House Appropriations Committee
Subcommittee on Health and
Human Resources

Independent Clinical Assessments and Care Coordination Model Update

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Presentation Outline

- ***Background***
  - ***Behavioral Health Service Expenditures***
  - ***Behavioral Health Service Description/Utilization***
- ***Independent Clinical Assessment***
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- ***Care Coordination for Behavioral Health Services***

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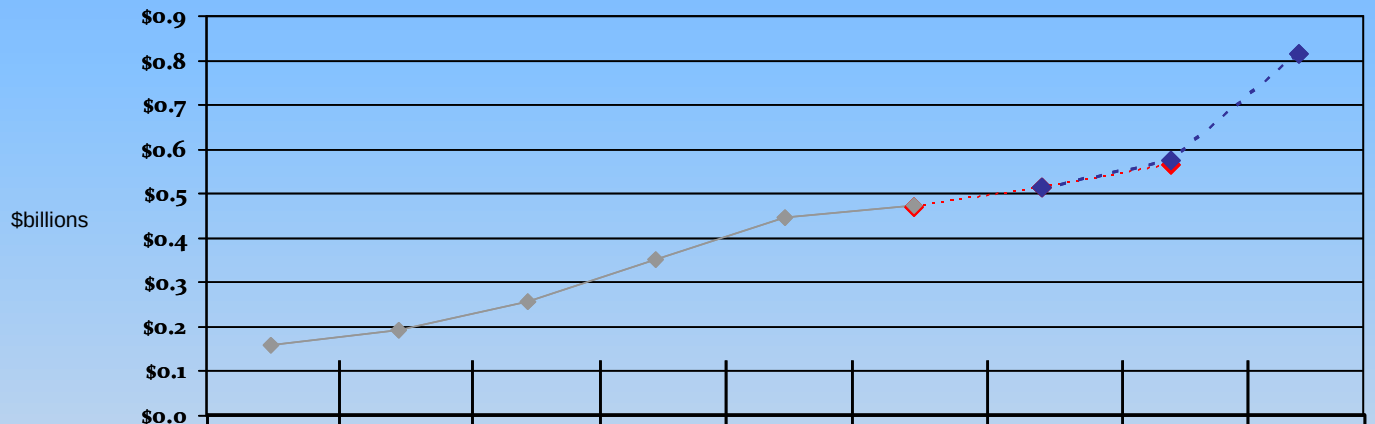
Background

- Due to concerns about unprecedented growth, the 2011 Acts of Assembly required that an independent clinical assessment be completed by a Community Services Board prior to receiving the following services from any provider:
  - Intensive In-Home (IIH)
  - Therapeutic Day Treatment (TDT)
  - Mental Health Support Services (MHSS) for youths up to the age of 21

Behavioral Health Expenditures

Historical and Projected Expenditures for Behavioral Health Services



	2006	2007	2008	2009	2010	2011	2012	2013	2014
2010 Forecast	$159.5	$194.0	$256.0	$353.2	$445.3	$468.8	$512.7	$563.5	
2011 Forecast	$159.5	$194.0	$256.0	$353.2	$445.3	$474.4	$515.8	$575.3	$813.9
($millions)		21.6%	31.9	38.0%	26.1%	6.5%	8.7%	11.5%	41.5%

- **Utilization of behavioral health services has been experiencing high growth rates over the past several years, however several initiatives implemented have curbed the growth**
- **The FY14 increase reflects expenditures associated with the enrollment of new populations under Federal health care reform**

Intensive In-home (IIH) Services to Children and Adolescents

SERVICE DESCRIPTION

Intensive, time limited interventions provided typically (but not solely) in the residence of a child/adolescent under age 21 who is at risk of being moved into an out-of-home placement, or who is being transitioned to home from out-of-home placement due to a documented medical need of the child

