Medicaid Mental Health & Substance Abuse Benefits

Overview of Policy Changes

Mental Health Sub Committee
Legislative Health Care Task Force
August 2009

Policy Directions

- 2006: Medicaid Modernization
  Statutory direction:
  Align benefits with participants health needs

  Resulted in three benchmark benefit plans:
  1) Basic Plan- benefits for individuals of average health
  2) Enhanced Plan - benefits for individuals with special needs
  3) Coordinated Plan - benefits for individuals with both Medicare & Medicaid coverage

Policy Directions

- HCR 48:
  1) Eliminate partial care for Basic Plan participants that don't have serious mental health problems
  2) Limit Basic Plan participants to 26 hours of outpatient mental health therapy/year & 10 days/year of inpatient mental health care
  3) Establish a health risk assessment that provides meaningful diagnostic information
  4) Continue provision of intensive mental health treatment benefits to Enhanced Plan participants
  5) Explore modifications of mental health benefits to be consistent with best clinical practice.

New Benefit Plans Implemented

Effective July 2006

- Basic Plan – began implementation of HCR 48 by removing partial care and establishing mental health coverage limits. Created triggers for moving into Enhanced Benefit Plan if health needs changed. Assessments covered in Basic Plan to determine enhanced benefit needs. Automatic triggers also established.

- Enhanced Plan – added preventive benefits to already established mental health and other disability supports.
  - Eligibility expanded to include Workers with Disabilities created improved access to Medicaid for individuals with mental health needs.

Monthly Meetings with Stakeholders

2007

- Routine meetings with service providers
- Broad scope of discussions including:
  - Reimbursement*,
  - quality assurance reviews,
  - benefits, and
  - other policy requirements.

* Reimbursement methodology meetings also were separately facilitated by Medicaid's program manager in charge of pricing. Rate increases proposed in 2008 and 2009 were disapproved by the legislature due to budget constraints.

New/expanded MH benefits

- Rules approved effective January 2007
  - Family therapy – best practice approach that enables parent education regarding their children's therapy needs.
  - Telehealth –expanded for physician use to improve access to needed MH services in remote areas. Added diagnostic interview to already existing medication management and psychotherapy coverage.

New Substance Abuse coverage

2008

- Collaborated with the Office of Drug Policy and the Division of Behavioral Health
- Rules approved effective July 2008, added substance abuse coverage in the Medicaid program including:
  - Assessment
  - Drug screening
  - Individual and group counseling
  - Service coordination
  - Family therapy
- Program Administration through Division of Behavioral Health and its contractor.

Medicaid Reform Project Initiated

2008

Objectives:

1. Develop & support an evidence-based continuum of care through benefits development to improve clinical outcomes in the most cost effective manner.
2. Identify appropriate assessment requirements and process for individuals seeking to access services paid by Medicaid.
3. Manage utilization of benefits for maximum effectiveness.
4. Develop a credentialing system that will ensure behavioral health providers are qualified by education, training, licensure, and experience to deliver quality services paid for by Medicaid and are compliant with agency rules and provider agreements.

Project Parameters: work within budget, policy, staffing and automation development capacity.

Project Assumptions

- Resources from Divisions of Medicaid and Behavioral Health will be available throughout the project for planning and implementation.
- The Project will be executed through a phased approach.
- Evidenced based best practices will be identified and serve as the model for the continuum of care.
- Associated rule changes and system updates will be identified throughout the phased approach.
- The elements and parameters of this reform plan will be steadily broadened and refined to include increased levels of detail and timeframes as they are identified.

Project Management

- Project Sponsors: Department oversight
  Administrators from Medicaid & Behavioral Health
- Project Lead: Program Manager, Medicaid
- Project Team: cross-section of department staff
- Work Teams: consumers, advocates, providers
- Consultation with Medicaid's Physician's Advisory Committee on key primary care topics

Analysis of benefits

"As Is"	"To Be"	Status
Partial Care: not best practice; not focused on therapeutic interventions	Phase-out partial care & add intensive outpatient benefit; consider peer supports	Reduced partial care benefit in year-one; propose adding new benefit
PSR: excessive use without concrete service outcome specifications	Reduce weekly amounts; skill training expectations added	Implemented through rule
Prior-authorization process onerous	Transition from widget-approach to comprehensive case management	In transition
Hospital & ER use high	Add evidenced-based benefit: partial hospitalization	Under review
Collateral contact excessive use	Clarify appropriate use; limit	Implemented through rule
Lack of supported services	Add supported housing, supported employment…	Under review; waiver options

Benefit changes/credentialing updates

Rules approved 2009

- Moved up effective date of partial care and PSR reductions to align with budget constraints (January 2009)
- Amended assessment requirements:
  - Clarified expectations regarding intake assessment, diagnostics, and functional assessments
- Clarified treatment plan expectations: must be individualized, be time-limited and conducted by qualified professional. Plans must identify goals and measurable objectives.
- Defined expectations regarding level of care.

Monitoring Impacts

Baseline 2008:

- 103 individuals had service plans that exceeded the 10 hour weekly limit for PSR at least one week in 2008.
- 2,540 individuals had service plans that exceeded the 12 hour weekly limit for Partial Care at least one week in 2008.

2009 (to date: January – May):

- Of the 103 individuals, Medicaid paid claims for crisis hours, ER, &/or hospital services for 13 (13%) individuals.
- Of the 2,540 individuals, Medicaid paid claims for crisis hours, ER, &/or hospital services for 66 (3%) individuals.

All of the above individuals accessing crisis and related services have under-utilized the PSR and Partial Care services authorized for them. Level of care use appears to be related to other factors than benefit limits.

Follow-up

- Statewide training has been initiated by program policy and credentialing staff for service providers. (2 sessions/region)
  Initial feedback from training participants has been positive.
- Periodic meetings with advocates. Continued communications with the State Mental Health Planning Council.
- Staff will follow-up on those individuals under review to ensure that treatment plans match participants needs.
- Technical assistance is offered by staff to modify plans or make referrals to ensure participant needs are met.
- Continued monitoring of crisis requests and claims data, including emergency room use and inpatient psychiatric admissions.

Status of Project Work Groups

- Established website for team's access to agendas, meeting minutes and related project materials.
- Workgroup topics for the upcoming year include:
  - Partial Hospitalization benefit
  - PSR Specialist Certification
  - Intensive Outpatient Services
  - Assessment Center Services
  - Alternative for Treatment Plan Supervision
  - Utilization Management (focus on outcomes)
  - Waiver Development
  - Primary Care and Mental Health Integration

No new policies proposed for 2010

- Amount of policy work significant in 2009 – focus will be on effectively communicating this policy, training and monitoring the outcomes.
- Before new benefits are implemented, certain components must exist:
  - provider competency and system capacity
  - quality assurance and oversight capacity
  - must be measurable- appropriate access, quality and cost

Questions?

Thank you for your time!

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