PRELIMINARY DRAFT

Building a healthier future for all Arkansans

Behavioral Health Transformation

Substance Abuse Treatment and Prevention Task Force

October 13, 2014

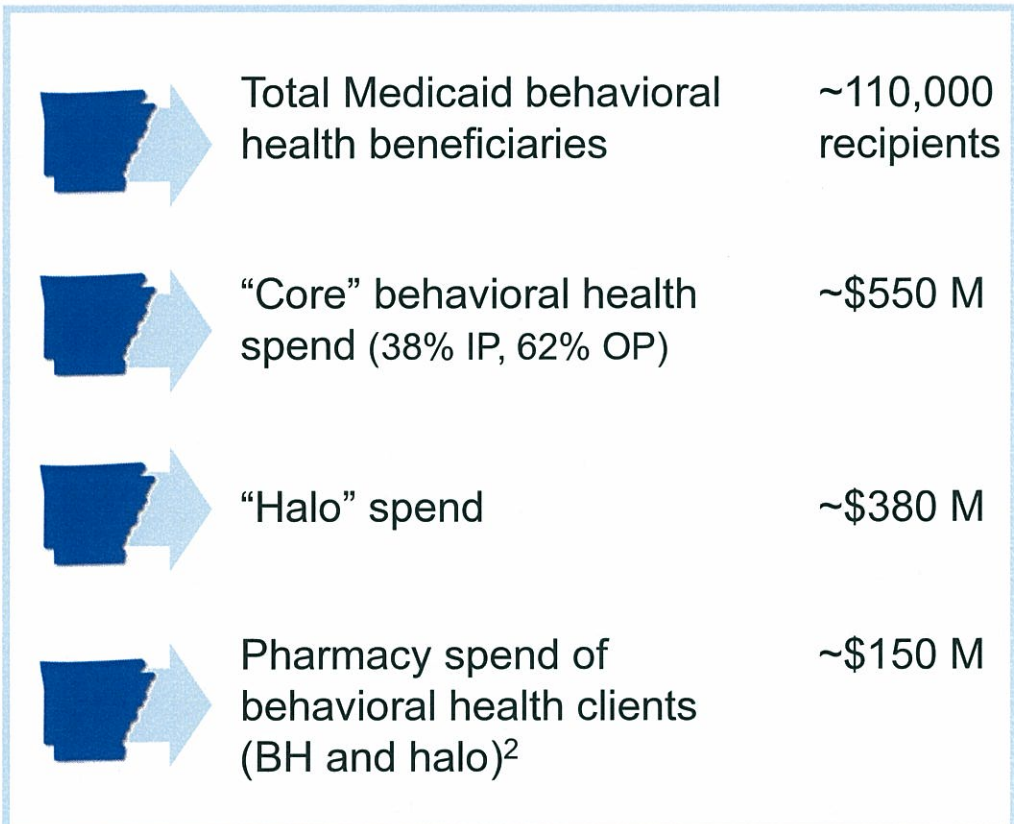
PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

There are many challenges specifically within the current behavioral health system

	Current challenges
Treatment	▪ Ability to bill and provide care coordination is limited ▪ Outcomes and data are not tracked effectively ▪ Limited and segregated Medicaid funding stream for substance abuse treatment ▪ Current disincentive to document and treat substance abuse through Medicaid ▪ Workforce limitations
Recovery / resilience	▪ There are gaps in the ways providers address recovery and resilience today ▪ Opportunity to improve consistency in existing recovery / resilience efforts ▪ Consumer, peer, family, and community supports are not always leveraged most effectively
Screenings and assessments	▪ Inconsistent screening and assessment process ▪ Need to improve the use of data ▪ Arkansas has a high prevalence of SED/SMI designations

Key facts in behavioral health for the Medicaid population

Early facts in Arkansas



Total Medicaid behavioral health beneficiaries	~110,000 recipients
"Core" behavioral health spend (38% IP, 62% OP)	~$550 M
"Halo" spend	~$380 M
Pharmacy spend of behavioral health clients (BH and halo)[2]	~$150 M

