AN ADVOCATE'S TOOLKIT

Medicaid Managed Care, Mental Health Services, and Pharmacy Benefits

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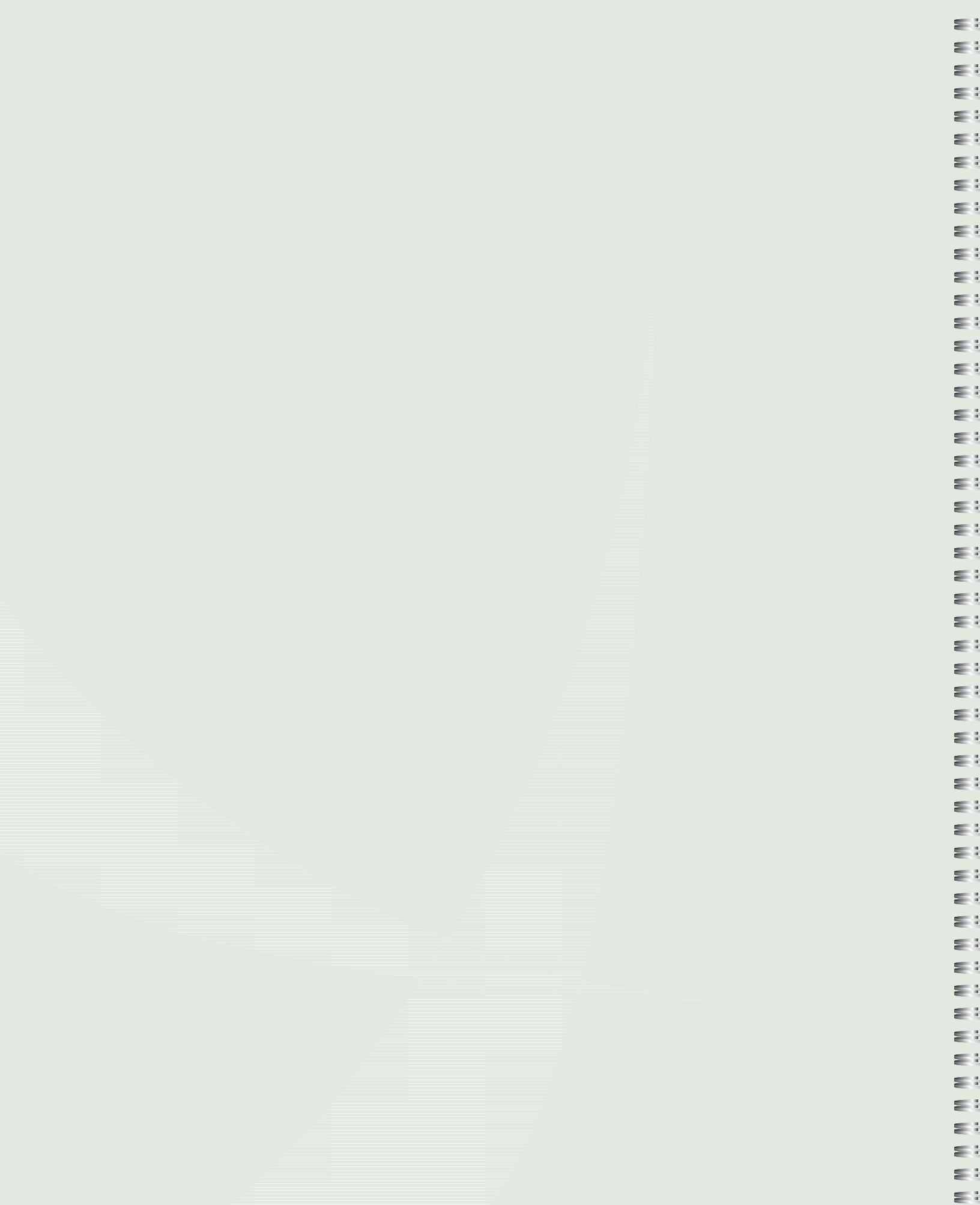
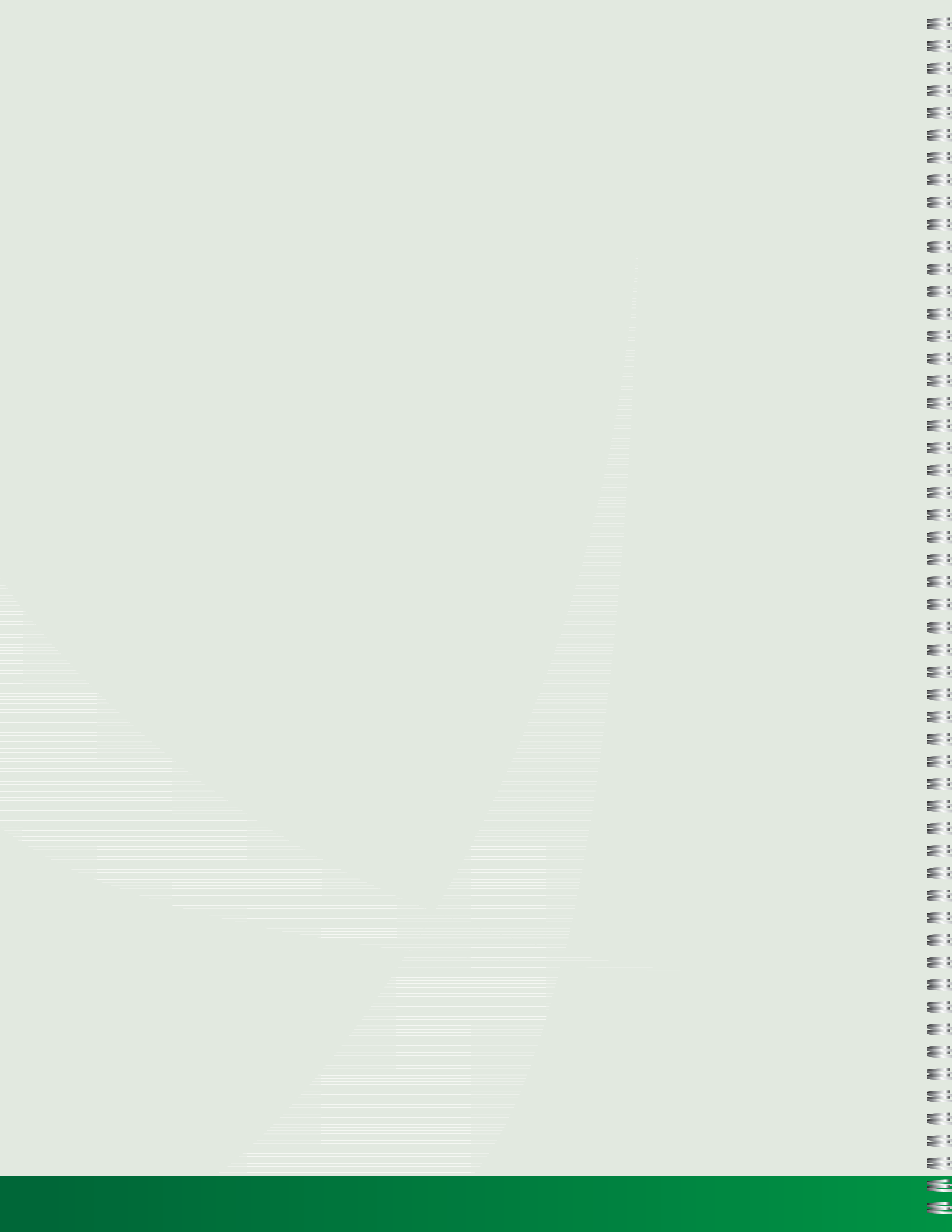Health Law and Policy Clinic of Harvard Law School

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Introduction

Although managed care plans have been declining as a share of the commercial insurance market in recent years, the opposite trend has been observed in Medicaid plans. In 1999, approximately 56% of Medicaid beneficiaries were enrolled in some form of managed care plan; currently, this number is close to 71%—or approximately 49 million people.[1] All states, except Alaska and Wyoming, have some percentage of their Medicaid beneficiaries enrolled in managed care plans—with enrollment rates ranging from 46% in West Virginia to 100% in Tennessee.[2] Forty-six states have more than half of their Medicaid beneficiaries enrolled in managed care for at least some healthcare services.[3]

According to the federal Medicaid and CHIP (Children's Health Insurance Program) Payment and Access Commission, or MACPAC, some state goals for pursuing managed care in their Medicaid programs include:

- Improved care management and coordination,

- Secure provider networks,

- Lower Medicaid spending and/or making expenditure amounts more predictable, and

- Improved program accountability.[4]

In addition to specializing in early identification and treatment of disease, managed care models are intended to encourage overall coordination and management of patient health, leading to cost savings. Medicaid managed care organizations and models of care can potentially offer states more cost predictability than traditional fee-for-service plans, making managed care programs especially attractive in a recessionary economy. A 2010 survey found that 20 states anticipated some expansion in Medicaid managed care programs in fiscal year 2011.[5]

Medicaid Overview

Medicaid is our nation's primary healthcare safety net for low-income individuals. It is a program that was established in 1965 under Title XIX of the Social Security Act. Unlike Medicare, which is operated solely by the federal government, Medicaid is a federal/state partnership that is administered separately by each state. The federal government contributes a matching percentage of state Medicaid outlays, paying a minimum of 50% of enrollees' healthcare costs but, in some cases, paying up to 83% of costs, depending on the state. Medicaid finances healthcare and related services for approximately 67 million people. Medicaid spending was $373.9 billion in 2009, 15% of the nation's total health expenditure.

Medicaid beneficiaries fall into a few main categories: children from low-income families who generally receive cash-assistance benefits, certain parents of children receiving these cash-assistance benefits, , pregnant women with income at or below 133% of the federal poverty level, low-income elderly individuals who require long-term care, and blind and disabled individuals. Although elderly, blind, and disabled beneficiaries together comprise the smallest beneficiaries, they account for a large proportion of Medicaid's costs. In addition, some states have extended coverage to additional patient populations who do not fit into these statutory categories through a §1115 waiver, a process that requires special application to the secretary of the US Department of Health and Human Services.

Most adults living with severe/serious mental illness who qualify for Medicaid do so on the basis of meeting income and disability requirements. As of 2014, people living with mental illness will no longer need to be deemed disabled to receive Medicaid benefits; instead, almost anyone living under 133% of the federal poverty level will be eligible for Medicaid.

Medicaid covers a range of mandatory services that all states must provide—and an additional range of optional services that states can elect to provide. Mandatory services include inpatient and outpatient hospital, physician, laboratory, x-ray, and nursing home and home health services. Optional services include prescription drug benefits (which all Medicaid programs currently elect to provide), clinic services, and prosthetic devices.

According to a study by the Bazelon Center for Mental Health Law (Washington, DC), all states currently cover a range of Medicaid services that are highly relevant to people living with mental illness, including: mental health therapy and counseling, medication administration and management, assessments, evaluations and testing, treatment planning, and emergency care. In addition, the majority of state Medicaid programs currently cover crisis intervention, mobile crisis services, crisis stabilization, partial hospitalization (day programs providing an alternative to inpatient hospitalization), day treatment, substance abuse outpatient treatment, substance abuse intensive outpatient services, ambulatory detoxification, and methadone maintenance therapy.

SOURCES: Kaiser Commission on Medicaid and the Uninsured, Medicaid Facts: The Medicaid Program at a Glance, 2010. Medicaid and CHIP [Children's Health Insurance Program] Payment and Access Commission, *Report to the Congress: The Evolution of Managed Care in Medicaid*, June 2011, http://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NTM4OGNmMTJlNjdkMDZiYw. Centers for Medicare and Medicaid Services, National Health Expenditure Fact Sheet, 2011. Bazelon Center for Mental Health Law, *Following the Rules: A Report on Federal Rules and State Actions to Cover Community Mental Health Services Under Medicaid*, 2008, www.bazelon.org/LinkClick.aspx?fileticket=zeqlTk_ltSk%3D&tabid=104.

Historically, states have chosen to enroll populations with lower and less complex medical needs (eg, young children and their parents) in Medicaid managed care plans. With the continued economic downturn and increasing pressure on state budgets, however, states have looked to expand managed care enrollment to populations who require more care and have more complicated medical needs. These populations include people living with severe/serious mental illness (SMI)[6] and other disabled individuals.

