REPORT on FAMILY CARE ENROLLEES ADMITTED to MENTAL HEALTH INSTITUTES

Executive Summary

In his veto message for 2013 Act 20, the 2013-15 biennial budget, the Governor directed the Department of Health Services (DHS) to report on the issues involved in identifying the most appropriate setting for individuals with long-term care and mental health needs.

DHS has identified the need for improved integration and coordination of behavioral health in Family Care and other long-term care programs as one of its top priorities.

DHS recognizes that behavioral health is a critically important component of a person's overall sense of health and well-being and his or her ability to live independently in community-based settings. DHS has made concerted efforts over the last two years to more fully leverage and coordinate internal resources, build capacity within the Department and the long-term care system, partner with stakeholders to better serve persons with complex behavioral needs in community settings and utilize the state's mental health institutes for acute psychiatric stabilization.

This report presents information regarding the factors that contribute to impediments in providing appropriate, patient-centered, and coordinated treatment for individuals with co-occurring mental health, behavioral health, and long-term care needs. Included are recommended options for addressing these factors, as well as proposed organizational changes. The proposed organizational changes would result in the improved development and implementation of policies to better address the needs of individuals with mental and behavioral health needs in the state's long-term care delivery systems. The report focuses on these areas:

- Intensive treatment program capacity
- Access to community psychiatrists
- Operational silos between stakeholders
- Access to technology

As indicated in the report, DHS has made significant progress over the past two years to better coordinate behavioral health and long-term care, and it is recognized that the need continues to exist as we work toward a more seamless and integrated care delivery system. DHS is actively exploring strategies to align payments and responsibility for behavioral health services and clarifying roles and responsibilities of DHS, contracted managed care organizations (MCOs), counties, providers, and the state's mental health institutes. Additionally, in 2014, DHS

proposed to the federal Centers for Medicare and Medicaid Services (CMS) that behavioral health services be included in the Family Care benefit package effective in 2016. CMS approved this change. Finally, in his 2015-17 biennial budget, the Governor has proposed further integrating the delivery of health services with long-term care services for Family Care members. These reforms will help ensure that members receive the behavioral health and long-term care they need.

In his 2013-15 biennial budget veto message, the Governor directed DHS to prepare a report to:

- Analyze the factors that contribute to impediments in providing appropriate, patient-centered and coordinated treatment for individuals with co-occurring behavioral health and long-term care needs; and
- Recommend options for addressing these factors as well as organizational changes to improve the development and implementation of policies to better serve individuals with mental and behavioral health needs in the state's long-term care delivery systems.

Analysis

DHS has analyzed several of the factors contributing to impediments in providing appropriate, patient-centered and coordinated treatment for individuals with co-occurring mental health, behavioral health, and long-term care needs.

Intensive Treatment Program Capacity

There are a limited number of intensive treatment program (ITP) beds in the state. These types of services are shown to be an effective alternative to placement in the state's mental health facilities.

Our recommended resolution is to *increase ITP capacity*. Wisconsin has three state centers for people with intellectual disabilities. They are: Northern Wisconsin Center (NWC), Central Wisconsin Center (CWC) and Southern Wisconsin Center (SWC). The Centers each provide short-term ITPs for individuals with intellectual and developmental disabilities. The purpose of these ITPs is to provide highly specialized treatment services for individuals with intellectual disabilities, with the intent to return to the community when the appropriate supports can be provided at the local level (Wis. Stat. § 51.06). NWC operates at current capacity, CWC plans to remodel its current facility to support admissions, and SWC has implemented a plan to increase the current capacity of 5 to 20 by the end of fiscal year 2016. Increasing ITP capacity is expected to result in the reduction of time spent in a state mental health facility and assist MCOs in maintaining community placements.

Availability of Community Psychiatrists

MCOs report that the number of community psychiatrists willing to treat the Medicaid population is a barrier in obtaining psychiatric care for their members. The MCOs cite a variety of reasons to support this:

- Providers are connected to service delivery systems. If a member ceases to be connected to that system, such as a county Community Support Program (CSP), he or she can no longer see that psychiatrist.
- Availability of psychiatric services is limited in rural areas regardless of payer.