IIH Service Description

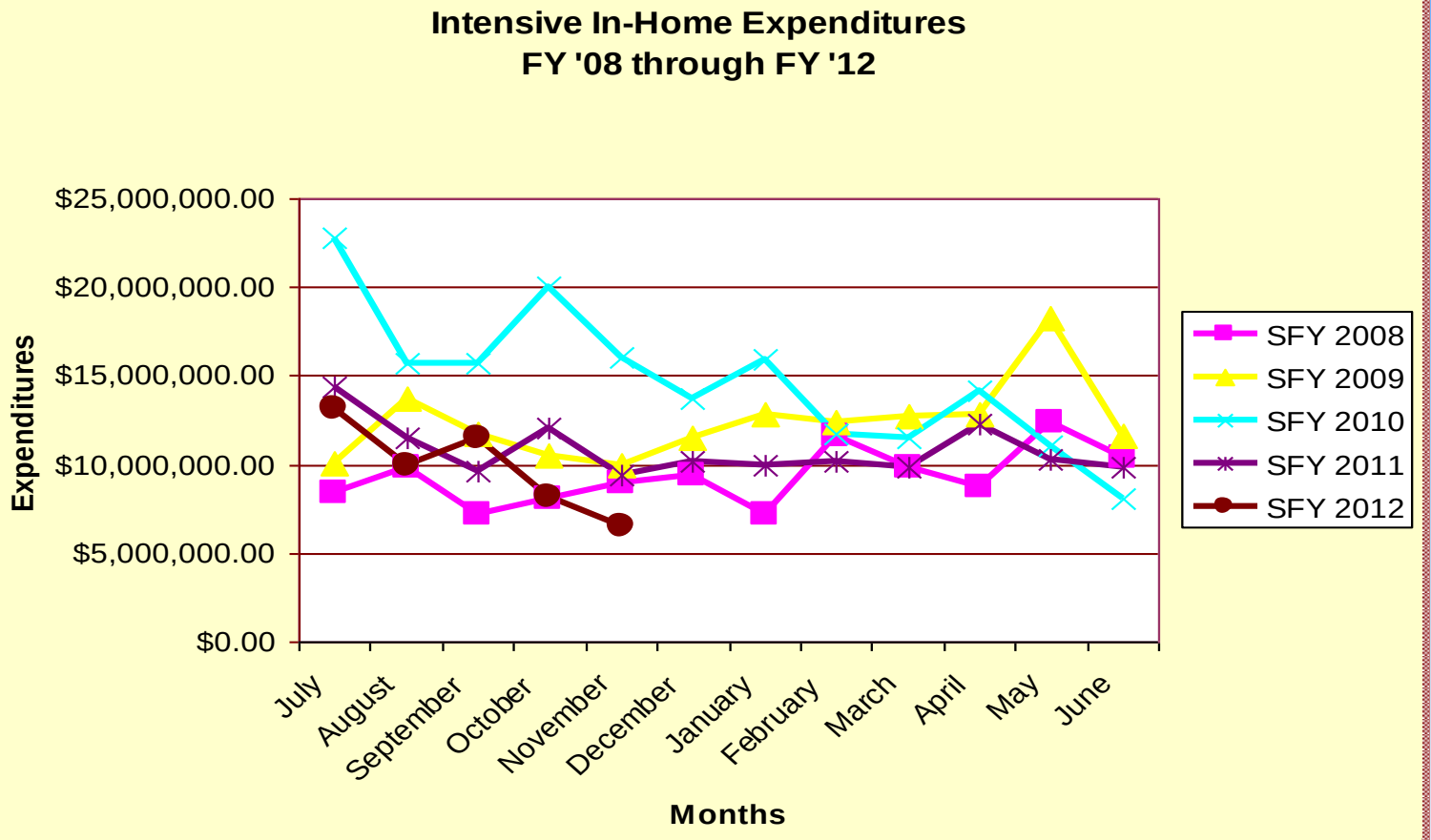
This service provides:

- Crisis treatment
- Individual and family counseling
- Communication counseling
- Case management activities
- Coordination with all other services child receives
- 24-hour emergency response

Clinical Example – Child Needing IIH Services

- A 14 year old girl was referred for (IIH) services
- Long and complicated treatment history- continued to exhibit symptomatic behaviors despite medication management & efforts of her outpatient therapist
- The girl reported auditory and visual hallucinations and suicidal thoughts, and suffered from clinical depression
- Suffered many traumatic losses
- Her mother had significant medical needs and was unable to sufficiently care for the child. The family lived on the girl's disability and her deceased father's death benefit. They relied heavily on food banks and other forms of assistance to meet their basic needs.
- Family previously attempted outpatient therapy, medication management – she was hospitalized 3 times before IIH recommended
- IIH therapeutic services worked with the girl and her family to stabilize her functioning - no additional hospitalizations occurred