Definitions of key terms

"Core" behavioral health spend[1]:

- Includes behavioral health services delivered to the client, (e.g., services for ADHD or depression)
- Does not include direct dementia or DD costs, but does includes BH spend from these populations

Halo:

- Includes non-behavioral health services (e.g., medical, support services) delivered to people who also use BH services

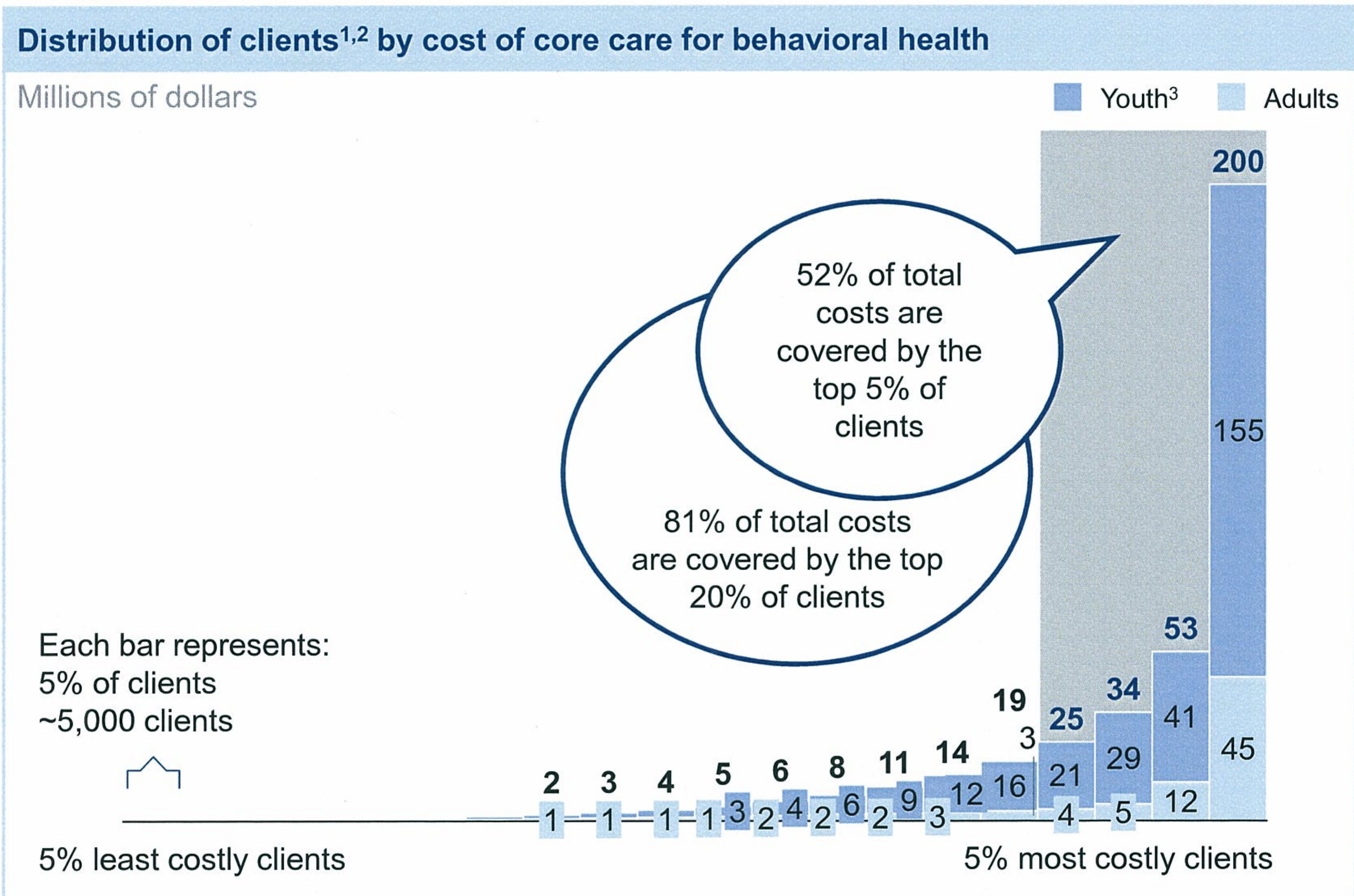
NOTE: Does not include those funded solely from state general revenue. Analysis underway to incorporate broader behavioral health programs