- There are limited services within the Family Care benefit. For those who receive psychiatric care, such care is limited to brief medication checks. Members with intellectual/developmental disabilities typically do not have access to a psychiatric provider possessing specific expertise with their conditions and diagnoses. MCOs report very long wait lists for community psychiatry, ranging from three months to a full year. This has resulted in delays for relocations from institutional settings, delays in obtaining medication reassessments for best practice care, and the delay of treatment for mental health needs. Further, this issue contributes to the ongoing use of state mental health institutes and ITPs.

Based on the factors above, DHS is *exploring opportunities to partner to increase capacity of community-based behavioral health supports*.

DHS staff assembled an updated roster of community psychiatrists who serve the Medicaid population which has been distributed to MCOs. DHS has hired a behavioral health manager who will expand relationships with the clinical community. The focus will be on providing education regarding the importance of providing service to the individuals served by the Family Care Program, as well as the integral role mental health providers play in building safe and sustainable community homes.

In addition, DHS engaged Jeffrey Marcus, M.D. of CWC, to serve as a resource to MCOs. Dr. Marcus has provided trainings on such topics as: psychotropic medications and monitoring side effects, working with individuals with personality disorders and how to establish boundaries. In addition, he provides case consultation services to MCOs, psychiatrists and primary care physicians for situations that pose significant challenges. Many MCOs have utilized Dr. Marcus' services and have expressed appreciation for access to this clinical resource.

Complex Behaviors Workgroup

Within state systems, there is a history of operational barriers between key stakeholder groups including counties, institutes, and MCOs. Coupled with an insufficient number of capable providers to serve an increasing volume of individuals with complex needs, this issue required immediate attention.

One of the Division of Long Term Care (DLTC) goals is to ensure the most integrated, community-based services for people with intellectual or developmental disabilities (IDDs) and complex mental health or behavioral health needs. Wisconsin's managed long-term care programs have largely succeeded in serving persons with long-term care needs within home and community-based settings. However, some people with IDDs and complex co-occurring mental health or behavioral health needs are not receiving the coordinated and fully-integrated supports and services needed to ensure a stable community home.

Some Family Care members with IDDs and complex behaviors were experiencing extended stays at institutions for mental disease (IMD), state centers and intermediate care facilities for individuals with intellectual disabilities (ICF-IID). These situations resulted in increased tension between stakeholders due to conflicting needs and resources. The IMDs and state centers allocated the beds for other individuals. MCOs and residential providers required time to develop placements, behavioral support plans, and restrictive measures plans, where indicated. Counties experienced financial implications through the requirement of having to fund placements without control over the planning process for the individual to move back into the community. In addition, DHS needed to ensure compliance with CMS regulations and federal court rulings that mandate individuals live in the least restrictive setting as possible.

The Division of Long Term Care sought to implement a series of system improvement and system change efforts that would:

- Reduce the use of emergency detentions (EDs).
- Ensure admissions to the ITPs or psychiatric hospitals are short term.
- Create and strengthen community capacity so people with the most challenging behaviors can experience improved quality of life and more stability in the community.
- Utilize the expertise and infrastructure of the state centers within community-based settings.
- Mobilize community partners and resources to effectively meet participants' needs in a stable and safe manner.

In order to develop collaborative solutions to the tensions and system improvements identified above, a workgroup was formed in 2013 made up of MCOs, community residential providers, counties and DHS staff from the Divisions of Long Term Care, Quality Assurance and Mental Health and Substance Abuse Services. The workgroup divided into four subgroups:

- Matching members with community resources
- Competence and training
- Care and transitions
- Restrictive measures

Significant accomplishments of the collaborative Complex Behaviors Workgroup:

- The "matching members with community resources" group developed a database where MCOs can enter a de-identified member profile for an individual with complex behaviors for whom they are having difficulty finding a community home using normal contracting channels. The other MCOs and providers, who have demonstrated the experience and ability to serve individuals with complex needs, receive an alert each time a profile is uploaded. This notification allows MCOs and providers to see who is in need of placement statewide. Any interested provider or MCO then contacts the placing

agency to learn more and determine whether they could work together to develop a successful community home for the individual.