IIH Service Utilization
18,816 Recipients in FY 2011



Therapeutic Day Treatment (TDT) for Children & Adolescents

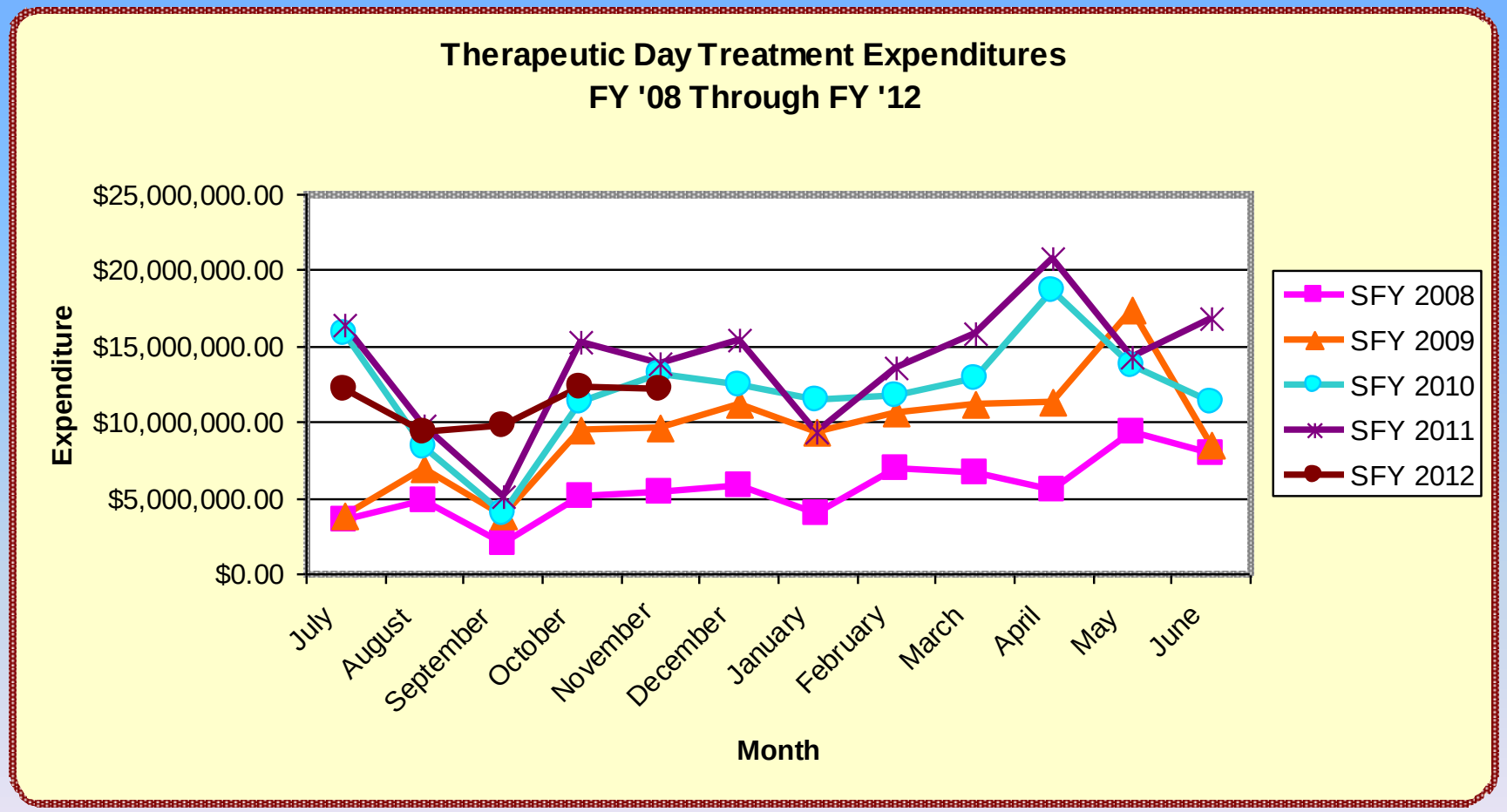
SERVICE DEFINITION

A combination of psychotherapeutic interventions and education and mental health treatment offered in programs of two or more hours per day with groups of children and adolescents (up to age 21 as an EPSDT service)

Clinical Example – Child Needing Therapeutic Day Treatment (TDT) Services

- A 7 year old female in 2nd grade was referred for TDT services
- Admitted to a inpatient psychiatric unit in August 2008 due to severe mood swings and anxiety
- She was diagnosed with Mood Disorder NOS, Anxiety Disorder NOS, and Enuresis
- She had suicidal ideations and hearing voices to hurt herself and sibling
- School setting
  - Behind academically – below reading skills for her grade (psychological evaluation demonstrated reading and mathematics difficulty)
  - Lagging social skills with peers
  - Isolates self and withdraws from group activities
- TDT assisting child with developing age expected social and emotional skills

TDT Service Utilization
14,515 Recipients in FY 2011



Mental Health Support (MHSS) Services

SERVICE DESCRIPTION

Mental health support services include training and support to enable individuals age 16 years and older with significant psychiatric functional limitations to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. The treatment focus is on assisting the client with independent living skills and is therefore appropriate for older adolescents and adults.

MHSS Description

Agencies must provide training in or reinforcement of functional living skills and appropriate behavior related to the individual's:

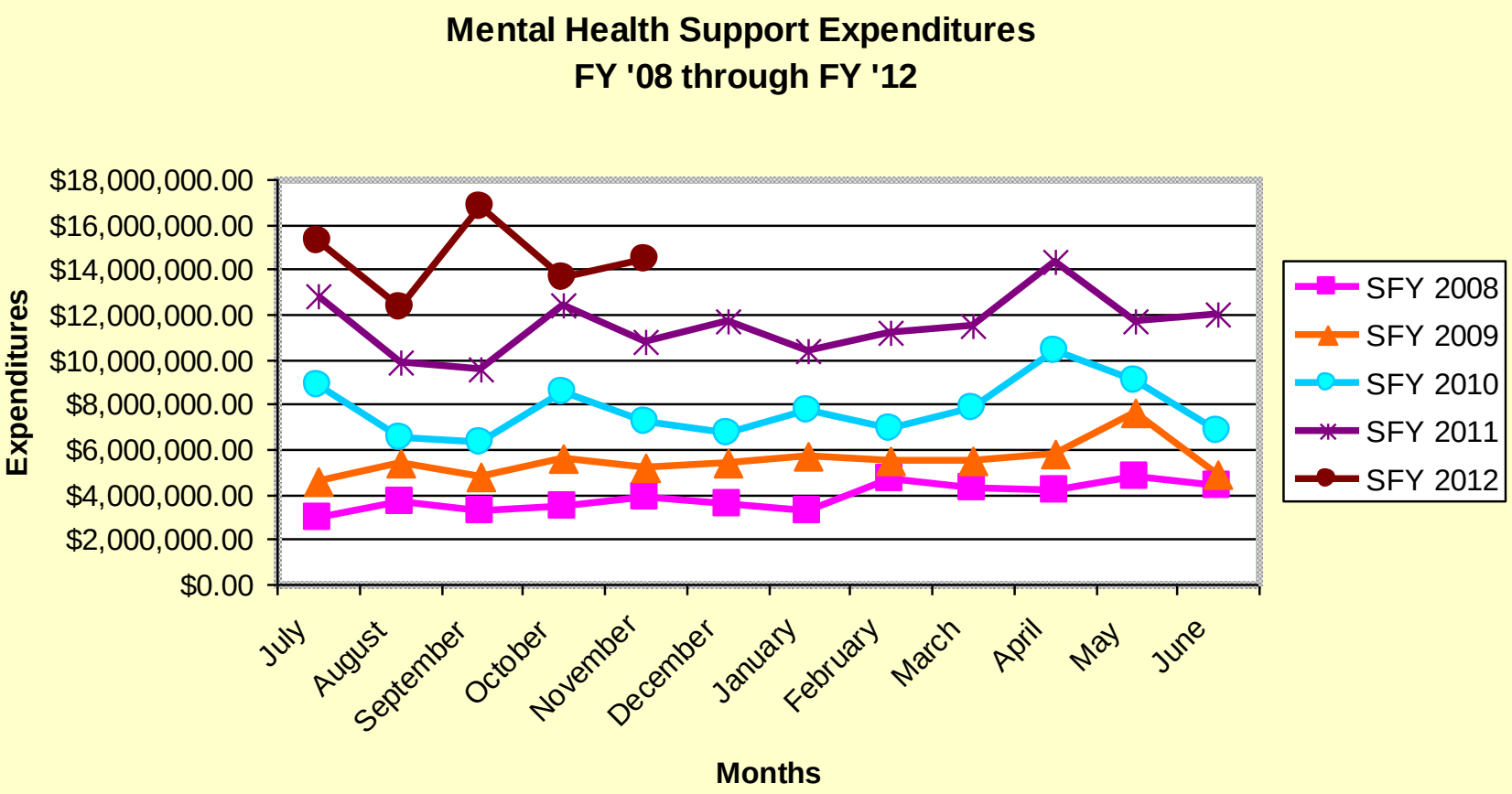
- health & safety
- activities of daily living
- use of community resources
- assistance with medication management,

  AND
- monitoring health, nutrition & physical condition

Clinical Example – Young Adult Needing MH Supports

- 20 year old male with a diagnosis of Schizoaffective Disorder and a history of drug abuse
- History of persistent and chronic symptoms of mental illness and periods of noncompliance with treatment
- Up to three psychiatric admissions per year
- History of being barred from businesses in his neighborhood due to inappropriate social behavior
- MH Support staff provide support (including reminding him to take medications and keep his appts)
- Remains stable in community with reduction in hospitalizations and has stopped misusing drugs

MHSS Utilization
10,833 Recipients in FY '11



Independent Clinical Assessment (ICA)– Also known as VICAP

- **Purpose**
  - To assure that children and families receive the most clinically appropriate services
  - This type of assessment is already required for all other Medicaid-funded vulnerable populations (such as intellectual disability, physical disability)
  - This initiative is the first step toward the development of a behavioral health care coordination system that will integrate behavioral, acute and primary health services (297.MMMM)

Independent Clinical Assessment (ICA)

- **Principles of the Program**
  - Freedom of choice of direct service provider for families
  - Responsiveness
  - Family-oriented/focused process
  - Least restrictive service(s) appropriate to safely and effectively meet the needs of family/child
  - Establish a link between fee-for-service behavioral health services and coordinated care

Community-based Mental Health Rehabilitative Services Affected

- On July 18, 2011, CSBs began conducting independent clinical assessments for new service requests

- Effective August 1, 2011, independent assessors began conducting assessments for re-authorizations

  - An estimated 60% of individuals who are currently receiving these service have been authorized more than one time for these services in the past

The ICA Process

- Assessments are conducted by CSB staff who are Licensed Mental Health Professionals or who have registered with the appropriate Virginia licensing board and is working toward licensure

- Appointments for the independent assessment are offered within five (5) business days for intensive in-home services and within ten (10) business days for other services (TDT and MHSS)

The ICA Process

(continued)

- Freedom of choice of service providers is documented by the independent assessor

- The independent assessor will review the need for all behavioral health services and may recommend outpatient therapy (individual, family, or group psychotherapy), or other services

Number of Service Requests

- Prior to the program beginning in July, providers submitted an increased number of requests to KePRO
- In June 2011
  - Requests for IIH Services more than doubled from June 2010 - 13 weeks per authorization)
  - Requests for TDT increased 2.5 times from June 2010 – 6 months per authorization
  - Requests for MHSS increased 2.4 times from June 2010 – 6 months per authorization

Highlights of CSB Reporting on Independent Assessments Conducted From July 18 through October 31, 2011

- CSBs had 14,590 calls and requests relating to Independent Clinical Assessments
- 11,206 appointments were accepted within the time frame; 327 appointments were outside the required time frame. This is 3% of the timely appointments
- CSBs completed 9,317 assessments
- There were 3,233 families who didn't keep their appointment (no-shows). This is a 29% no show rate for scheduled appts