The federal Balanced Budget Act of 1997 made it easier for states to implement mandatory enrollment in Medicaid managed care.[7] Currently, 58.4% of disabled Medicaid beneficiaries nationally are enrolled in some form of managed care program.[8] Approximately 28% of disabled Medicaid beneficiaries are currently enrolled in comprehensive, risk-based managed care—a model based on that used by health maintenance organizations, which will be discussed in **Section 2: Managed Care Models and Participants**.

As the single largest payer for mental health services in the United States,[9] Medicaid is an important source of care and treatment for low-income people living with mental illness and/or emotional disorders.

Nationally, approximately 1 in 17 adults lives with SMI. Ten percent of children have a serious mental and/or emotional disorder.[10] People with SMI are at increased risk of other chronic medical conditions (eg, diabetes, high blood pressure) and die an average of 25 years earlier than other Americans.[11] Given that non-Medicaid state funding for mental health services has been cut by $1.6 billion between 2009 and 2011,[12] it is more important than ever to preserve adequate access to mental health care and services in state Medicaid programs—particularly with regard to access to prescription drugs.

It is difficult to overstate the importance of open access to prescription medications for people living with SMI. In this context, open access means that medication choices are made between the prescribing healthcare provider and the patient based solely on the patient's unique circumstances—and that these decisions are unencumbered by the restrictions placed by the use of preferred drug lists, prior authorization requirements, or "fail first" policies, which will be discussed in **Section 3: Medicaid Pharmacy Benefit Cost-containment Approaches and Advocacy Responses**.

Mental health medications are at the core of high-quality clinical care for people living with mental illness. They are essential to keeping people in community treatment—and out of more expensive institutional care. The consequences of poor or disrupted access to mental health medications will also be discussed in Section 3.

Nationally, approximately 1 in 17 adults lives with severe/serious mental illness.

It is critical that providers and patients have access to a range of options for mental health drugs, including newer medications. Mental health medications are not clinically interchangeable. Different drugs—even within the same drug class—have different chemical mechanisms, work differently, and have entirely different side effects among different patients. Finding the appropriate medication and dosage level to treat a patient with SMI is both an art and a science.

Many states have opted not to include pharmacy benefits in Medicaid managed care, opting instead to pay for these benefits on a fee-for-service basis. According to the National Conference of State Legislatures (Denver, CO), at least

21 states "carve out," or exclude, a portion of their Medicaid pharmacy programs from managed care plans.[13] Nine states carve out all drugs from managed care contracts,[14] whereas 12 carve out pharmacy benefits for specific populations, specific drugs, or specific drug classes.[15] For example, approximately 20% of states carve out antipsychotics and other mental health drugs from Medicaid managed care. In light of continuing state budget shortfalls, the end of enhanced Medicaid federal match rates on June 30, 2011, and the gradual implementation of the federal Patient Protection and Affordable Care Act, however, states may increasingly look to managed care as a way to control the costs of Medicaid pharmacy benefits. This shift raises concerns among mental health advocates as to whether Medicaid beneficiaries living with mental illness will have adequate access to the medications they need.

A well-designed, accountable Medicaid managed care plan can provide enrollees with high-quality, accessible, coordinated care that uses limited state resources efficiently and cost-effectively. This toolkit will provide community-based advocates with the information needed to help ensure that state Medicaid managed care programs meet the care, service, and treatment needs of individuals living with mental illness—and that they are held accountable for doing so. ◆

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Managed Care Models and Participants

What is managed care? Managed care is a form of healthcare that integrates the medical care system (ie, physicians, laboratories, and others) with the insurance system that pays for their services. Although managed care focuses on controlling costs, it can also improve care.

Traditional Medicaid is a fee-for-service (FFS) system. In such a system, Medicaid pays a set fee for each individual service a beneficiary uses. Within this system, a beneficiary can seek care from the provider of his or her choice. In addition, providers are not necessarily assigned to help beneficiaries coordinate their care. However, because physicians bear neither the risks nor costs of unnecessary or expensive services, they may overuse them. Finally, within the FFS system, physicians sometimes refuse to take Medicaid patients because established Medicaid FFS payment rates are notoriously low.

There are different models of managed care, but most of them share certain features. For example, members are usually limited in their choice of providers. They also must receive approval from a primary care provider (PCP) before seeing a specialist. In addition, for program administrators within this system, there are several different areas of managed care responsibilities. These responsibilities include:

- Quality assurance,

- Setting rates and monitoring claims,

- Customer service,

- Provider network management, and

- Use management, including data collection and analysis.

Medicaid managed care pays either an organization or a physician to manage patient care. Some Medicaid managed care plans pay a monthly per member fee to providers to cover any services their members might need. Other plans are a mixture of capitated (stipend-based) and FFS payments.

Federal regulations governing Medicaid managed care can be found at 42 Code of Federal Regulations Part 438.

What Are the Models of Managed Care?

Managed care can take one of many forms. Common forms include contracting for care and management, having a provider coordinate and manage care, or contracting for administrative services but not care. The Centers for Medicare and

> A full-risk plan could, for example, increase preventive and diagnostic procedures because they hope to avoid more expensive treatment regimens later.

Medicaid Services, or CMS, generally uses three classifications of managed care: comprehensive risk-based managed care plans, primary care case-management (PCCM) plans, and limited benefit plans.[16]

Comprehensive risk-based managed care plans/managed care organizations

Managed care organizations (MCOs) are contracted to provide specified services to members. They are paid a fixed monthly amount for each member regardless of the services actually used. This payment, referred to as capitation, can cover all—or only some—of the services a member might need.

One common form of MCO is a health maintenance organization (HMO). Members of HMOs can go to providers who have a contract with that organization. Each member has a PCP who gives basic care and referrals (much like in PCCMs, which are described in detail on the next page).

In 2009, 34 states and the District of Columbia had comprehensive risk-based managed care plans in their Medicaid programs; 21 states and the District of Columbia had more than 50% of their total Medicaid population enrolled in comprehensive risk-based managed care.[17] Of the 16 states without comprehensive risk-based managed care, many are largely rural.[18] The states with the highest percentage of Medicaid beneficiaries enrolled in comprehensive risk-based plans are Hawaii (97%), Tennessee (94%), and Arizona (90%).[19]

Full-risk managed care organizations

If all services are covered, the MCO bears the entire risk that a member will cost more (or less) than the payment rate. This risk encourages the MCO to consider costs when deciding on the appropriate treatment plan for a given member. If the patient uses few services that month, the MCO keeps the profits. If a patient uses expensive services, the MCO does not receive any extra money to cover its losses. Although such a system discourages unnecessary procedures, it can also reduce the use of helpful but costly ones. A full-risk plan could, for example, increase preventive and diagnostic procedures because they hope to avoid more expensive treatment regimens later. The primary advantage of full-risk plans to state Medicaid agencies is that they can predict monthly expenditures much better than FFS plans.

Federal Medicaid regulations define a "comprehensive risk contract" as one that (1) covers inpatient hospital services[20] *and* at least one of the following services listed, *or* (2) covers any three of these services:

- Outpatient hospital services,
- Rural health clinic services,
- Federally qualified health center services,
- Other laboratory and x-ray services,
- Nursing facility services,
- Early and periodic screening, diagnostic and treatment services, or EPSDT services, for children,
- Family planning services,
- Physician services, and/or
- Home health services.[21]

Partial-risk managed care organizations

Some Medicaid managed care plans share risks between Medicaid and MCOs. One way is to pay MCOs a monthly fee to provide a subset of services and a per service fee for everything else. This payment method shifts the risk related to the FFS portion from the MCO to Medicaid.

Another way to place part of the risk on Medicaid is to limit the amount an MCO can lose or gain. With a risk corridor, if the costs go too far above or below the aggregated monthly payment rate, the MCO receives extra money or must return it to the Medicaid program.

"Stop-loss," or reinsurance, is a similar concept, but it works on a more individual level; when the MCO reaches a threshold level of coverage for an enrollee, the state assumes any costs above that amount.

Provider-based managed care

Primary care case-management plan

In a PCCM model, PCPs provide basic care as well as referrals to specialty services. Members must see a designated PCP before going to a specialist. The PCP acts as a "gatekeeper" for all healthcare services and thus manages member care. In return, Medicaid pays the physician a small monthly fee (typically $2.00-

3.00) for each member-patient. Other services from the managing physician or specialists are paid on an FFS basis. PCCM is considered a no-risk plan because the managing physician does not gain or lose according to the overall costs of the member.

In some states, the use of PCCM systems is used mainly in rural areas that lack MCOs and adequate provider networks. However, PCCM is the primary model of Medicaid managed care in other states. Thirty states used PCCMs to coordinate care in FFS Medicaid in 2009.[22]

Enhanced primary care case-management plan

Enhanced PCCM uses a wider range of services and has greater care coordination. The goal is to reduce spending on high-cost members. These plans focus on chronic conditions like severe/serious mental illness. They may include social as well as medical services to serve members better. In addition, they generally use case managers—not just physicians—to manage member care. The goal is to reduce costly care like hospital stays through better chronic condition management.

Patient-centered medical home

This approach emphasizes expanded access and culturally effective care. A PCP coordinates services, which

are provided by a team that includes specialists. The PCP is expected to have continued contact with the member and to direct overall care.

In the patient-centered medical home, or PCMH, model patient-centered care involves communication between providers and patients. It is also meant to address the needs of the specific populations served. Members receive care through the health system and the community. This team can involve nurses, social workers, behavioral health specialists, and others to provide care that meets members' specific needs.

Limited benefit plans[23]

Limited benefit plans include a diverse assortment of plans that typically cover only a single type of benefit. They are used to complement FFS models and other forms of managed care, and are usually paid on a capitated basis.

Examples of limited benefit plans are prepaid inpatient health plans, or PIHPs, and prepaid ambulatory health plans, or PAHPs. These plans are often used to provide mental and/ or behavioral health, oral health, or transportation services.

In 2009, 34 states and the District of Columbia used limited benefit plans to provide selected services

to Medicaid beneficiaries. Among individuals in limited benefit plans, 4.3 million were in plans covering inpatient mental health services; 3.1 million were in plans that combined inpatient mental health and substance abuse services.

MEDICAID MANAGED CARE MODELS, 2009

Managed Care Model	Participating States, No.*
Comprehensive risk-based plan	34
Primary care case-management plan	30
Limited benefit plan	34
Combination of models	—
Two or more	37
All three	13

*The District of Columbia uses two managed care models, a comprehensive risk-based plan and a limited benefit plan.

SOURCE: Medicaid and CHIP [Children's Health Insurance Program] Payment and Access Commission, *Report to the Congress: The Evolution of Managed Care in Medicaid*, June 2011, http://docs.google.com/ viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NTM4OGNmMTJlNjdkMDZiYw.

Administrative services organizations

Companies that only provide administrative services are known as administrative services organizations (ASOs). Although ASOs primarily manage claims and benefits, they may also provide other services, such as data reporting, care coordination, or customer service.

ASOs are paid a fixed fee, which is not tied to the cost of care, to provide these services. Although ASOs do not have financial incentives directly related to the amount or cost of services used by Medicaid enrollees, they are still monitored and held accountable for efficient performance.

How Are Mental Health Services Provided in Medicaid Managed Care?

Mental health services are often separated from other medical services. Just as Medicaid managed care plans often carve out their mental health pharmacy programs, they also carve out mental health services. When they opt to do so, mental health services are paid for separately—even when provided by the same healthcare professional.

Medicaid sometimes pays community mental health centers to provide care. Payments can be made on an FFS or capitation basis. As noted, mental health services can be provided through a limited benefit plan, like a prepaid inpatient health plan or prepaid ambulatory health plan. Other times, Medicaid pays an independent organization to manage mental health services.

Managed behavioral health organizations

Companies that specialize in providing mental health services on behalf of managed care entities are called managed behavioral health organizations (MBHOs). They may, or may not, collaborate or network with other healthcare providers.

MBHOs come in a range of forms, just like managed care in general, and may opt to provide administrative services only. In such cases, they do not bear any risk and are paid only for the administrative services they control. Although MBHOs, like other ASOs, do not have financial incentives directly tied to the amount or cost of services used by plan members, they are still monitored and held accountable to the state program or MCO that subcontracts with them.

Other MBHOs have partial or full risk arrangements. These MBHOs make more money by keeping costs for each member low. To do so, they provide guidelines and review provider decisions. They may also limit care to "medical necessity," which will be discussed in **Section 4: Transition From Fee-for-Service to Managed Care in Medicaid**. However, providers and MBHOs sometimes disagree on what treatments are medically necessary. In fact, some MBHOs do not allow providers to dispense any care that the MBHO does not find

necessary—even if it is charged to the patient instead of the MBHO.