- The "competence and training" group developed a comprehensive list of provider competencies and correlated trainings. They are now working on making regional trainings available to providers and MCO staff to ensure the system has the necessary competence to effectively serve individuals with highly complex behaviors.
- The "care and transition" group collaboratively developed transition flow sheets that clearly lay out the role of each stakeholder when transitioning a member with complex behaviors (IMD to community transition, ITP to community transition, and community relocation). They also developed a list of definitions to supplement flow sheets to ensure all stakeholders were starting with the same knowledge and understanding. The group is currently establishing pilots across the state involving MCOs, counties, providers, and institutes.
- To ensure consistent practice, the "restrictive measures" group collaborated to develop a Best Practices Guide for the restrictive measures application process. This group made great strides in streamlining processes by inviting each MCO's restrictive measures lead to participate.
- In addition to the specific work products from each subgroup, the group also improved understanding, communication, and collaboration among all of the stakeholders. Together, they have a shared commitment to take ownership of the need to identify strategies to assure stable and safe community placements for Family Care members who are in an institution, or who are at risk of institutionalization.

Communication at the Time of an IMD or State Institute Admission

In 2012, DHS identified that mental health institute (MHI) staff were not always aware at the time of admission whether an individual was enrolled in Family Care or not. As a result, communication between MHI staff, Family Care Program staff and the Family Care MCO in which the person was enrolled, often lagged. Recognizing that intra-agency stakeholder communication is critical, DHS led a process improvement effort designed to engage all stakeholders at a member-specific level when a Family Care member is admited to an IMD or state institute. The process is led by DHS Family Care regional oversight staff, and includes collaboration through a series of ongoing teleconferences involving MCOs, counties, ITP and institute staff, community providers, and others as needed. The teleconferences commence shortly after the point of admission so that discharge and community placement plans are developed immediately. The team evaluates issues and concerns with the former placement in order to ensure sustainable community placements, and minimize future admissions for the member.

Initial data for the 2012-2014 period demonstrate that Family Care members admitted to MHIs are staying for shorter periods of time, indicating this collaborative process is having a positive

impact. In 2014, only 25 percent of those admitted stayed for longer than 28 days, compared to 36 percent in 2012. Only 3 percent stayed for more than 90 days, down from nearly 11 percent in 2012.

Collaboration with County Mental Health Staff

The behavioral health team within the Division of Long Term Care has partnered with DHS Area Administration and the Division of Mental Health and Substance Abuse Services to *facilitate collaborative relationships between county mental health staff and MCOs to ensure that each at-risk member has an effective response plan, which defines roles and responsibilities of all involved entities*. The team has also looked at means for developing capacity for comprehensive community crisis response.

To date, 57 counties have hosted meetings led by DHS staff to discuss the importance of diversion from ITPs and other institutional settings and to develop systems to ensure appropriate delivery of crisis services.

Intensive Treatment Program LEAN Initiative

DHS is committed to evaluating all opportunities to improve its current model. As part of a LEAN initiative in 2014-2015, the Central Wisconsin Center (CWC) ITP conducted a project to improve the process of discharge and placement of individuals back to the community.

They invited key stakeholders involved in the overall coordination of care for individuals with IDD. Participants included county, MCO, and community partners as well as DHS/DLTC staff and CWC ITP staff. This team reviewed the ITP's overall process of identifying opportunities to better ensure successful community placement following ITP service. The group also discussed means for reducing ITP re-admissions by increasing capacity and improving coordination between all stakeholders and partners. The event led to key process improvements, including the creation of a shared case summary document accessible to all partners, means for involving all partners in assessment and goal-setting processes, improved use of technology to ensure all partners are able to participate in member planning meetings, and collaborative discussion of discharge recommendations 30 days prior to community placement.

Due to limited admissions to CWC, initial findings are still being gathered; however, there are notable improvements to overall communications between partners and stakeholders. Next steps will include implementation of these practices at all three state centers with the intent to improve access to services and reduce the time Family Care members spend in state mental health facilities through the expansion of ITP bed availability.

Wisconsin Council on Mental Health and Wisconsin County Human Services Association

DHS is committed to the ongoing collaborative engagement with community partners to ensure ongoing process improvements and service delivery models. In addition to several ad-hoc

stakeholder efforts, *DHS participates in initiatives led by the Wisconsin Council on Mental Health and the Wisconsin County Human Services Association*.

