OVERARCHING PRINCIPLES FOR MEDICAID COST CONTAINMENT
A document of the Behavioral Health Planning Council with input from the Local Collaboratives

This document offers a list of overarching principles that the Behavioral Health Planning Council asks the Collaborative and the Human Services Department to take into account when deciding what Medicaid cost containment measures to implement. These principles are as follows:

1. Any decisions made should take into consideration their effect on the infrastructure of rural and frontier areas, as well as the resource and service disparities between urban areas and rural/frontier areas.
   - “. . . in rural and frontier environments limiting [comprehensive community support] services (CCSS) to Core Service Agencies (CSA) would severely reduce options for those with very limited resources and would ultimately reduce access to the primary mental health care system and therefore increase costs.”
   - “There is a huge lack of mental health providers that are qualified to provide services as outlined in the Medicaid regulations for these areas. . . . If Medicaid rates are cut and the Wal-Mart approach continues to be implemented in these areas, limited and vital resources already in place may have to close. . . . Transportation is also a major issue in rural and frontier areas.”
   - “The further north, the lack of resources grows. Pueblos such as Picuris are lacking many resources because of lack of these services and no transportation to compensate.”

2. Increase the use of community-based and evidence-based services while reducing out-of-home/out-of-community placements.
   - “Use funds to develop transitional/crisis facilities in every community for consumer stabilization vs. short-stay hospitalization. This model would reduce cost of inpatient hospitalization, will keep consumer in his/her community, reduce staff cost and transportation issues, and allow continuity of care within the consumer’s hometown.”
   - “Residential care is a necessity and needs to be better balanced, not cut. More outpatient and support services are needed to help balance the cut in residential services. Perhaps each region could be allowed to come up with their own plan to reduce costs.”

3. Insist in-state care be provided to those currently receiving services out-of-state.
   - “If [more in-state services are not made available], could the in-state services that are currently available be maintained at a higher function while outpatient and support services are increased?”

4. Increase use of peer and family specialists in CCSS as a way to manage costs.
   - “An increased use of peer and family specialists would definitely be a way to help manage costs and to reduce recidivism.”

5. Examine alternative revenue resources (e.g., co-pays/cost sharing) as a strategy where allowed by law and regulation

* Items are listed in no particular order of importance
“Most Medicaid consumers cannot afford to pay for co-pays. This would put an added burden on providers. Perhaps the eligibility requirements for Medicaid should be reviewed and amended. Those that would be affected could probably afford a co-pay.”

“While Local Collaboratives and communities are constantly exploring self-sustainability and plans to manage their resources, the state should look at raising taxes on tobacco and alcohol with a specific focus on . . . behavioral health. If this is already in place, it should be increased.”

6. Support recovery services to help consumers stay in recovery.
   - “The implementation and addition of Recovery Support Services would definitely be beneficial and could help to keep treatment costs down in the long run.”

7. Reevaluate those Medicaid regulations and requirements that are not consistent with cost containment initiatives (e.g., number of and/or duplicative assessments, evaluations, etc.) Address areas in Medicaid regulation where there is redundancy or waste.
   - “The use of master’s level interns . . . should be revised to help agencies to provide more services. Proper supervision, training and technical support should be a priority with any these services, but could potentially help to reduce costs tremendously. . . . The Medicaid requirements for agencies who are not CMHCs, FQHCs, or CSAs to have independently licensed clinicians should be waived, especially for the rural and frontier areas where there are not enough clinicians.”

8. According to FY10 MAD projections (5/5/09), behavioral health services are approximately 2% of the total Medicaid budget. Therefore, any cost containment that affects behavioral health services should not exceed more than 2% of the total Medicaid budget.

9. Any cost containment measures should not be enacted unless the measure’s impact on other costs has been fully considered.
   - “. . . limiting [therapy] sessions to a number such as 20 would be a waste of money and could defeat the purpose of treatment. Limited sessions, prior authorizations and continued stay requests for outpatient services will add to the paperwork requirement of clinicians all over the state who are already overloaded, which ultimately creates burn out and affects the quality of care for clients. Due to the reduction of higher levels of care, the length of stay for outpatient services has increased dramatically . . .”
   - “Limiting behavioral health therapy sessions to 20 per year . . . may be manageable if there is room for exception when there is both a demonstrable need and a therapy that has been shown to require more intense delivery to be effective (e.g. Dialectical Behavioral Therapy) in order to avoid more expensive inpatient, emergency room and other avoidable uses of the health care system.”