How Are Pharmacy Benefits Provided in Medicaid Managed Care?

Many states have preferred drug lists (PDLs; discussed further in **Section 3: Medicaid Pharmacy Benefit Cost-containment Approaches and Advocacy Responses**) for Medicaid participants and require enrollees to use drugs from a preapproved list. Members—or, more accurately, their healthcare providers—must get prior approval (also called prior authorization) to have Medicaid pay for a drug that is not on the PDL. Prices to members depend on whether the prescribed medication is classified by the plan as generic, preferred, or nonpreferred.

However, as previously noted, psychiatric medications may be treated differently than other drugs. In some states, rules on drug choice are less restrictive for mental health medications than for other drugs. Prescription drug services for mental health medications may be separated, or carved out, from other pharmacy benefits—much as mental health services are often separated from other healthcare services. As noted in **Section 1: Introduction**, approximately 20% of states currently carve out all mental health medications from their Medicaid

managed care pharmacy benefit plans. States often contract out pharmacy services to specialty organizations.

Pharmacy benefits managers

Some states directly contract pharmacy benefits to a pharmacy benefits manager (PBM). In other states, MCOs with Medicaid contracts subcontract these services to PBMs. In either case, PBMs may provide a range of services and interact with public and private MCOs, healthcare providers, patients, and retail pharmacies.

PBMs are usually paid through a management fee rather than capitation. The three largest PBMs are CVS Caremark Corporation (Woonsocket, RI), Express Scripts, Inc. (St. Louis, MO), and Medco Health Solutions, Inc. (Franklin Lakes, NJ).

Among the services PBMs can provide are claims processing and discounted drug prices, based on negotiating with drug manufacturers for rebates. PBMs often get lower prices from a manufacturer by agreeing to place that manufacturer's drugs on their preferred lists and based on the quantities sold. PBMs also contract with pharmacies to get lower dispensing rates. The state Medicaid plan that contracts with the PBM also gets a portion of the discount, so it saves money as well.

In addition, some PBMs provide pharmacy services themselves in the form of mail-order prescription services. Members are often eligible to receive discounts for buying prescriptions through these mail order services and can often make bulk purchases (90-day supply vs traditional 30-day supply), which lowers their out-of-pocket costs as well.

PBMs also analyze usage patterns and set limitations. They are often able to profile provider prescribing patterns and offer provider education materials that outline more effective prescribing practices. PBMs create PDLs and dispensing rules by looking at drug costs and effectiveness. Dispensing rules can include which drugs can be used and how often a member may get a prescription refilled. PBMs also ensure that members are staying within these predefined prescription benefit limits.

PBMs may also provide disease-management tools to patients to help prevent complications or adverse drug interactions in members with chronic conditions. PBMs seek to ensure that members are taking the appropriate drugs and getting refills at the recommended intervals. ◆

State Examples: New York, Arkansas, and Massachusetts

New York – Medicaid in Transition

On January 5, 2011, Governor Andrew Cuomo announced that he had issued an executive order aimed at redesigning New York's Medicaid Program. The executive order created the Medicaid Redesign Team (MRT), which is tasked with finding ways to reduce program costs and increase quality and efficiency for fiscal year 2011-2012.

According to a media release put out by the governor's office, New York spends more than twice the national average on Medicaid on a per capita basis. In addition, the state's spending per enrollee is the second highest in the nation. At the same time, New York ranks 21st out of all states for overall health system quality—and has the most avoidable hospital use and highest avoidable costs of any state.[24]

Phase 1 of the MRT's work began in January 2011 and consisted of developing a package of reform proposals. The MRT submitted its report with findings and 79 reform recommendations to the governor on February 24, 2011, for consideration in the fiscal year 2011-2012 budget process. The governor accepted the MRT's recommendations without changes. Subsequently, on March 1, 2011, the New York legislature approved a budget bill containing 73 MRT recommendations.

Phase 2 of the MRT's work is to develop a multiyear quality improvement and care management plan. To address more complex issues, the MRT has been subdivided into nine workgroups, each with a specific charge and recommendations due to the governor by November 2011.[25]

Currently, the state's Medicaid program uses a capitated MCO to provide physical health services to Supplemental Security Income, or SSI, beneficiaries with severe and persistent mental illness (SPMI). In addition, mental and behavioral health benefits are provided through an FFS system. Some commentators have noted that this model leads to fragmentation and a lack of coordination among providers—potentially resulting in poorer health outcomes for beneficiaries with SPMI.[26]

The MRT's recommendations will significantly change how care is provided to people living with SPMI. As the MRT noted in its June 2011 progress report, "New York is getting out of the...FFS business."[27] Among the MRT proposals that will impact Medicaid beneficiaries living with SPMI are:

- Three-year phase-in of care management for all Medicaid beneficiaries, with new models developed to ensure that special populations obtain the services they need;

- Use of patient-centered medical homes and health homes, with health homes targeting high-need and high-cost populations;

- Carving in, or specifically including, prescription drug benefits in new HMO contracts; and

- Immediate FFS rate reform in home healthcare to encourage "more appropriate utilization" and begin transition to episodic pricing—and eventually care management for all.[28]

New York's Medicaid redesign offers good opportunities for state mental health advocates to weigh in on the process, especially as the MRT and its workgroups—including a Behavioral Health Reform workgroup—move into phase 2.

One of the MRT's policies is to engage a broader set of stakeholders in this second phase. Workgroup hearings and meetings provide a chance for mental health advocates to ensure that reforms meet the needs of Medicaid's most vulnerable beneficiaries, including people living with SPMI and other mental and/or emotional health issues.

Arkansas – Proposed Medicaid Transformation

Arkansas is one of the 16 states that does not use comprehensive risk-based managed care (ie, HMO) in their Medicaid programs.[29] Instead, Arkansas uses a PCCM model called ConnectCare, which is administered by the state's Department of Human Services Division of Medical Services (DMS). ConnectCare enrolls most Supplemental Security Income beneficiaries with chronic health problems, as well as other public cash benefits recipients.[30]

Services relevant to people living with mental illness that are covered include community mental health and licensed mental health practitioner services, personal care services, rehabilitative services for individuals with mental illness, and, for enrollees younger than 21 years, inpatient psychiatric services, school-based mental health services, individual and group therapy, and psychologist services. Most services require a referral from a PCP, and some services require prior authorization from state Medicaid administrators.

In February 2011, Governor Mike Beebe submitted a request to the US Department of Health and Human Services for a §1115 waiver to "transform" Arkansas' Medicaid program and, more broadly, its whole healthcare system. The proposal would end FFS in the state's Medicaid program and would move it to an "episode-of-care" reimbursement model. The approach would require a new partnership among Medicaid, Medicare, and private health insurers. Thus far, among private insurers, Blue Cross Blue Shield has signed on with all healthcare systems using the same "price system."[31] The initiative would pay partnerships of local providers to act as health homes, with reimbursement being paid for episodes of quality care rather than FFS.

According to DMS, Arkansas is not proposing full-risk capitated payments or cuts to benefits, provider rates, or eligibility. Rather, it is proposing a novel public-private partnership and statewide payment reform that would promote cost-effective and coordinated quality care.[32]

This proposal calls for phasing-in the new model between July 2012 and January 2014, when Medicaid expansion under federal health reform is due to take place. The DMS work plan for "Transforming Arkansas Health Care" calls for "meaningful input from patients and providers," with stakeholder meetings and public comment periods scheduled.[33] Mental health advocates are encouraged to take advantage of the state's invitation to participate in the process and ensure that issues important to people living with mental health conditions are addressed.

Massachusetts – Integrated Medicaid Care Management

Medicaid in Massachusetts is called MassHealth. It includes a number of programs with different eligibility requirements and different levels of services. MassHealth Essential is a program for long-term (longer than 1 year) unemployed individuals who have a family income of up to 100% of the federal poverty level and who are not eligible for unemployment benefits.

MassHealth will pay either for all or part of a beneficiary's existing health insurance premium. If the individual does not have other insurance, he or she must choose a MassHealth physician.

Although MassHealth Essential has a more limited benefits package than most other types of MassHealth, covered services include inpatient hospital, outpatient (hospitals, clinics, physicians), pharmacy, medical (laboratory, x-ray, medical equipment, and supplies), and behavioral health (mental health and substance abuse) services.[34]
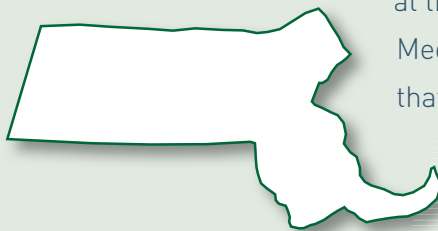
The Massachusetts Behavioral Health Partnership, or MBHP, is a behavioral health organization that manages physical and behavioral health benefits for MassHealth Essential enrollees in an integrated care management model. The program provides care management using field-based nurse and social work case managers who schedule and accompany enrollees to appointments, facilitate communication between enrollees and their various health providers, provide patient health education materials, and generally support enrollees' care plans.[35]

A study by the Center for Health Policy and Research at the University of Massachusetts Medical School (Shrewsbury) found that enrollees in the program generally followed treatment plans, received more targeted and integrated medical and behavioral health care, had improved physical and mental functioning, had better access to primary care, and used fewer acute and emergency services.[36] As states consider moving to health delivery and financing approaches that better integrate physical and mental health care, the MassHealth Essential program may provide a valuable model.

Medicaid Pharmacy Benefit Cost-containment Approaches and Advocacy Responses

For people living with severe/serious mental illness (SMI), prescription drugs are a critical and integral part of medical treatment. In this patient population, access to medication can mean the difference between being a productive, fully engaged participant in a community and being institutionalized, incarcerated, or homeless.

Mental health treatment is highly effective; 70-90% of people can experience decreased symptoms and increased quality of life with the right pharmacologic, psychosocial, and supportive services.[37] Like most preventive care, effective medications tend to improve health outcomes and prevent more expensive medical interventions from becoming necessary in the future. Access to prescription drugs is therefore crucial to the health and well-being of people living with SMI—and to reducing overall Medicaid expenditures for this population.

Nevertheless, states often attempt to limit the access of Medicaid beneficiaries to prescription drugs. Medication costs have historically been a major expense for Medicaid—though, recently, Medicare Part D has transferred some of that cost away from the program. Most states have put in place some sort of cost-containment measures for Medicaid prescription drug expenses.

Although prescription drugs are considered an optional service under federal Medicaid law, all states (to this point) have chosen to cover medications—at least to some extent. States can opt to limit access to prescription drugs. In fact, prescription drug benefits can be eliminated without a federal waiver. It is for this reason that pharmacy benefits are most vulnerable to budget cuts and other attempts to restrict access.

Some of the cost-containment approaches used by state Medicaid programs include:

- Preferred drug lists (PDLs) and restrictive drug formularies,

- Prior authorization (PA) requirements,

- Beneficiary cost-sharing arrangements,

- Limits on the number of prescriptions allowed per month,

- Requiring or incentivizing the use of generic drugs,

- "Fail first," step therapy, or therapeutic substitution policies,

- Supplemental rebates, and

- Multistate purchasing coalitions.

This section of the toolkit describes all of these cost-containment approaches, primarily focusing on PDLs, PA requirements, and beneficiary cost-sharing arrangements. In addition to suggesting effective advocacy responses to each approach, alternative ways of containing pharmacy costs are outlined—with an emphasis on promoting healthcare quality and minimizing barriers to access.

Preferred Drug Lists, Restrictive Formularies, and Prior Authorization Requirements

One way states try to control the cost of Medicaid pharmacy benefits is to restrict the number and range of medications (the formulary) for which Medicaid will pay. States create PDLs of medications that providers can prescribe, within certain limits, without needing to get permission first.

Forty-five states use PDLs, but approximately half of those carve out whole drug classes for specific (generally costly) medical conditions, such as mental illness, HIV/AIDS, and cancer.[38] If a provider wants to prescribe a medication that is not on the PDL, he or she must obtain PA so that Medicaid will cover the cost of the prescription.

STATE AND DISTRICT OF COLUMBIA MEDICAID PHARMACY COST-CONTAINMENT MEASURES, FISCAL YEAR 2010

Cost-containment Measure	Participating States, No.
Prior authorization requirement*	48
Preferred drug list	44
Supplemental rebates	44
Multi-state purchasing coalition	26
Prescription limits	16

*Outside of preferred drug lists.

SOURCE: Kaiser Commission on Medicaid and the Uninsured, *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends*, September 2010, www.kff.org/medicaid/upload/8105.pdf. Figure 33.