The Wisconsin Council on Mental Health (WCMH) is legislatively mandated under Wis. Stat. § 15.197(1) as the mental health planning council for the state. It was created to advise the Governor, the Legislature, and DHS on the allocation of federal Mental Health Block Grant funds. WCMH has 20 to 25 members appointed by the Governor, meeting bi-monthly. At least 50 percent of the members are consumers and/or family members. Other members represent state agencies, mental health providers, and other organizations or groups. WCMH evaluates and reviews the mental health system's progress toward achieving improved client outcomes and the adequacy of mental health services in the state. WCMH's duties are specified in Wis. Stat. § 51.02. WMHI oversees state compliance with federal Public Law 102-321.

The Wisconsin County Human Service Association (WCHSA) is a statewide association of county departments of human services, community programs, social services, and IDD services. The membership of WCHSA includes 71 of Wisconsin's 72 counties. WCHSA has four Policy Advisory Committees (PAC)—Behavioral Health; Children, Youth, and Families; Economic Support; and Long Term Support—representing the programs and services of the County Human Services system. The membership of each committee is comprised of individuals who express an interest in the programs or services represented by each committee. The Behavioral Health Policy Advisory Committee meets bi-monthly to discuss issues with DHS representatives. The past several meetings have focused on crisis services and reducing the number of emergency detentions. The Long Term Support (LTS) Committee meets bi-monthly to discuss issues with DHS representatives related to long term care programs. Earlier this year, the LTS PAC invited leaders of the MCOs to discuss their relationships and look at areas for collaboration.

Access to Technology

Lack of technology, such as electronic health records (EHR), at the centers and institutes impedes planning and coordination components such as provider assessment and transition to community-based psychiatry.

DHS is exploring means for leveraging technology, including EHR and telepsychiatry, to maximize efficiencies and ensure a seamless transition to community placement.

Looking to the Future – Integrated Care

DHS supports the development of strategies to align payments and incentives within the proposed structure of fully integrated care, which includes behavioral health. DHS is exploring *mechanisms for paying for services to Family Care members in IMDs, including MCOs paying for this level of service.*

Currently, federal regulations prohibit federal Medicaid funding for services to IMD residents ages 21-64.Under Wisconsin Medicaid policy, Fee for Service (FFS) IMD claims for members ages 21-64 are denied. IMD residents cannot be enrolled in Family Care and, per state policy, no other claims or capitation payments can be made on behalf of the individual.

With the integration of behavioral health services into the Family Care benefit, managed care plans will be able to use IMDs in lieu of an acute stay for a psychiatric condition in a non-IMD acute care hospital. As long as eligibility and enrollment policies are updated for consistency with this provision, Family Care members will be able to remain enrolled in the program and have IMD services paid by the managed care plan as part of the inpatient behavioral health benefit. Further, DHS will be able to include the cost of these services when calculating MCO rates as long as they are priced similarly to psychiatric stays in non-IMD hospitals.

Recently, proposed revisions of federal Medicaid managed care regulations, including provisions regarding the use of IMDs in managed care, would give states additional flexibility to make payments for Medicaid managed care enrollees during IMD stays. If adopted, the proposed regulations would allow states to pay managed care plans a capitation payment for a member during an IMD stay that would otherwise not be allowed as long as the stay is less than 15 days in the month, and the IMD is either a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing crisis residential services. The MCO will be able to pay the cost of this stay using the “in lieu of” provisions of managed care. The utilization of these stays can be included in the capitation rate priced similar to an inpatient psychiatric hospital claim.

Conclusion

DHS recognizes that behavioral health is a critically important component of a person’s overall sense of health and well-being and his or her ability to live independently in community-based settings. DHS has made concerted efforts over the last two years to more fully leverage and coordinate internal resources, build capacity within DHS and the long-term care system, partner with stakeholders to better serve persons with complex behavioral needs in community settings, and utilize the state’s mental health institutes for acute psychiatric stabilization. The reforms proposed by the Governor in the 2013-15 biennial budget will further strengthen the state’s long-term care system to meet the care and treatment needs of each individual in a comprehensive way.