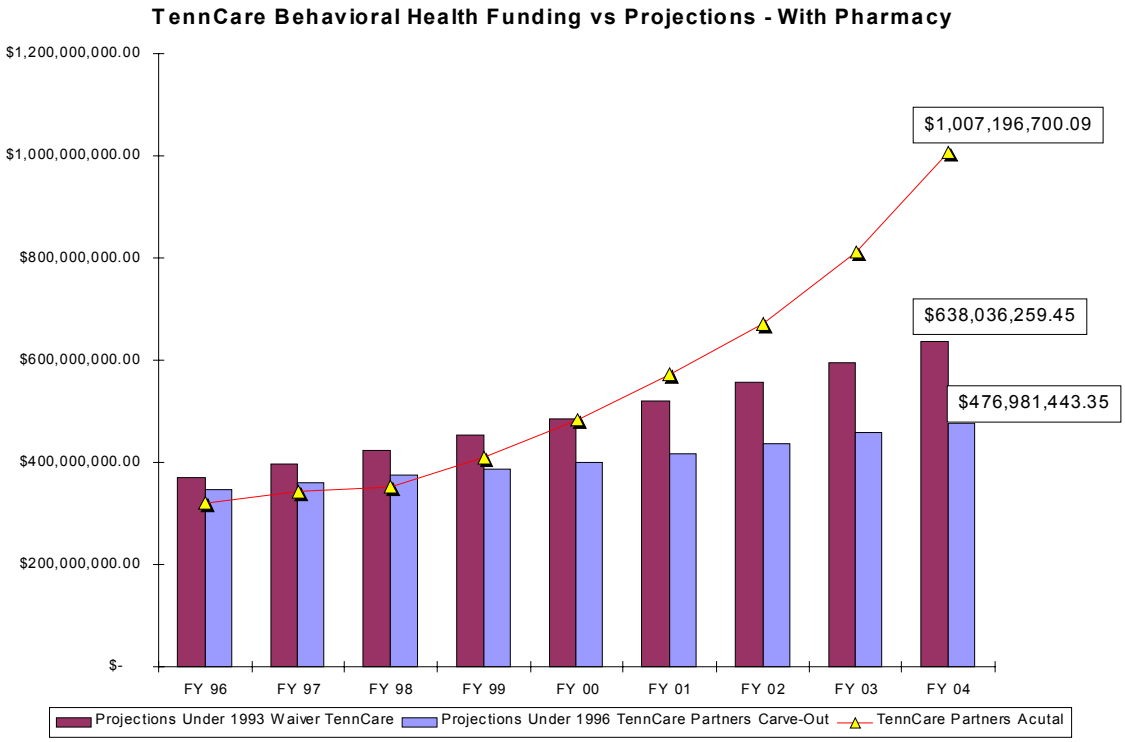
Appendix 1

Historical behavioral health costs vs. projections




TennCare Behavioral Health Funding vs Projections - With Pharmacy
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Projections Under 1993 Waiver TennCare
Projections Under 1996 TennCare Partners Carve-Out
TennCare Partners Acutal

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