Advocacy responses to PDLs, restrictive formularies, and PA requirements

Research has shown that restricting access to mental health medications does not, in fact, save money. Instead, it simply shifts costs to more expensive forms of care within Medicaid budgets (eg, emergency department visits, hospitalizations) and results in higher costs for other government programs—such as the criminal justice system (eg, law enforcement, public safety, corrections) and homeless services.

Unlike state spending for medications, increased local costs for public safety and corrections due to improperly treated mental illness are not eligible for federal Medicaid matching payments. The National Conference of State Legislatures (Denver, CO) notes, "Pharmaceutical use is documented to save money by avoiding costly hospitalization, emergency department use, [and] nursing home placement."[39] For example, a year's supply of a leading brand product used to treat depression and obsessive compulsive disorder costs approximately $1,200, compared to $4,500-8,100 for one episode of a psychiatric hospital stay.[40]

Restrictive formularies and PDLs increase the chance that patients will have a lapse in treatment—or stop treatment altogether. One recent study examining medication access in 10 states with PA requirements found that 26% of patients faced barriers to access and gaps in medication adherence; these patients were three times more likely to experience homelessness and twice as likely to be incarcerated.[41] Another study found that patients with irregular access to medication had twice the rate of hospitalization, were hospitalized three times longer, and were four times more expensive to treat than people with consistent medication access.[42] Yet another report found that per capita spending on inpatient mental health services was more than 39% higher in states with restrictions on pharmacy access.[43]

Conversely, patients who had continuous access to medication had inpatient hospital costs 65% lower and emergency costs 55% lower than patients with interrupted access—resulting in an average monthly savings of $166 per patient.[44]

Ideally, all mental health medications would be exempt from PDL and PA requirements. When this level of access is not possible, advocates can argue for other measures to help

maintain quality care for patients with mental and/or emotional disorders. These include:

- "Grandfathering" Medicaid prescription benefits for patients who are already stabilized on nonpreferred drugs,

- Not using "fail first" policies (see page 17),

- Allowing providers a "dispense as written" option,

- Ensuring a PA process that is easy to use and provides a quick response,

- Educating patients and providers about PA,

- Making sure that Medicaid rules about PA response time (within 24 hours) and provision of emergency supplies of medications (72-hour supply) are followed,

- Ensuring that the PDL is based on the most recent clinical evidence and current standards of care,

- Including practicing mental health clinicians on the Pharmacy and Therapeutics Committee that determines the program's PDL, and

- Holding the state accountable for tracking administrative costs, healthcare costs, and the impact on beneficiaries of restricted access to medication.[45]

Beneficiary Cost-sharing Arrangements

State Medicaid programs have also attempted to shift some of the cost of medications back onto patients by using beneficiary cost-sharing arrangements. For Medicaid beneficiaries, the most common form of cost sharing is copayments, or copays, for prescriptions, which most states have implemented.

Research has shown that restricting access to mental health medications does not, in fact, save money.

Under the Deficit Reduction Act of 2005, copays for nonpreferred prescription drugs can be up to 20% of the cost for Medicaid beneficiaries with incomes above 150% of the federal poverty level.

Advocacy responses to beneficiary cost-sharing arrangements

Even modest copays of $2.00-5.00 can be a hardship for Medicaid enrollees, who, by definition, have very low incomes. In addition, people living with mental illness often have other medical conditions that require multiple prescriptions, further compounding the financial hardship to these individuals.

Copays do not generate significant revenue—nor do they offset a significant percentage of the cost of medications. In fact, any cost-sharing amount paid by a Medicaid beneficiary is not eligible for matching federal funds. Instead, copays may save states money primarily because they discourage low-income beneficiaries from filling prescriptions at all.

Studies have shown that cost-sharing arrangements can have major adverse consequences for Medicaid beneficiaries. One study found that, after cost-sharing arrangements were implemented, patient emergency department use increased by 88% and hospitalization, institutionalization, and death increased by 78%.[46]

A study of Medicare Part D patients with mental illness found that nearly 25% had problems accessing their medications because of copays; consequently, more than 1 in 4 visited an emergency department, and 1 in 10 was hospitalized.[47]

The use of copays just shifts costs; it does not necessarily save money. After Oregon implemented Medicaid cost-sharing arrangements, though pharmacy spending decreased,

overall per person spending for other medical services increased.[48]

States also need to factor in the administrative costs of collecting copay fees. If copays are small, the amount collected will probably not be enough to offset the cost of collection. Conversely, larger copays might generate more Medicaid-related revenue, but they will also likely discourage beneficiaries from using medications, leading to more expensive medical care later.[49]

Limits on Number of Prescriptions

Some states set limits on the number of prescriptions that a Medicaid beneficiary can fill in any given month, the number of pills allowed to be dispensed at one time, or on the number of refills permitted before a new prescription is required. States may also limit the number of brand-name prescriptions a beneficiary may have. In fiscal year (FY) 2010, a total of 16 states used such limits; in FY 2010-2011 six states (Kansas, Kentucky, Maine, Mississippi, Virginia, and Wisconsin) imposed more restrictive quantity and/or refill limits.[50]

Advocacy responses to limits on number of prescriptions
People living with SMI are more likely to have multiple chronic medical conditions that require additional medications. Numerical prescription

limits pose significant challenges to people trying to manage multiple health issues.

As with PDLs, PA requirements, and cost-sharing arrangements, creating barriers to pharmacy access through prescription limits may not save money in the long run. When beneficiaries are unable to take prescribed medications, they are likely to need more expensive medical care in the future as a result of deferred treatment.

Requiring or Incentivizing Use of Generic Drugs

Because generic drugs cost 80-85% less than brand-name medications (ie, before drug rebates are deducted), states may require providers to prescribe generic equivalents when they are available.[51] Thirteen states require pharmacists to dispense generics.[52] Another nine states, including Illinois and North Carolina, have implemented tiered reimbursement policies (ie, paying pharmacists more to dispense generic drugs) as an incentive to the use of generics.[53]

Other ways to incentivize the use of generic drugs are to have lower copays for generics and to require PA for a brand-name medication when a generic version is available.

However, some states allow providers to override Medicaid requirements to prescribe generic drugs.

Advocacy responses to requiring or incentivizing the use of generic drugs

Policies that restrict access to brand-name drugs can be particularly harmful to people living with SMI because newer and more effective medications generally do not have generic equivalents.

In addition, mental health medications are not interchangeable—even medications in the same drug class can differ from each other. Mental health drugs have different chemical structures and may work differently and have different efficacy and side effect profiles in different people.

Providers and patients should be able to make the choice of the most effective medication based on the individual patient's situation. Mandating the use of generics takes away that choice.

Finally, if a generic drug fails to work for a patient, treatment will ultimately cost more than if the patient had been allowed access to a brand-name drug in the first place.

"Fail First," Step Therapy, and Therapeutic Substitution Policies

Under a "fail first" policy, providers must prescribe the oldest and least expensive drug available to treat a given disease or condition. If that medication fails to help the patient, the provider can then move to the next least expensive model.

Step therapy and therapeutic substitution (ie, requested or required substitution of one drug for another when a patient goes to fill a prescription) are similar methods of trying to have Medicaid beneficiaries use less expensive medications.

Advocacy responses to fail first, step therapy, and therapeutic substitution policies

There have been tremendous advances in mental health medications during recent decades. Newer drugs are often more targeted and more effective and have fewer severe side effects.

As noted previously, mental health medications are unique and cannot be used interchangeably. Substituting one medication for another poses health and safety risks. In addition,

changing mental health medications is often difficult and time consuming. It can take 6-12 weeks to see if a medication works; if it does not, a patient's condition can worsen.[54]

A study of Medicare patients with mental illness looked at beneficiaries who were stabilized on medications but then switched by their Part D plans to other drugs; more than one in three had an emergency department visit, and 15% were hospitalized.[55]

Different drugs—even within the same drug class— have different chemical mechanisms, work differently, and have entirely different side effects among different patients.

As with policies that mandate the use of generic drugs, the implementation of fail first, step therapy, and therapeutic substitution policies interferes with the provider-patient relationship and is neither cost-effective nor compassionate.

Supplemental Drug Rebates

In addition to the federal Medicaid rebate program, most states

negotiate additional rebates from pharmaceutical companies. In FY 2010, supplemental rebates were used by 44 states.[56] The basic mechanism of supplemental rebates works like this: (1) a state creates a Medicaid PDL, then (2) manufacturers that agree to pay an increased, or "supplemental," rebate to the state have their drugs included on the PDL. Alternatively, manufacturers that do not enter such agreements often find that their drugs are given nonpreferred status in the Medicaid PDL and require PA when prescribed to Medicaid enrollees.

The Patient Protection and Affordable Care Act of 2010 (also known as ACA and federal health reform) will increase the federal Medicaid drug brand-name rebate from 15.1% to 23.1% (applicable only to the federal portion of the drug cost). The legislation will also extend the prescription drug rebate to Medicaid managed care organizations for the first time, retroactive to January 1, 2010.[57] According to the National Conference of State Legislatures, changes from the Patient Protection and Affordable Care Act of 2010 mean that states will need to recalculate their costs, savings, and purchasing arrangements; the state Medicaid share of revenue from existing state-negotiated supplemental rebates will be reduced, but the exact amount of this reduction is not yet known.[58]

Advocacy responses to supplemental drug rebates

To the extent that supplemental rebates reduce access to certain medications, the advocacy responses to PDLs and PA requirements discussed previously also apply to these rebates.

Multistate Purchasing Coalitions

To contain costs and leverage more bargaining power with pharmaceutical manufacturers, approximately 27 state Medicaid programs have voluntarily joined multistate buying pools.[59] As of mid-2010, there were three multistate buying pools and one state-based pool.

The pools use common PDLs and obtain supplemental rebates from manufacturers. Medicaid buying pools include states with approximately 32% of the nation's Medicaid enrollees and 38% of total US Medicaid pharmacy expenditures.

These pools include two that are administered by Provider Synergies, LLC (Cincinnati, OH): the National Medicaid Pooling Initiative, or NMPI, started in 2003 and serving 11 states; and the Top Dollar Program, which serves eight states.[60] Goold Health Systems (Augusta, ME) administers the Sovereign States Drug Consortium, or SSDC, which has a seven-state nonprofit structure with all supplemental rebate revenues returned to member states.

Advocacy responses to multistate purchasing coalitions

To the extent that multistate purchasing reduces access to certain medications, the advocacy responses to PDLs and PA requirements discussed previously also apply to this state-initiated cost-saving measure.

Alternative, Quality-driven Ways to Contain Medicaid Pharmacy Costs

All the approaches discussed previously represent cost-driven utilization management of Medicaid pharmacy benefits—all of which can actually prove not to be cost-effective if beneficiaries end up needing more expensive medical interventions because of inadequate access to medications. The following section lists other cost-containment approaches that focus on improving the quality and effectiveness of pharmacy benefit use.

Provider education and feedback programs

These programs review pharmacy claims and prescribing patterns with the goal of educating providers about best practices.[61]

The Missouri Mental Health Medicaid Pharmacy Partnership uses pharmacy data to identify prescriber patterns that fall outside of clinically recommended practices (eg, unusually high or low doses of medication) and then sends providers information designed to improve prescribing practices.[62]

"Academic detailing" programs, used in at least six states, have state-employed pharmacy experts visit providers to distribute data about drug effectiveness and costs.[63]

Research indicates that, for every $1.00 invested in these programs, there are $2.00 in savings.[64] There is one caveat, however; the state PDL and the recommendations of the provider education program need to be aligned.

Prescription case-management programs

Using clinical reviews, these programs help monitor and ensure appropriate use of medications when prescribing activity is unusually high or outside of usual clinical practice.[65] These programs can be particularly helpful for patients with complicated health needs, such as those living with mental illness and/or other chronic medical conditions.

The North Carolina Nursing Home Polypharmacy Initiative, for example, has a state physician/pharmacist team review the cases of nursing home residents who take more than 18 medications in 90 days, making recommendations to improve care. By carrying out nearly three-quarters of the teams' recommendations, North Carolina nursing homes saved the state $16 million in 2002 and helped improve patient health.[66]

Retrospective drug utilization review

By analyzing pharmacy claims after prescriptions are filled, this form of initiative tries to "develop quality edits at the point of sale."[67]

Indiana's Mental Health Quality Advisory Committee, for example, looked for ways to improve the safety and effectiveness of mental health medication treatment plans. Without restricting patient access to medications, Indiana's program used pharmacy claims edits to prevent therapeutic duplication, overdosing, and drug interactions.[68]

Value-based insurance design

Most often used in the private sector, this cost-saving option actually encourages the use of "high value" services, such as medications for chronic conditions, by reducing or eliminating patient cost-sharing arrangements and other potential obstacles to access.