Assessment Recommendations Through October 31, 2011

Intensive In-Home	3,149
Therapeutic Day Treatment	4,384
Mental Health Supports	517
Outpatient Therapy	4,403
Psychiatric or Medical Evaluation	4,402
Case Management	2,561
Recommended not continuing a service	1,052

Revisions and Changes

- Ongoing review and input from CSBs and Service Providers for process improvement opportunities, including:
  - Weekly calls with CSBs
  - Webinar with private providers to review how process implementation
  - Trouble shooting as individual situations occur
    - Service provider needing assistance
    - CSB needing assistance

ICA Implementation Issues

- Initially, there were some issues regarding assessments being submitted and accepted through KePRO's online system
- A few CSBs with large demand struggled to respond to the volume of phone calls and requests for appointments. There were also difficulties meeting the required time lines for assessments for some CSBs
- DMAS follows up on every complaint or issue reported and works to resolve the situation with the CSB or the Service Provider

CSB Strategies to Address Issues

- Additional CSB staff added to answer phones
- Evening and weekend appointments increased
- Sharing staff and resources among CSBs
- Hiring of additional licensed professionals
- Reminder calls to parents
- Conference calls with assessors

Expected Outcomes

- Children, youth and families will receive the most clinically appropriate services

- Improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for children or youth and their families

- Progress toward improved care coordination for those in need of behavioral health services

Points for Clarification:
Assessments & Authorization

- The ICA serves a different purpose than the service specific assessment performed by the provider
  - The ICA provides an overview to recommend a service
  - The assessment conducted by the service provider is specific and is the basis for the treatment plan and developing therapeutic interventions

- CSBs only recommend a service; KePRO serves as the decision-maker for service authorization
  - KePRO reviews information from the ICA and the service provider prior to a determination for service authorization

Points for Clarification:
Freedom Of Choice

- The protocols for the CSB require that families be given freedom of choice. CSBs give the family a DMAS generated list of providers in the area

- In January 2011, CSBs provided only 3.25 percent of IIH services. In October 2011, the CSBs percentage decreased to providing two (2) percent

- Of 40 CSBs, 25 provide either IIH or TDT services. Three CSBs dropped one of the services since the ICA process began

Points for Clarification:
Assessor Recommendations

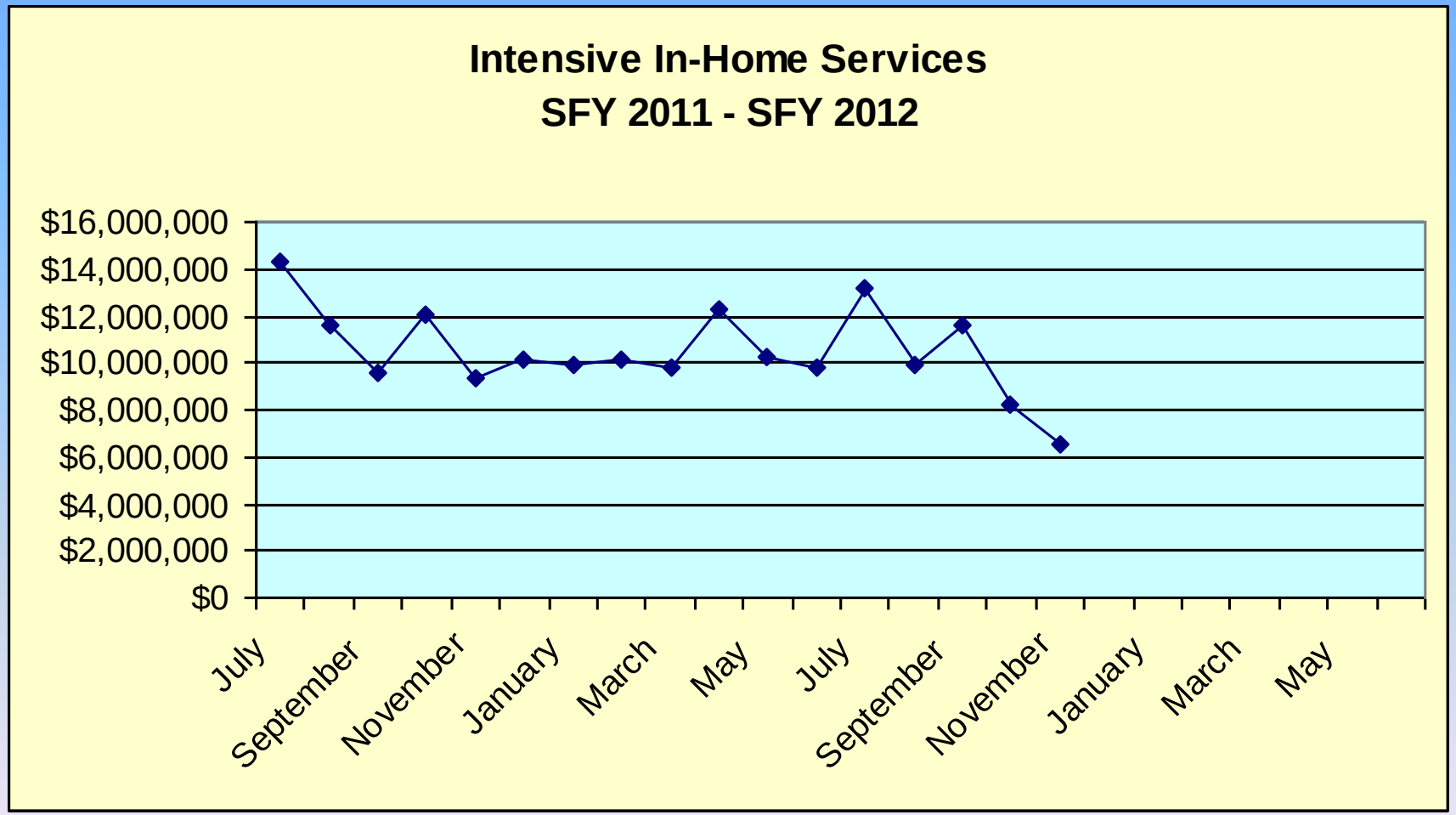
- Reasons that assessors may not recommend continuation of a service include:
  - Services provided prior to the ICA have been effective and the child can recommended for a lower level of care; or
  - It appears the services provided have been ineffective and another service is recommended