1 Details of BH spend: ICD9 291 – 314 excluding autism (299) and dementia codes in 294, excludes pharmacy

2 Pharmacy includes some spend from some DD and dementia clients that has not yet been excluded

SOURCE: 2011 Medical claims for behavioral health diagnosis codes. Does not include pharmacy, crossover or third party liability

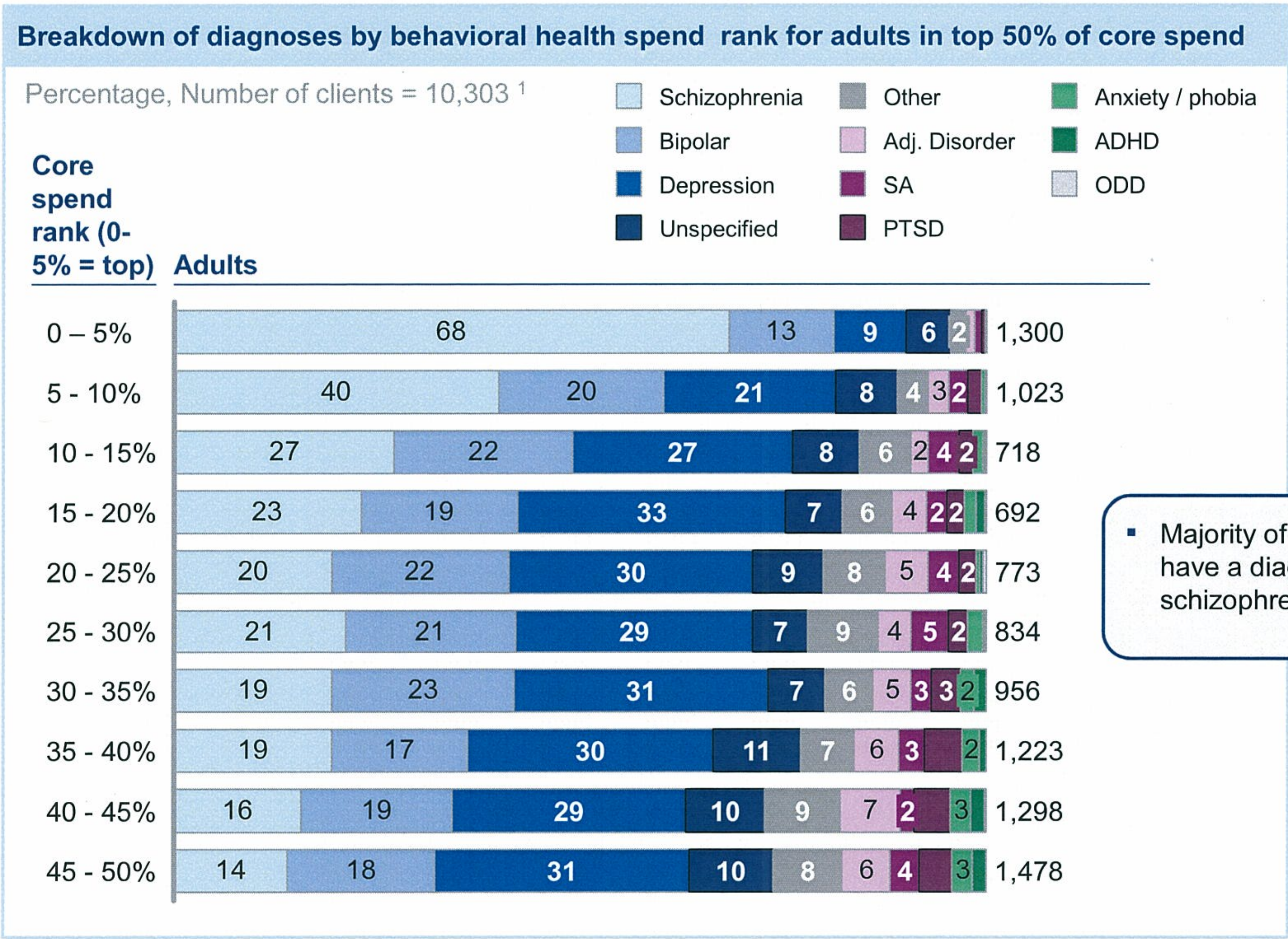
Behavioral health core spend is concentrated amongst the highest need clients