Marriott Hotels & Resorts (Bethesda, MD) used a value-based insurance design program to reduce the amount of drug copays for employees with chronic health conditions. In the first year of the program, the company made up all its lost copay revenue in health services savings.[69] ◆

Transition From Fee-for-Service to Managed Care in Medicaid: Issues to Consider

When a state is planning to transition all or part of its Medicaid program from a fee-for-service (FFS) model to a capitated, risk-based managed care model, it generally issues a request for proposals (RFP). An RFP is an invitation to organizations to submit proposals that will show how their particular organization would best meet the state's requirements for providing care to Medicaid beneficiaries, within the parameters laid out in the RFP.

Although advocates may believe that transitioning from FFS to managed care is undesirable for people living with mental illness (and managed care certainly has a mixed record in terms of delivering quality care to people with complex chronic illnesses), the transition also presents opportunities for advocates to help shape what these new and revised Medicaid programs will look like and how well they will meet the care, service, and treatment needs of people living with mental illness.

It is important to note that the RFP process is only one "advocacy opportunity point"—community-based advocates can also have influence on state Medicaid programs in other ways, including, but not limited to, public comment on state rule-making, state Medicaid waiver applications, at Medicaid Pharmacy and

Therapeutics Committees (which make recommendations for preferred drug lists), during managed care contract renewals, and within managed care plans themselves, such as through formal member grievance procedures. The best way for mental health advocates to ensure that they have a voice in what happens with Medicaid is to develop and cultivate good working relationships with state Medicaid officials.

An enforceable contract with clear and measurable responsibilities between a state Medicaid agency and the managed care organization is at the foundation of a strong Medicaid managed care program for people living with mental illness. Although managed care plan contract terms and conditions vary among states in the level of specificity of plan requirements,

all include a basic set of activities, many of which are mandated by federal law.[70] Federal managed care contract requirements are set out at Title 42, Part 438 of the Code of Federal Regulations and include:

- General provisions,
- State responsibilities,
- Enrollee rights and protections,
- Quality assessment and performance improvement measures,
- External quality review requirements,
- Grievance system,
- Certifications and program integrity,
- Sanctions, and
- Conditions for federal financial participation.[71]

Following are some of the key elements and issues that advocates should ensure are effectively addressed in RFPs and managed care plan contracts.[72]

Definition of "Medical Necessity"

Medicaid will only pay for care that is "medically necessary." However, this term is largely undefined by federal law.

Medical necessity should be defined clearly in state Medicaid managed care contracts. In addition, the definition should be broad enough to cover the comprehensive services needed by people living with mental illness.

Well-defined, current clinical standards should be used to guide decision-making processes regarding whether a service is necessary and therefore covered. Finally, medical necessity determinations for mental health services should be made in a timely way by licensed clinicians with experience in treating people with mental illness.

Covered Services

As with medical necessity, there should be clear definitions that address which services are covered, any specific eligibility criteria, and the amount, duration, and scope of services. Coverage of evidence-based services that support recovery-focused treatment should be prioritized. State Medicaid plans need to make coverage decisions in a consistent and appropriate way based on the medical condition of the beneficiary.

Delivery of Care and Access to Covered Services

A plan may cover a comprehensive range of services. However, for coverage to be meaningful, members must be able to access the services when they need them. Contracts should spell out timelines and waiting time standards in addition to providing guidance regarding language access for members who are not proficient in English. Members should have a choice of at least two providers within a reasonable geographic range of where they live.

The best way for mental health advocates to ensure that they have a voice in what happens with Medicaid is to develop and cultivate good working relationships with state Medicaid officials.

Network Development and Maintenance

State Medicaid managed care plans are responsible for developing and maintaining a network of healthcare providers. Adequate numbers and types of qualified, credentialed mental health providers are essential to meet the needs of members living in all geographic areas that are covered by the contracted plan. Likewise, as noted, plans must ensure access to culturally and linguistically competent providers.

Although mental health services have often been carved out of managed care plans and paid for on an FFS basis, or contracted with managed behavioral health organizations, many mental health advocates believe that integrated management of physical and mental health services can better serve people with severe/serious mental illness (SMI), because it means having to navigate fewer systems of care.

Care Management and Coordination

For people with complex medical conditions, like mental illness, coordination of care is especially important. Therefore, in addition to specifying how and when a beneficiary may select a primary care provider (PCP)—including when a specialist may be designated as PCP—contracts should include provider incentives to encourage care coordination (eg, allowing PCPs to bill for time spent coordinating with other providers). Alternatively, plans might designate conditions that require care managers.

Marketing Activities, Enrollment, and Disenrollment

Contracts should describe permissible and impermissible marketing activities.

Federal law prohibits discrimination by plans based on health status.

Plans should describe default enrollment procedures (eg, how PCPs are assigned to members who do not select one for themselves). Federal law requires that Medicaid beneficiaries be given the option to disenroll from a plan within the first 90 days without cause—and at least every 12 months thereafter.

Customer Service and Member Education

Contracts should define the information that must be provided to members (eg, member handbooks, confidentiality information). In addition, they should specify how members can contact the plan with questions and to obtain more information (eg, customer hotlines, ombudsman programs).

Grievance and Appeals Processes

A thorough description of formal processes should be provided to members in writing in a format that is easy to understand. Grievance and appeals processes should be straightforward. They should specify and clearly define the steps that members need to take to file a grievance or an appeal. Similarly, reasonably prompt response times

from plan administrators after a grievance or an appeal has been filed should be well defined.

Quality Assurance and Data Collection and Reporting

Although all managed care plans must comply with federal requirements for external quality review as well as data collection and reporting, states may choose to include additional contract obligations.

Among the factors that should be assessed as part of quality assurance and improvement measures are the timeliness of service provision, care accessibility, and service effectiveness. These factors should be evaluated using health outcomes measures that include a focus on improved health.

Two commonly used quality monitoring tools are the Healthcare Effectiveness Data and Information Set, or HEDIS, from the National Committee for Quality Assurance (Washington, DC), and the Consumer Assessment of Healthcare Providers and Systems, or CAHPS, from the US Department of Health and Human Services' Agency for Healthcare Research and Quality (Rockville, MD).

Quality assurance measures should also include member assessments of plan performance through Consumer Assessment of Healthcare Providers and Systems or another mechanism. To monitor and assess quality, there must be a strong data collection and evaluation system to assess what is and is not working within the Medicaid plan.

Plans should collect data and report on utilization of healthcare services as well as healthcare outcomes and the financial operations of the managed care organization. Reported information should also be available to members and the public.

Payment and Cost-sharing Arrangements

Contracts generally include capitation payment amounts and specify the amount of time that plans have to process claims and pay providers. Although there are federal requirements that address this component of Medicaid contracts (ie, 90% of claims to be paid within 30 days of receipt; 99%, within 90 days), advocates should push for prompt payment to providers because this standard makes it more likely that providers will be willing to be part of a Medicaid plan network.

Advocates should also urge clear definition of member cost-sharing obligations and work to limit such arrangements, particularly for prescription drugs that are included in plan-covered services.

Utilization Review

Managed care plans often use utilization reviews (URs) to determine whether services are necessary— and to avoid paying for those that are deemed unnecessary. Contracts should describe the permissible use of UR. Advocates should push for exempting certain services, such as pharmacy benefits, from UR.

Enforcement, Corrective Action, and Sanctions

State Medicaid contracts need to specify how they will be enforced, including the corrective actions that will be taken if a plan performance problem is identified. Sanctions for noncompliance are recommended— and they should be significant enough to give plans an incentive to comply. ◆

State and Federal Advocacy Tools

There are a number of different ways for mental health advocates to communicate their messages to various audiences—and to encourage others to join them in promoting their priorities and goals. Some of these tools are listed in this section. In addition, the following pages contain examples of these state and federal advocacy tools.

Social Media

Also referred to as new media. Advocates continue to explore new uses for web-based and mobile technologies with a goal of transforming existing one-way communication models (ie, "traditional media," such as newspapers, radio, and television) into interactive dialogues that foster online communities. Social media is used to share information and to mobilize advocates, allowing supporters and key stakeholders to connect in "real time."

Types of social media include social networking sites (eg, Facebook), blogs and microblogs (eg, Twitter), content communities (eg, YouTube), and collaborative projects (eg, Wikipedia).

Fact Sheet

A reference document that provides concise information about a particular topic, including a description of the issue, relevant statistics, and a summary of supporting information and research.

Ideally, fact sheets should not be longer than one double-sided page. However, they can be longer for more complex issues. An example is provided on page 29.

Organization Sign-on Letter

A template letter to lawmakers or policymakers, to which multiple organizations can attach their names, that advocates for a particular action or position.

Organization sign-on letters are intended to demonstrate "strength in numbers," and can help persuade public officials that the action or position called for has broad support among his or her constituents. (The example provided on page 34 is courtesy of Chuck Ingoglia, National Council for Community Behavioral Healthcare [Washington, DC].)

Action Alert

Time-sensitive request from organizations that asks advocates to take a particular action, such as calling elected officials to voice concern about an issue and ask for the official to support their position. Action alerts are often

sent via email and usually ask people to take action either immediately or within a day or two. (Examples are provided on pages 36-40, courtesy of National Alliance on Mental Illness and the Health Care Access Working Group.)

Constituent Letter

Personal correspondence addressed to elected officials from people within their districts. These letters convey a specific message about an issue and reflect how it relates personally to the constituent.

For constituent letters to have the most impact, the sender should be a registered voter. In fact, the elected official (or a member of his or her staff) will often verify the sender's voting status. An example is provided on page 41.

Talking Points

A brief list of key arguments and responses for advocates to use as they speak about an issue.

Talking points can be used for telephone calls to elected officials, in one-on-one meetings with legislators and representatives, or in "town hall" meetings. They should present the most persuasive arguments in favor of the advocate's position and anticipate and address objections and opposing views. An example is provided on page 42.

Op-Ed

A short article that appears opposite the editorial section of a newspaper or magazine. An op-ed is basically a long letter to the editor. It seeks to convey a particular opinion and is often used to advocate a cause, draw attention to an issue, and educate the public. (Examples are provided on pages 43-45, courtesy of National Alliance on Mental Illness and Mental Health America.)

Although op-eds are generally published by invitation only, some publishers accept unsolicited manuscripts. Before writing an op-ed, however, it is recommended that writers contact the editor of the editorial page to "pitch" their idea (ie, promote the topic and inquire as to the publisher's level of interest). Op-eds that are signed by a prominent individual (eg, well-known physician, state legislator, public health official) are more likely to be published. In addition, to ensure the accessibility and timeliness of their content, editors generally have word count guidelines and submission deadlines for writers.

Telling Your Story

Highly structured, strategic testimonials are another tool available to advocates.

Personal stories of this kind can be used effectively in one-on-one meetings with legislators and representatives, town hall meetings, and in multimedia promotional materials. (The sample story, story-writing tips, and story practice sheet provided on pages 46-48 are courtesy of Angela Kimball, National Alliance on Mental Illness [NAMI; Arlington, VA].)

Social Media Tips: Best Practices

- Know exactly why you want to use social media (ie, goals, objectives).

- Before jumping into social media, familiarize yourself with the vehicles and platforms available (eg, blogging, Facebook, Flickr, Twitter, YouTube). Observe and "listen" first. Get to know the culture of the different sites and how they operate.

- Decide who you want as your target audience: Who might be aligned with your interests? Who are the key stakeholders? Who has the ability to influence others? Look for your audience online (eg, Twitter Search).

- Once you find allies and stakeholders online, begin building trusting relationships with them. Be respectful, offer information and help, and do not ask for money at first. Help your social media followers and fans connect with each other and promote their own work. Always remember to say "thank you" when you ask your followers to take action.

- To help increase the number of fans and followers you have online, use social media links on your website and in email communications with your networks.

- Post new content often. Exactly how often depends on organizational capacity and the social media platform.

- Be responsive to your followers, responding to all comments—especially those that are negative—respectfully.

- Use complementary content across different platforms. The same underlying messages should be tailored to fit the style and requirements of each outlet (eg, tweets are limited to 140 characters; blog entries should be limited to three paragraphs).

- Use multimedia content, including photos and videos. Include or link to information from other sources that you think will be useful to your followers. The main idea behind social media is to connect people with the information that they want.

- Keep content brief and use simple, easy-to-read language.