Paid Claims Data Beginning to Show Some of the Effects of the ICAs

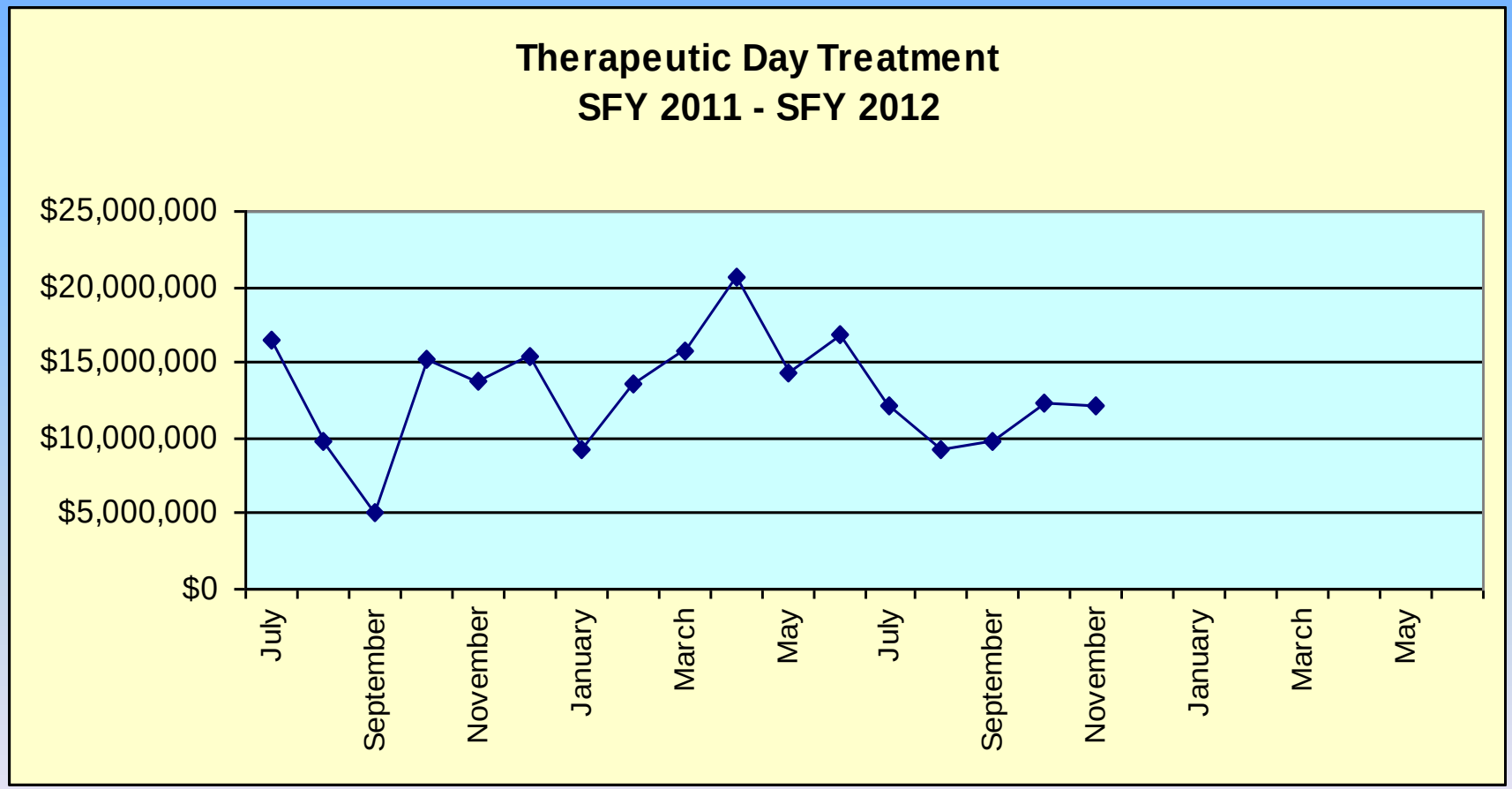
- The number of assessments are approaching 3,000, with an expenditure of $0.75 million dollars per month ($252 per assessment).