1 Includes all clients with at least one core related claim
2 Excludes clients with DD and LTSS because this group is likely to have multiple health home options
3 Youths are clients<21 years of age; Adults are clients ≥ 21 years of age

SOURCE: 2011 Medicaid BH claims (ICD-9 291 – 314 excluding 299 and dementia codes in 294), excludes pharmacy and crossover claims

Diagnostic profiles for adult BH clients by level of core spend



- Majority of top 5% adults have a diagnoses of schizophrenia

1 Excludes clients with DD and LTSS because this group is likely to have multiple health home options

SOURCE: 2011 Medicaid BH claims (ICD-9 291 – 314 excluding 299 and dementia codes in 294), excludes pharmacy and crossover claims; each client must have at least one core related claim

Goals of the behavioral health home

To deliver integrated care management in a manner that facilitates quality care and positive outcomes through:

Providing care coordination

- Providing clients with integrated care coordination within and across BH, medical health, developmental disabilities, long-term supports, and other systems

Managing core care delivery

- Ensuring effective treatment of behavioral health conditions, including pharmacy effects

Behavioral Health Homes will provide care management services

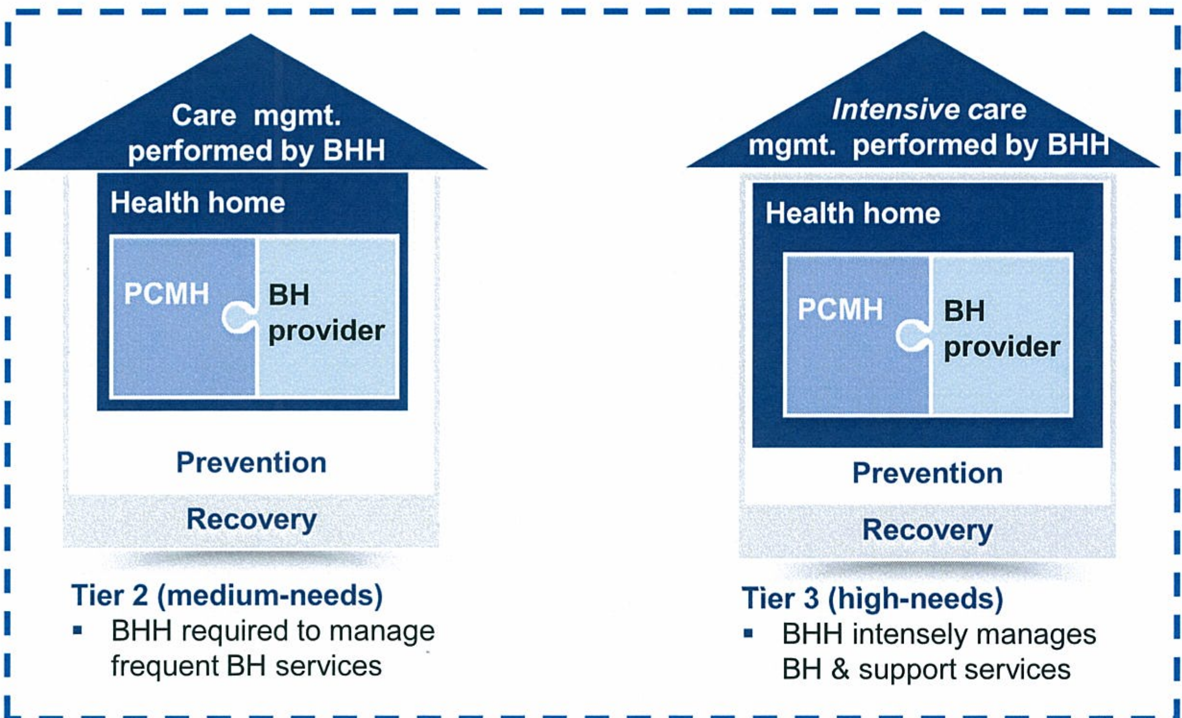
Care management activities			
Care coordination	**Health promotion**	**Support services**	**Comprehensive transitional care**
▪ Support and enable care plan adherence by providing assistance with referrals, scheduling and getting to appointments, etc. ▪ Regularly check-in with client to understand barriers to plan adherence ▪ Maintain client documentation ▪ Monitor chronic disease indicators and performance metrics ▪ Integration of care plans across systems	▪ Arrange for / provide client-specific health education services ▪ Educate and support client on self-management plans and routine clinical care	▪ Match individuals (and families) to support services and advocate on their behalf for participation ▪ Maintain awareness of and interact with key services to ensure they are meeting client needs	▪ Establish process to ensure prompt informing on unplanned care ▪ Coordinate and share transition planning with relevant coordinators ▪ Provide regular education on client access to services, especially at transition points ▪ Develop crisis intervention plan, including creating options for increased access