Fact Sheet

Note: Much has changed since this sample fact sheet was written. Nationwide enrollment in the pre-existing condition insurance pools (PCIPs) has not been as robust as some predicted; approximately 20,000 people have enrolled nationwide.[73] To increase availability of healthcare insurance through the PCIPS, the US Department of Health and Human Services (HHS) recently announced that, for the 23 states (and the District of Columbia) that elected to have federally run PCIPs, premiums will be lowered by as much as 40%. In addition, starting July 1, 2011, federally run PCIPs will no longer require that enrollees show proof of denial of coverage from an insurance company. Instead, an enrollee applying for coverage can simply provide a letter from a physician, physician assistant, or nurse practitioner dated within the past 12 months stating that he or she has or, at any time in the past, had a medical condition, disability, or illness.[74] HHS also sent letters to the 27 states running their own programs to inform them of the opportunity to modify their current premium rates. Finally, HHS announced that it will begin paying agents and brokers for successfully connecting eligible people with the PCIP program starting in the fall of 2011.

See the sample on the following pages for clarification.

Health Care Reform: Temporary Pre-Existing Condition Insurance Pool (PCIP) Program

On March 23, 2010, President Obama signed the health care reform bill into law. The passage of health reform will extend health insurance coverage to many uninsured persons living with chronic mental health conditions, but a majority of these insurance opportunities will not exist until 2014 when the Medicaid expansion and insurance exchange implementation take effect. To offer help prior to 2014 to individuals who cannot obtain coverage due to a pre-existing condition, a temporary national pre-existing condition insurance pool is being established this summer. The health reform bill provides $5 billion to support the program until 2014. The new pre-existing condition insurance pool could provide a cost-effective opportunity to secure medical and prescription drug coverage for uninsured individuals with mental illness until the coverage expansion takes place in 2014.

What is a pre-existing condition pool?

Pre-existing condition health insurance pools are programs created to provide insurance options for "medically uninsurable" individuals. These are people who have been denied health insurance coverage because of a pre-existing health condition, or who can only get private coverage that has strict limitations or extremely high rates.

Today 35 states operate pre-existing condition insurance pools. Eligibility and coverage vary from state to state, but risk pools generally offer benefits that are comparable to the basic private plans available in that state with certain limitations. Some states have annual or lifetime caps on the amount of coverage that you are eligible to receive and some states limit the number of months that you are eligible for coverage through the risk pool. Many state pre-existing condition pools have high cost sharing requirements that can be prohibitive to persons with limited income.

When will coverage begin?

The Secretary of Health and Human Services (HHS) is required to establish a federal pre-existing condition pool by July 1, 2010. The program ends on January 1, 2014 when the Medicaid expansion and insurance exchanges are implemented. While funding will become available in July, it will likely take several months for the programs to be up and running.

Who is eligible for coverage under the new federal pre-existing condition pool?

While additional details are expected to be forthcoming, current bill language specifies the following eligibility criteria:
- Must have a pre-existing health condition, as determined by guidance from HHS;
- Must be a US Citizen or be lawfully present in the US;
- Have been uninsured or without creditable coverage for 6 months prior to the date you apply for risk pool coverage. Creditable coverage is defined in Section 2701 (c) (1) of the Public Health Service Act as coverage under a group health plan, Medicaid, Medicare, health insurance coverage, medical care through the Indian Health Service, state risk pool, or other medical care coverage. Creditable coverage does not include worker's compensation insurance, automobile medical insurance coverage, vision or dental insurance only, accident coverage, nursing home or long term care.

What qualifies as a pre-existing condition?

For the purposes of the federal pre-existing condition insurance pool, HHS determines that you meet the pre-existing condition requirement if one of the following situations applies:
- You have been denied coverage due to a health condition;
- Your insurance coverage has an exclusion rider (a clause that restricts coverage for specific health conditions);
- You have a specific diagnosis that your state has determined makes you automatically eligible for risk pool coverage.

How much will coverage cost?

People enrolled in the federal pre-existing condition pool will pay a premium that is similar to what persons with no pre-existing condition are charged on the individual open market in the same state or region.
- Premiums charged under the pre-existing condition pool may not exceed 100 percent of the premium for the applicable standard risk rate in the state, and may vary by no more than 4:1 due to age (charging higher premiums based on age is standard practice for individual insurance plans but the current variance in cost can be much more extreme);
- Eligible individuals will pay copayments, co-insurance and deductibles no more than 35% of the cost of covered benefits. In addition, there will be a cap of $5,950 for an individual and $11,900 for a family in 2010 (the cap may increase in subsequent years); this cap does not include premium costs.

What type of coverage is available through a risk pool?

Coverage options are very similar to what is available through traditional individual health insurance. It is generally a comprehensive major medical plan with a range of cost-sharing options. The most common risk pool plans are Preferred Provider Organizations (PPOs – you pay less if you go to a provider who is contracted with the plan, more if you go out of plan) or Health Maintenance Organization (HMOs – you are limited to a group of providers who are contracted with the HMO). Most pools offer coverage of prescription drugs, and mental health and substance abuse services.

How will the risk pool be administered?

States will be permitted to participate in the program through one of the following options:

- Combine the new federal pool with an existing state risk pool;
- Establish a new pool in states that do not have a risk pool program;
- Build on other state programs designed to cover high risk/uninsurable individuals;
- Contract with a non-profit, Health Insurance Portability and Accountability Act (HIPAA) covered entity to provide coverage;
- Take no action, HHS will provide coverage directly to the state's eligible constituents through a contractor.

On April 2, 2010, HHS sent a letter to each state requesting that states indicate their willingness to work with HHS to administer the national risk pool program.

As of June 8, 2010, 29 states and Washington DC have indicated that they will work with the federal government to set up a new pre-existing condition pool in their areas. They include Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Vermont Washington, West Virginia and Wisconsin.

At this time, 19 states, Georgia, Hawaii, Idaho, Indiana, Louisiana, Minnesota, Mississippi, Nebraska, Nevada, North Dakota, South Carolina, Tennessee, Texas, Virginia and Wyoming, have indicated that they will not set up a new pre-existing condition program. The federal government will contract to set up a pool for residents in states that choose not to run a program.

Rhode Island and Utah are still undecided.

How will the federal program work in states that have an existing risk pool?

HHS plans to work closely with states to "piggy back" on existing program infrastructure if possible. To be eligible to participate in the federal pool, states must agree to not reduce the amount expended for operating its existing pre-existing condition pool in the preceding year. Persons currently enrolled in a state risk pool plan will not be eligible to move into the federal risk pool.

Where will information about the Federal Pre-existing condition Pool Program be available?

HHS has established a new department, the Office of Consumer Information and Insurance Oversight (OCIIO) that will be dedicated to implementing many of the insurance related provisions of health care reform including the risk pools. The OCIIO is expected to launch a website that will include information that individuals and small businesses can use to identify affordable insurance options including information about the risk pool. This site is scheduled to be phased in beginning July 1, 2010. (www.hhs.gov/ocii)

Additional Resources

US Department of Health and Human Services (www.hhs.gov)

Kaiser Family Foundation, Health Care Reform Gateway (www.healthreform.kff.org)

[i]Baker, Sam, The Hill – Healthwatch, High-risk pool enrollment grows steadily, June 10, at http://thehill.com/blogs/healthwatch/health-reform-implementation/165865-high-risk-pool-enrollment-grows-steadily.

[ii]News Release, "HHS to Reduce Premiums, Make it Easier for Americans with Pre-Existing Conditions to Get Health Insurance," May 31, at http://www.hhs.gov/news/press/2011pres/05/20110531b.html.

Organization Sign-on Letter 1

[DATE]

[ADDRESSES]

Dear _____:

As you and your colleagues begin to address health care reform, the undersigned organizations would like to urge your support for improving and enhancing the children's mental health system. Over 25 years ago Jane Knitzer, in the report *Unclaimed Children: The Failure of Public Responsibility to Children in Need of Mental Health Services*, documented policy and program disconnects that meant children and youth with mental health needs and their families did not get the services they needed.

Last year, a follow-up report entitled *Unclaimed Children Revisited* illustrated how states are still struggling to respond appropriately to the needs of children and youth with mental health conditions, HIV/AIDS, and other disabilities. It also underscored the critical need to address the needs of children and youth at risk for those conditions. While it is clear that some progress has been made, the needs of children, youth, and families will not adequately be addressed without a comprehensive set of children's mental health policies at the national level, and a focused strategy for attaining the same.

The report's overarching goal is to provide guidance that will offer policy recommendations to move current care-delivery systems toward the vision of a comprehensive public health framework for children and adolescents' mental health. *Unclaimed Children Revisited* recommends:

Family-centered Infant and Early Childhood Mental Health Services. There is an explosion of knowledge that calls attention to the importance of early relationships in setting the stage for a child's social and emotional development and mental health. There is a need to support state efforts to infuse early childhood mental health services into early childhood settings, including child care and home visiting programs, as well as to address widespread parental depression that can have lifelong negative consequences for the children.

Comprehensive Financing Strategy. Develop and implement a comprehensive financing strategy that supports a public health focus to mental health. Place empirically supported, family-based treatment and supports at the center of financing children's mental health care.

Public Health Approach to Children's Mental Health. Incorporate a public health approach to children's mental health services, which provide age and developmentally appropriate comprehensive services and supports, and incorporate strategies of prevention, early intervention,

and positive behavioral interventions and supports.

Service Delivery to Transition Age Youth. Transition youth with serious mental illness encounter numerous obstacles as they transition from school and child welfare systems to their adult lives.

Efforts to address the needs of this population require the provision of crucial programming to prepare them to address their own housing and independent living needs, increased collaboration across systems providing services to these young adults to facilitate access, and access to health insurance and social services for youth with mental health conditions up to age 25.

Cultural and Linguistic Competence. Overall, mental health services meet the needs of only 13% of minority children. Despite the fact that minorities are less likely to receive mental health services, when they do access services, those services tend to be ineffective and of low quality. Increasing the cultural competence of service programs and providers is essential to improving mental health services to racial and ethnic minority children because when a program is developed with consideration of the culture of the community being served, there is an increase in service utilization and decrease in early termination of treatment.

Health Professions Training and Education. Increase and enhance mental and behavioral health workforce education and training. As documented in the report of the Annapolis Coalition on the Behavioral Health Workforce (2007): There is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness in partnership with the people who need services. The improvement of care and the transformation of systems of care depend entirely on a workforce that is adequate in size and effectively trained and supported.

Too few resources have been expended to develop and implement a comprehensive framework for addressing the needs of children and youth with mental health conditions, HIV/AIDS, and other disabilities. We have an opportunity to improve the trajectory of children's mental health policy and improve the overall health, education, and employment of children and adolescents in our country. Thank you for your thoughtful consideration and continued efforts on this important issue.

Sincerely,

[organizations list]

Organization Sign-on Letter 2

June 17, 2011

Charles Duarte
Administrator, Nevada Department of Health and Human Services
Division of Healthcare Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

Dear Administrator Duarte:

On behalf of the millions of Americans living with mental health disorders, their families and communities, the undersigned organizations are writing to express our deep concern and desire that all atypical antipsychotics be made available through the Nevada Medicaid program. Research clearly indicates that limiting access to clinically indicated medications results both in adverse outcomes for the consumer and increased costs to the state. In your upcoming review of these medications, we urge you to ensure that all FDA-approved antipsychotic medications, including those that have been recently approved, maintain preferred status so as to ensure that all individuals may access the appropriate treatment at the right time.

Access to the full spectrum of antipsychotic medications, including those most recently approved by the FDA, is a critical component of community-based care. New advances in medications, and their combination with other services and supports, allow people with mental health disorders to lead healthy and productive lives in their communities. These advances over the past 50 years have enabled the care and treatment of serious mental illness to take place in large part in the community, leading to a decreased reliance on inpatient facilities. Community services are substantially less expensive to the Medicaid program than institutional care.
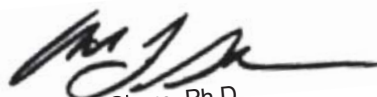
Antipsychotic medications are not clinically interchangeable, and providers must be able to select the most appropriate, clinically indicated medication for their patients. Patients respond differently to different antipsychotic medications, and it can often take several trials and many months to find an appropriate drug regimen that stabilizes an individual's condition. For people with serious and persistent mental illness or those suffering from co-morbid conditions, providers must be able to select from a full range of drug options so as to maximize treatment efficacy, minimize side effects, and avoid drug-to-drug interactions.