- Intensive In-Home and Therapeutic Day Treatment are showing a downward departure from trend starting in October signaling the potential for realizing general fund savings

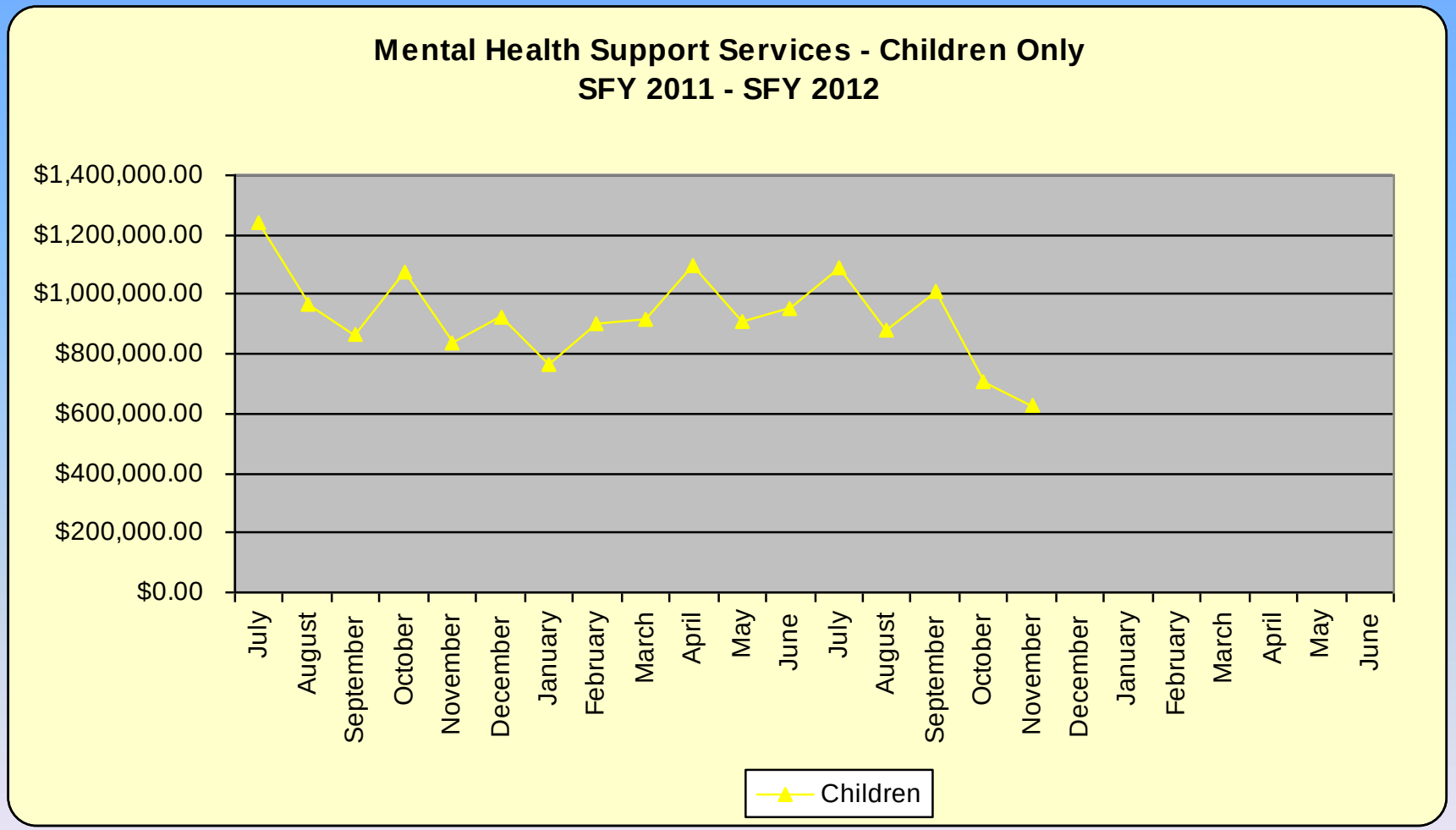
IIH Monthly Expenditure Changes



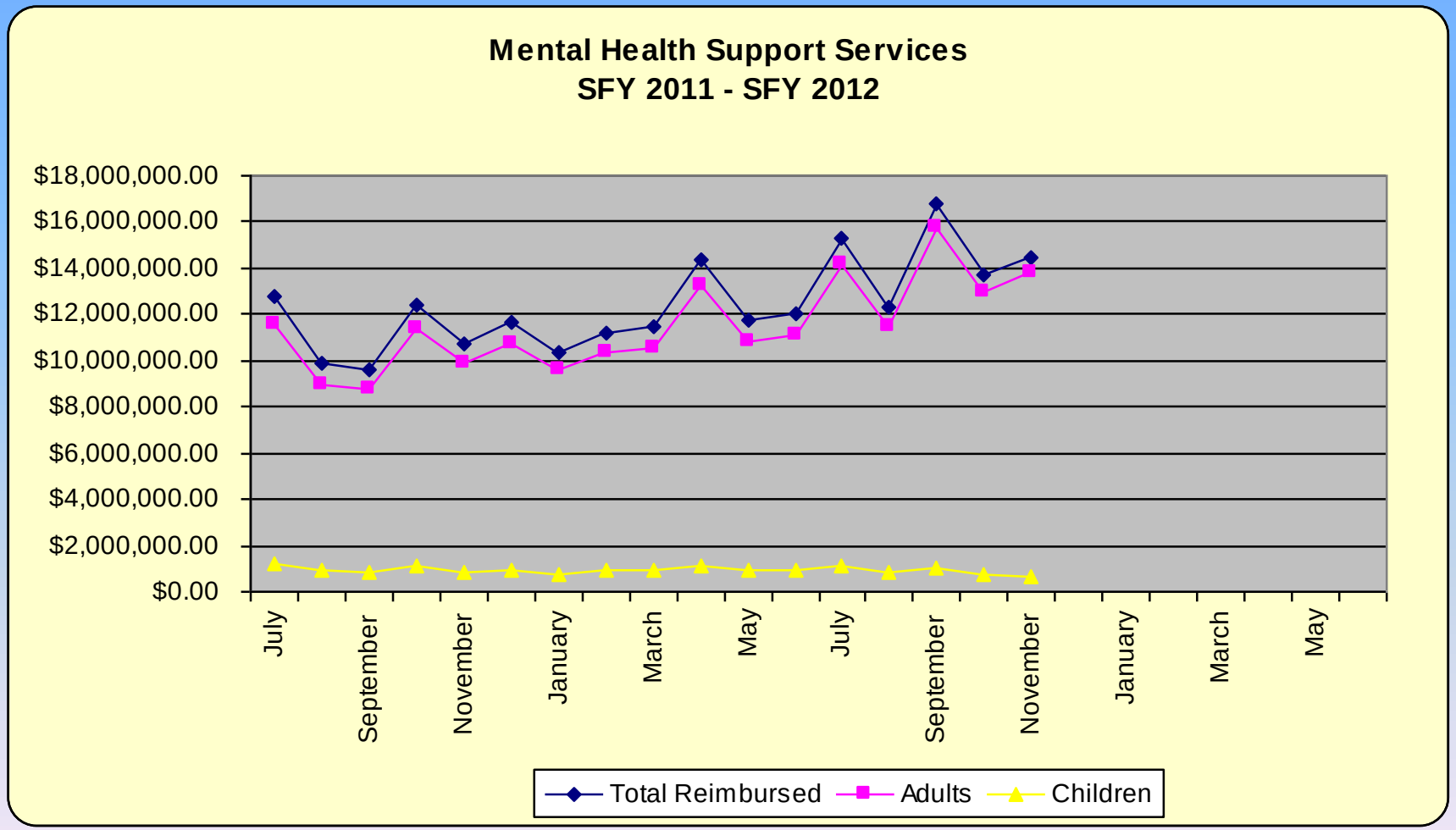
TDT Monthly Expenditure Changes



MH Support Monthly Expenditure Changes For Children



MH Support Monthly Expenditures for All Populations



ICA Lessons Learned

- Further claims analysis will be necessary to adequately assess expenditure trends, including looking for increases in other alternative services such as outpatient therapies

- CSBs have been receptive partners and have worked hard with stakeholders and the State to set up capacity to conduct independent assessments

- Service Providers have responded to the process and are working hard with clients and their families to meet the new requirements

- While it is still early, a certain number of children have been recommended for lower intensity services and 1,052 (11%) have been recommended not to continue a service

Care Coordination: Behavioral Health Services

- Item 297 MMMM (e) and (f) direct DMAS to develop and implement, respectively, a care coordination model for individuals in need of behavioral health services not currently provided through a MCO
  - The overall goal of the initiative is to improve the value of behavioral health services
  - Language in (e) directing the "blueprint" of such a system articulates 18 "principles" to which the care coordination model must adhere

Care Coordination: Behavioral Health Services

(continued)

- The language in (e) also specifies that the model must continue to recognize that Targeted Case Management is the responsibility of the Community Services Boards – the entity coordinating care cannot replace that function

- The language in (f) then allows DMAS to implement the model on a mandatory basis

- DBHDS, CSBs and other critical Stakeholders have been involved in planning for the new care coordination model

Care Coordination: Behavioral Health Services

(continued)

- Because of many recent changes in the administration of Medicaid community mental health services and the uncertainty of their affect on utilization, among other concerns, DMAS is currently developing an RFP for an Administrative Services Organization (ASO) to coordinate these services
  - It is fully intended that the principles articulated in the Appropriation Act will be applied under the ASO (i.e. the RFP will serve as the “blueprint”)

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Care Coordination: Behavioral Health Services

(continued)

- It is intended that the ASO contract will be replaced by a risk-based capitation model in the near future (after three years of the ASO model)
  - Beginning coordination of these services as an ASO model will allow for DMAS to analyze utilization based on recent changes prior to memorializing existing utilization in the development of capitation rates

- The ASO RFP should be released before the end of the calendar year, with implementation on July 1, 2012