The new behavioral health system will be conscious of varying severity of needs as well as intensity of care management required for the different tiers

ILLUSTRATIVE

Care managed by health homes

BH client population



Tier 1 (low-needs)
- PCMH care mgmt. adequate for BH care

Tier 2 (medium-needs)
- BHH required to manage frequent BH services

Tier 3 (high-needs)
- BHH intensely manages BH & support services

1IP=Inpatient OP= Outpatient; SOURCE: 2011 Medicaid BH claims (ICD-9 291 – 314 excluding 299 and dementia codes in 294), excludes pharmacy and crossover claims

In addition to care management, the new behavioral health system will reimburse new, tier-specific services to deliver necessary care

- **New community and evidence-based practices** will be reimbursed through the 1915(i)[1] Medicaid funding mechanism
- 1915(i) allows drawing down **federal funds to support reimbursement of needed services for the first time**
- **Benefits can be targeted** to a specific population, services can differ in amount, duration, and scope

1 This Federal state plan option allows states to offer Home and Community Based Services under a Medicaid state plan to individuals who are Medicaid-eligible.

Preliminary: new behavioral health services to be offered

BH client population

Existing Services
Expanded Services
Proposed Services (including 1915i)

Tier 1

Clinic-Based
- *Individual behavioral health counseling*
- *Group behavioral health counseling*
- *Marital/family behavioral health counseling*
- *Multi-family behavioral health counseling*
- *Psychoeducation*
- *Mental health diagnosis*
- *Interpretation of diagnosis*
- *Substance abuse assessment*
- *Psychological evaluation*
- *Psychiatric assessment*
- Pharmacologic management

Tier 2[1]

Includes low needs services +...

Home/Community-Based
- Master treatment plan
- Home and community individual psychotherapy
- Community group psychotherapy
- Home and community marital/family psychotherapy
- *Home and community family psychoeducation*
- *Partial hospitalization*
- *Peer support*
- *Family support partners*
- *Behavioral assistance*
- *Aftercare recovery services*
- *Pharmalogic Counseling by RN*

Clinic/Home/Community-Based
- Psychiatric diagnostic assessment

Tier 3[1]

Includes medium needs services +...