Consumers who are unable to access the most appropriate, clinically indicated psychiatric medication experience higher rates of emergency department visits, hospitalizations, and other health services. Policies such as prior authorization that restrict choice and access to medications have been shown in multiple studies to cause increases in hospitalizations, lengthier hospital stays, more emergency room visits, more outpatient hospital visits, and more physician visits[1] – and this base of evidence continues to grow. Most recently, a study by Joyce West, Ph.D in *General Hospital Psychiatry* analyzed Medicaid data from 10 states and found that psychiatric patients who reported access problems with their medication visited the emergency department 74 percent more often than those who had no difficulties accessing their medications. Rates of suicidal behavior and homelessness also rise among consumers who report difficulties accessing their needed medication.[2]
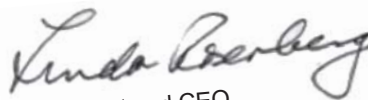
These outcomes are not only bad for consumers, they are typically far more expensive to Medicaid or other state agencies than the cost of covering antipsychotic medication or outpatient behavioral health visits. Our organizations support public policies that ensure that all consumers have access to the right treatments at the right time. For this reason, we strongly recommend that you maintain or include all FDA-approved antipsychotic medications on the Nevada preferred drug program, and allow all consumers to access the behavioral health outpatient services they need.

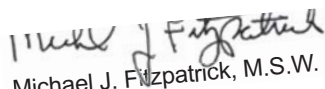Thank you for your attention to this important matter.

Respectfully,

David L. Shern, Ph D
President and CEO
Mental Health America

President and CEO
National Council for Community
Behavioral Healthcare

Michael J. Fitzpatrick, M.S.W.
Executive Director
National Alliance on Mental Illness (NAMI)

[1] West May 2009 *Psychiatric Services*, Huskamp May 2009 *Psychiatric Services*, Zhang April 2009 Psychiatric Services, Soumerai April 2008 *Health Affairs*, West May 2007 *American Journal of Psychiatry*, Murawski Abdelgawad 2005 *American Journal of Managed Care*, and others.

[2] Mościcki, June 2010 presentation Academy Health & November 2010 presentation *American Public Health Association*, Mościcki, accepted for publication in the *Journal of Clinical Psychiatry*

YOUR VOICE IS NEEDED

We know that the Virginia's budget outlook is "scary." Billions must be cut from the state budget to balance it with decreased revenues. The proposed two-year biennial budget for the state is bleak. To offset drastic cuts, retiring Gov. Tim Kaine is proposing increased taxes, but given Republican opposition to any tax increase, program cuts are the only alternative. Commonwealth Hospital and the child and adolescent beds of the Southwest Mental Health Institute are again on the cutting board – despite a committee report recommending continued operation of these facilities – Virginia's only facilities for children and adolescents who have a serious mental illness.

Your voice is needed to make a difference!
There are several ways for you to do this.

PLEASE HELP US TO SPREAD THE WORD!
WE NEED A GREAT RESPONSE TO SEND A STRONG MESSAGE!

We want to know what you will do to help – whether to attend a meeting with lawmakers…testify before our Arlington delegation (a hearing televised on cable TV)…testify at the Regional Budget Hearing…or write a letter to your State Senator and State Delegate. Just email NAMI-Arlington at namiarlington@gmail.com.

THE OPPORTUNITIES TO ADVOCATE:

1. NAMI-Arlington has set up a meeting with members of the Arlington delegation to Richmond for Monday morning, January 4, at 9 a.m. at either the office of Delegate Bob Brink or at the Chesapeake Bagel shop at the Harrison Shopping Center. We want you to attend. If you wish to speak, tips on what to say are below, but just showing up to lend support to the messages of others is important.

2. If this is not convenient, members of our delegation are also holding a pre-legislative hearing Monday evening, January 4, at 7 p.m. in Arlington at the County Board Room, Third floor of the County Office building, 2100 Clarendon Boulevard. Good parking is available. Again, we want you to attend. If you wish to speak, tips on what to say are below, but just showing up to lend support to the messages of others is important. The hearing is always televised on cable TV.

3. Plan to attend (bodies are always helpful to show interest and how cuts affect people) – and maybe even speak – at the Northern Virginia upcoming Regional Budget Hearing, <u>Friday, January 8, at 10 a.m. at the Ernst Center Theater at the Annandale Campus of the Northern Virginia Community College, 8333 Little River Turnpike, Annandale, VA 22003</u>. **These regional hearings are important. Legislators listening to testimony are members of the all-important House Appropriations and Senate Finance Committees. These are the "money" committees that make decisions about**

how to prioritize cuts in spending. They need to hear from people in the community who care about mental health!

4. Write a letter to members of the General Assembly "Money" Committees or to our Arlington delegation, whose addresses are below. It doesn't need to be a long letter. In fact, one-pagers are the best to send.

WHAT TO SAY

If you wish to speak at either the delegate meeting or at one of the hearings, <u>tell your story</u> and/or include one or two brief and compelling stories of success and need. Tips on how to speak effectively at a budget hearing:

- Arrive early to sign up. Speaker sign-up begins about one hour prior to the regional hearing itself and about one-half hour prior to the Arlington delegation hearing. To be early on the list, arrive much earlier to sign up. Speakers are taken in the order of registration. Each person may register only one speaker at a time.

- Comments are limited to 3 minutes per person. However, you may even be shortened if there is a long waiting list of people. Prepare for 2 minutes only.

- <u>Don't "wing it". Be prepared</u>. Write your comments out ahead of time. What is the key message that you want them to hear?

- Even though it can be difficult, temper the emotions of the situation with facts and "reality-based" scenarios. <u>Strike a balance between something that is emotionally moving and also factually true</u>.

- Be sure to thank the legislators for their past assistance and support.

What to say:

- **Put a personal face on mental illness**. What worked WELL in the system? What needs to be improved? What will the challenges be if funding is reduced, if services are reduced, or if access to treatment is reduced in other ways?

- Make the point that Virginia cannot afford to scale back any further on mental health services and treatment. **Virginia cannot afford to cut care when it is most needed. In times of economic distress, the need for mental health services increases**.

- People are still in need of services even in bad budget times. **If access to care is cut, people in need will show up in other service areas - criminal justice system, homelessness, hospital emergency rooms, etc.**

- The system has already endured several rounds of budget cuts. Further cuts affect direct services and direct care staff.

- Virginia cannot afford to close its only public hospital beds that serve children and adolescents

who are seriously mentally ill. The General Assembly acted responsibly last year when it rejected a similar recommendation and asked for a study of the situation instead. The report submitted to the General Assembly does not reflect the recommendations of the committee, which is aware that there are no safety-net community facilities or local wrap-around programs to care for adolescents or children who need intensive care.

The CSBs last year sustained cuts of 5 per cent for 2010. Again, details are sketchy but the governor does not appear to be proposing any further cuts. But, no new funds are being proposed for much-needed programs.

If you cannot advocate in person, you can write to members of the Money Committees –

Delegate Lacey Putney, Post Office Box 406, General Assembly Building, Richmond, VA 23218 or to Senator Charles J. Colgan, 10th floor, General Assembly Building, Richmond, VA 23219

Or to members of our own Arlington Delegation:

HOW TO CONTACT OUR ARLINGTON STATE LAWMAKERS

STATE SENATORS:

The Honorable Patricia S. Ticer
City Hall -- Room 2007
301 King Street
Alexandria, Virginia 22314
(703) 549-5770
district30@sov.state.va.us

The Honorable Mary Margaret Whipple
3556 North Valley Street
Arlington, Virginia 22207
(703) 538-4097
district31@sov.state.va.us

STATE DELEGATES:

The Honorable Robert Brink
2325 North Glebe Road
Arlington, Virginia 22207
(703) 531-1048
delBBrink@house.state.va.us

The Honorable David Englin
301 King Street – Box 65
Alexandria, Virginia 22314
(703) 549-3203
david.englin@gmail.com

The Honorable Adam Ebbin
Post Office Box 41827
Arlington, Virginia 22204
(703) 549-8253
delaebbin@house.state.va.us

Email Action Alert 2

Dear Mental Health Advocates:

The mental health budget is being threatened by members of the Ohio Senate as they wrestle with how to address the $851 million hole in Ohio's state budget. Please contact key lawmakers (see below) TODAY and let them know in no uncertain terms that they cannot cut the mental health system any more than they already have.

Let them know that:

- The loss of more than $90 million in funding since the passage of H.B. 1 in July has brought Ohio's system of care to its knees. **Further cuts in community mental health services will be a death sentence for many Ohioans who will be unable to access needed but unavailable critical care and supports**.

- Any further cuts will have adverse short and long term consequences for many of our public institutions at the local and state levels, including prisons, jails, schools, child welfare, hospitals, and emergency rooms.

- Any further cuts to the community mental health system will cripple our county mental health boards and health care providers in their duty to serve some of Ohio's most vulnerable citizens.

Please make calls and send e-mails TODAY to your own State Senator and to the members of Senate Leadership (see below) and get as many others as you can to do this as well!

SENATE LEADERS TO BE CONTACTED

The Hon. Bill Harris — 614-466-8086 SD19@senate.state.oh.us

The Hon. Tom Niehaus — 614-466-8082 SD14@senate.state.oh.us

The Hon. Capri Cafaro — 614-466-7182 senatorcafaro@maild.sen.state.oh.us

The Hon. Shirley Smith — 614-466-4857 senatorsmith@maild.sen.state.oh.us

The Hon. John Carey — 614-466-8156 SD17@senate.state.oh.us

The Hon. Dale Miller — 614-466-5123 SD23@maild.sen.state.oh.us

The Hon. Mark Wagoner — 614-466-8060 SD02@senate.state.oh.us

Thank you for your immediate attention to this request!

Your friends at NAMI Ohio

Email Action Alert 3

Dear Friends:

The Medicaid program is under serious attack on several fronts in Congress, and it is critical for Members of Congress to know the impact of the proposed Medicaid cuts and changes on people living with chronic mental illness. Medicaid is the single largest supporter of care and treatment for individuals living with chronic mental illness. **Steep cuts or changes to the program threaten this important safety net and the lifesaving care and treatment it provides.**

The Health Care Access Working Group (HCAWG) is circulating two Medicaid advocacy letters that will be sent to the U.S. Senate and the House of Representatives. One letter urges Congress not to repeal the provision in the Affordable Care Act that requires states to maintain their current Medicaid eligibility and application rules (known as the "Maintenance of Effort" requirement). The second letter urges Congress to protect the Medicaid program from harmful federal proposals, including converting Medicaid into a block grant or putting in place across the board federal spending caps that would require drastic cuts to Medicaid and shift more costs onto already struggling states.

Please take action now by letting legislators know your organization opposes a repeal of the Maintenance of Effort requirement and proposals to restructure and defund Medicaid. CLICK HERE to add your organization as an endorser of these important Medicaid advocacy letters. **Please circulate widely to your networks!!!**

Thank you!!! Best Regards,

The Health Care Access Working Group

Constituent Letter (to a state senator)

Honorable Senator [NAME]

[ADDRESS]

[DATE]

Re: Medicaid provider reimbursement rate

Dear Senator [NAME],

As a public school teacher and a Meals-on-Wheels volunteer in Indiana's [# DISTRICT], I was deeply concerned to hear recently that the Legislature is considering reducing payment rates to doctors and other medical providers who participate in Indiana's Medicaid program.

Each day I see children, seniors, and families who depend on Medicaid for access to the health care that they need to stay healthy. I have heard from many of my Meals-on-Wheels clients that their doctors have stopped accepting Medicaid—or in some cases, their doctors' offices simply closed. Most of these people don't have transportation or the means to go elsewhere for care, so they are just doing without.

Surely, even in a recession, the Legislature will not turn its back on Indiana's most vulnerable residents. Please make sure they have access to medical care when they need it and **vote against the proposal to reduce Medicaid payment rates.**

Sincerely,

[NAME], Constituent

Talking Points
(for a phone call to an elected official)

"Hi, my name is _____, and I am calling from [City]. I'm calling because I want to urge Representative [NAME] to vote to preserve access to medically necessary prescription drugs for Medicaid beneficiaries in our state.

The health of individuals with chronic conditions such as mental illness, diabetes, asthma, and heart disease often requires taking multiple prescription drugs per month.

Monthly numerical limits on prescription drugs under Medicaid means our state's low-income elderly and disabled can't get the medications they need.

And even though $5 copays don't sound very high, when you have to take a dozen medications, that adds up—especially when you are living below the poverty level.

I hope that Representative [NAME] will consider the needs of our state's low-income seniors and people living with serious illnesses and vote against monthly numerical limits and support eliminating copays for prescription drugs.

Thank you."

Submitted by:

[NAME]

[NAMI title]

[NAMI State or City]

[Mailing Address]

[Day and Evening Phone Numbers]

[E-mail address]

The High Cost of Cutting Mental Health

Tough times require tough choices. We hear this phrase a lot during the state's budget debate, but legislators need to be reminded that budget cuts can sometimes be penny-wise but pound foolish.

For example, we know there is a high cost to cutting mental health.

When mental health is cut, burdens only gets shifted elsewhere—to emergency rooms, schools, police and local courts. Businesses lose productivity. Families are broken. People end up living on the street or dead.

When economic distress began in 2008, the need for mental health services increased, but the state cut them by $ _____. Now the governor and legislators want to cut them even more.

It's time to tell them to stop cutting. Protect and strengthen mental heath care instead.

Mental illness does not discriminate. It can affect anyone at anytime, including Democrats, Independents and Republicans.

Three quarters of people living with mental illness had it appear by age 24.

In [STATE], approximately [state number] adults live with serious mental illness, such as major depression, bipolar disorder or schizophrenia. The number of children and teenagers is about [state number]. In fact, suicide is the third leading cause of death among young people ages 15 to 24.

These numbers represent family members, friends, neighbors and co-workers. They represent voters. Everyone knows someone who is affected.

Treatment works, there is often a delay of about 10 years before people get the help they need, especially for young people. When state mental health care is cut, appointments may not be available for months—assuming that there is still a local clinic orl qualified mental health professionals still available..

..

None of us would tolerate a system that abandons people who suffer heart attacks or epileptic seizures—or simply tells them to take a number and come back in three months when they are in crisis. Yet too often, mental illness is overlooked, marginalized, trivialized or stigmatized

For mental health concerns, we need to make sure that the right care is provided at the right time in the right place. This includes integrating mental health care with primary health care and providing an adequate, qualified work force to provide community-based services.

[Insert a personal story or local facts about mental illness and recovery. Op-ed submissions should be about 600 words in length. This example is about 400].

Please, no more mental health cuts. Tell the governor and the legislature: It's time to protect and strengthen mental health care.

# # #

Gaining Support for Health Care Reform

Whether the new health reform law achieves its goals of accessible and affordable care will depend upon implementation at the state and federal level. That is especially true with respect to the establishment of state-based exchanges and the expansion of Medicaid.

The exchanges are important for a number of reasons. Policies that are sold through them will provide mental health and addiction treatment to individuals who would otherwise be forced to go without coverage. The exchanges as well as the Medicaid expansion provision will also provide health insurance coverage to up to 32 million Americans, including many of the __% of individuals in STATE who are uninsured (you can find the percentage of uninsured in your state here).

The establishment of the exchanges, which are to be operational by 2014, will provide a marketplace for individuals and small businesses who are currently unable or struggling to purchase health insurance. The exchanges will pool risk and thus offer lower premiums than previously available.

There is much work to do to establish the exchanges and MHA of _____ has offered to assist with implementation and looks forward to working with the state insurance commissioner (or other appropriate governing body) to be ready for 2014.

Under the law, Medicaid will expand in 2014 to 133 % of the federal poverty level regardless of the traditional eligibility categories. That allows childless adults who make $14,404 per year or families of four with an income of $29,327 to have access to public health insurance they would not have been able to afford otherwise. This expansion will not significantly add to the state's healthcare costs, as those newly eligible for Medicaid will be covered entirely by federal funding, phasing down to 90% federal by 2020.

For the behavioral health community, perhaps the most exciting provisions include the parity requirements in both the exchanges and the Medicaid expansion. Mental health care and addiction treatment are included on the list of essential benefits that must be covered in new plans offered through the exchanges. These benefits (and others on essential list including rehabilitative services, prescription drugs, preventive services, etc) are being defined by the Secretary of Health and Human Services, and Mental Health America is working with her office to ensure a meaningful behavioral health benefit. Additionally, ACA includes a mandate that the mental health and substance use benefits that are required of plans offered through the Exchanges will apply to the newly eligible Medicaid beneficiaries. ACA clearly recognizes the importance of prevention and treatment of mental health and addiction and the need to integrate mental and general health.

MHA stands ready to provide assistance and consultation for appropriate and timely implementation of ACA and encourages the Governor and legislature to continue to move forward with implementation of ACA.

Together we have a historical opportunity to ensure that all individuals living in STATE, especially those living with mental health and substance use conditions, are able to have access to adequate and affordable health coverage. We must now take advantage of the opportunity before us.

_____is the CEO of Mental Health America of _____.

Sample Story

1. My Introduction

My name is Jenny Jones. I'm from Springville and I am the proud mother of a 23 year old son who lives with bipolar disorder. Today, I would like to share his story and ask for your support in preserving mental health services.

2. What Happened

When my son was still a toddler, I had a thought that no mother should have: I wondered if my beautiful boy would be in juvenile detention on his 16th birthday. He just did not respond the way other children did to requests, to routines, to daily life and love.

For years, I tried parenting classes and behavior management. I prayed he would mature, but instead, he got bigger and angrier. His responses were unpredictable; we never knew what would be broken, who might be hurt or when it would happen.

And then, in fifth grade, my son's teacher said, "Jenny, honey, I've taught hundreds and hundreds of kids. And I know when a boy is misbehaving and when something is wrong. And something is wrong. You just keep looking for help--you'll know it when you find it."

3. What Helped

That teacher's words prompted us to keep searching. It took months to get in to a child psychiatrist, but finding him saved our lives.

NAMI Smarts: Telling Your Story

3803 N. Fairfax Drive, Suite 100, Arlington, VA 22203 • 703.524.7600 (Rev Apr 2011)

Andy was diagnosed with bipolar disorder and with therapy, school supports and the right medications, he made progress. He started smiling, enjoying school and making friends. On his sixteenth birthday, my son wasn't in juvenile detention; he was pursuing his love of art.

4. How I'm Different Today

Today, my son is a young adult who's enjoying life. He's working hard and making me proud.

5. My Point

Andy's challenge is more common than one might think: one in seventeen adults lives with a serious mental illness like bipolar disorder, major depression, or schizophrenia. But with treatment, recovery is possible--my son is living proof.

6. My "Ask"

You can help. Every day, individuals and families find themselves in need of mental health care. Your support can protect mental health services and preserve the hope of recovery. Thank you.

Six Steps to Telling Your Story

The following six steps will help you craft your story in a succinct and powerful way. Each step includes examples. Make sure you include each step, but feel free to put things in your own words.

1. Introduce yourself

Share your full name and city or town.
This helps your audience connect with you.
Example: I'm Jenny Jones and I'm from Springville, Oregon.

Let your audience know how you are affected by mental illness. This gives a "real face" to mental illness and prepares your audience to empathize with your story.
Example: I am the mother of a son who lives with bipolar disorder.

Let your audience know why you are speaking or writing. If you are advocating for funding, legislation or a policy issue, let your audience know what you want them to support or oppose.
Example: I am here to share my son's story and ask for your support in preserving mental health services.

2. What happened?

What happened before you received the help you needed? Keep this very brief–think about the main highlights that you could share in 30 seconds.
Example: For years, I tried parenting classes and behavior management. I prayed he would mature, but instead, he got bigger and angrier...

3. What helped?

Describe what helped in your recovery.
Example: It took months to get in to a child psychiatrist, but finding him saved our lives...

4. How are you different today?

Share what is going right in your life or how you are experiencing recovery.
Example: Today, my son is a young adult who's enjoying life. He's working hard and making me proud.

5. Make your point

Talk about mental illness or mental health care and the hope of recovery. This is a transition from your personal story to a message for your audience.
Example: Andy's challenge is more common than one might think: one in seventeen adults lives with a serious mental illness like bipolar disorder, major depression, or schizophrenia.

6. Make your "ask"

Let your audience know how they can help. Say thank you.
Example: We need your help to protect mental health services and to preserve the hope of recovery. Thank you.

Story Practice Sheet

1. **My introduction**

   Aim for 3-4 sentences. Your name and city or town, what you are advocating for and how you are affected by mental illness.

2. **What happened**

   Aim for 5-9 sentences. Briefly describe what happened before you got the help you needed.

3. **What helped**

   Aim for 4-7 sentences. Describe what helped in your recovery.

4. **How I'm different today**

   Aim for 1-3 sentences. Share what is going right in your life or how you are experiencing recovery.

5. **My point**

   Aim for 1-3 sentences. Talk about mental illness or mental health care and share a message of hope.

6. **My "ask"**

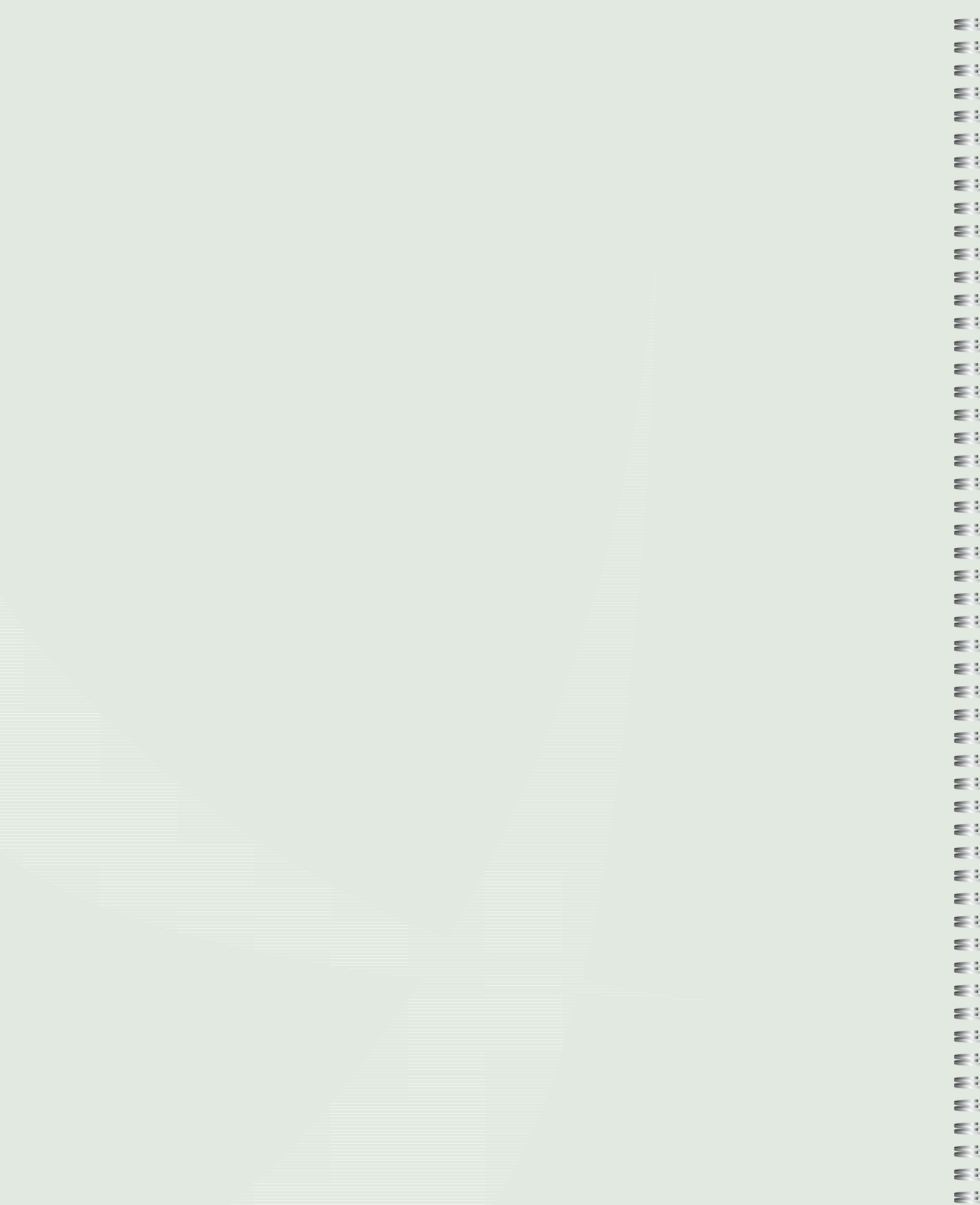   Aim for 1-2 sentences. Let your audience know how they can help. Say thank you.

REFERENCES

1   Medicaid and CHIP [Children's Health Insurance Program] Payment and Access Commission (MACPAC), Report
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     viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NTM4OGNmMTJlNjdkMDZiYw.

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