Home/Community-Based
- *Individual life skills development*
- *Group life skills development*
- *Child and youth support services*
- *Individual recovery support*
- *Group recovery support*

Residential
- *Planned respite*
- Residential treatment unit and center
- *Residential treatment*
- *Therapeutic communities*

Health Home services available in Tiers 2 & 3
- *Care management (Tier 2)*
- *Intensive care management (Tier 3)*
- *Wraparound facilitation (Tier 3)*

Services available to all Tiers[1]
- Acute psychiatric hospitalization
- *Mobile response and crisis stabilization*
- *Acute crisis units*
- *Substance abuse detoxification*
- *Intensive outpatient substance abuse treatment*

1 Services are cumulative; any service available in Tier 1, will also be available in Tiers 2 and 3. Similarly, any service available in Tier 2 will also be available in Tier 3

Example profiles of adults in different tiers

ILLUSTRATIVE

Tier 1 client: George

- George, age 26, was diagnosed with depression 2 years ago.
- George had previously been in a Tier 2 health home but has greatly improved.
- George now manages his depression through regular medication appointments and occasional clinic-based therapy appointments; he does not need a case manager.
- George is living independently and maintaining a steady job.

Tier 2 client: Roy

- Roy, age 32, has been diagnosed with depression and drug addiction, but he is on a path of recovery.
- During his recovery, Roy experienced a crisis event. He relapsed, lost his job, and lost his apartment. He was undergoing intensive outpatient substance abuse treatment at the time of his relapse.
- Roy and his therapist are of the opinion that his recovery would likely be successful if he was provided with the opportunity to enter a partial hospitalization program and had a peer specialist working with him in the community.

Tier 3 client: Liz

- Liz, age 44, has been diagnosed with schizophrenia and has substance abuse issues.
- Liz had recently been hospitalized and she is currently in a residential substance abuse program.
- Liz needs ongoing behavioral health and substance abuse treatment after she discharges from residential treatment.
- Liz will also need housing support, assistance with her budget, and help meeting her nutritional needs including meal planning.
- Liz has a history with the criminal justice system and is at risk of returning to jail is she relapses.

Client Journey – George

George
Age: 26 years

Diagnosis

At George's primary care visit, the nurse screens for mental health and substance abuse issues and identifies signs of depression and excessive alcohol use. George's physician prescribes medication and begins to provide medication management.

Tier 1: Treatment and Coordination

George is also referred for additional Tier 1 services, including individual behavioral health therapy to address depression and substance abuse. While receiving Tier 1 services, George's care is coordinated by his PCMH.

Referral

After receiving Tier 1 services for over a year, George has a relapse, and his symptoms worsen. George also loses his job and his living situation becomes unstable. With input from George, his therapist, and physician, George's care coordinator refers George for an independent assessment.

Independent Assessment

A face-to-face independent functional assessment with George confirms that he has a functional impairment that requires care management through a behavioral health home and confirms the need for Tier 2 services.

Independent Care Plan

The independent assessor develops an initial individualized care plan that is supplemented with input from George, and specifies the types of services, including aftercare recovery support, that he will need to maintain stability and make inroads to recovery.

Tier 2: Treatment and Care Management

Through a behavioral health home, George receives care management. He also utilizes peer support services and intensive outpatient substance abuse treatment through a Tier 2 provider.

Independent Assessment and Transitional Planning

It has been a year since George's last independent assessment. Since then he has gained employment and a stable living situation. The re-assessment confirms that he is ready to transition out of the health home. After an interdisciplinary team meeting with George and his providers, transitional planning occurs to transition George's care to his PCMH.

Tier 1: Treatment and Coordination

George now manages his depression through regular medication management and occasional clinic-based therapy appointments in Tier 1; his care is coordinated through his PCMH.

For more information…

Online

- More information on the Payment Improvement Initiative can be found at www.paymentinitiative.org