



**House Appropriations Committee
Subcommittee on Health and
Human Resources**

**Independent Clinical Assessments
and Care Coordination Model Update**

Steve Ford, Deputy Director, Administration
Department of Medical Assistance Services

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Presentation Outline

Independent Clinical Assessment

-Independent Clinical Assessment – Background & Authority

-Implementation Issues

-Impact & Outcomes – One Year Later

Concerns & Proposed Changes to MHSS

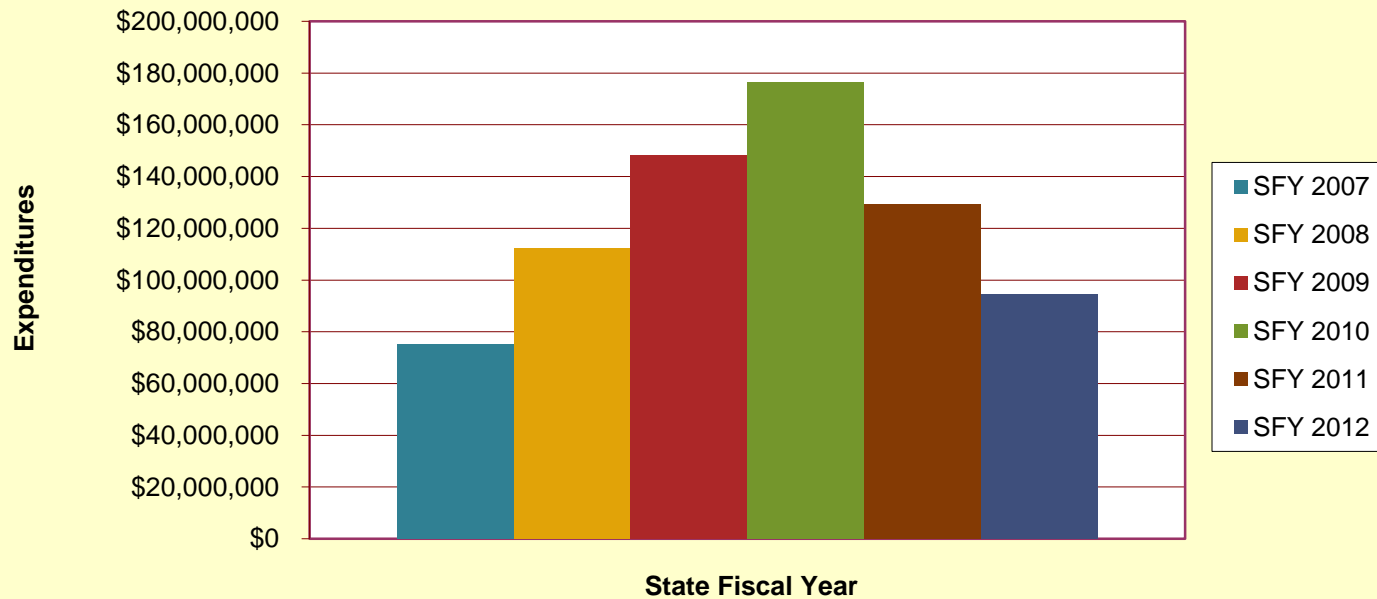
Update - Care Coordination for Behavioral Health Services

Background & Authority

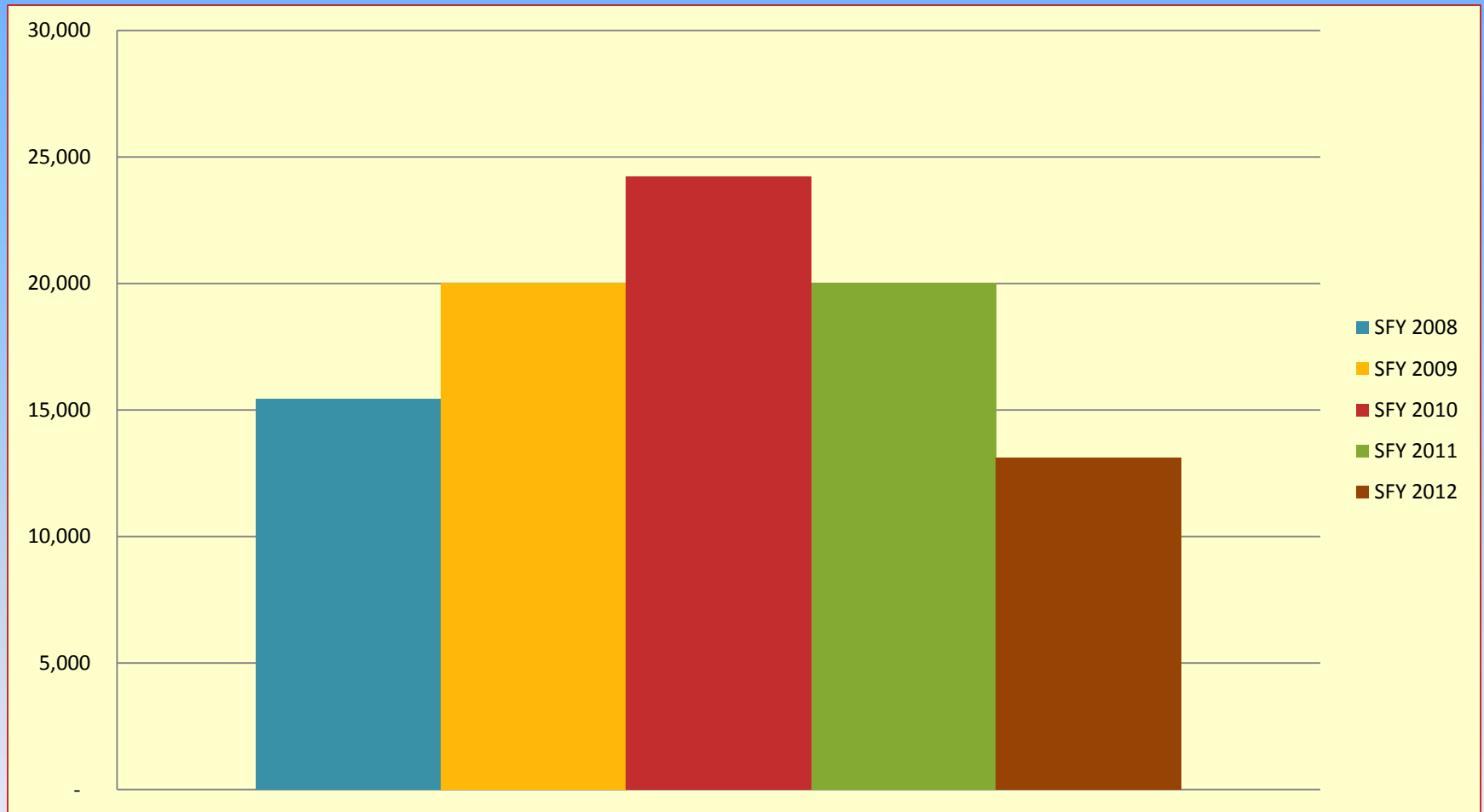
- Due to concerns about unprecedented growth, the 2011 Acts of Assembly required that an independent clinical assessment be completed by a Community Services Board prior to receiving the following services from any provider:
 - Intensive In-Home (IIH)
 - Therapeutic Day Treatment (TDT)
 - Mental Health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

IIH Service Utilization

Intensive In-Home Expenditures
FY '08 through FY '12

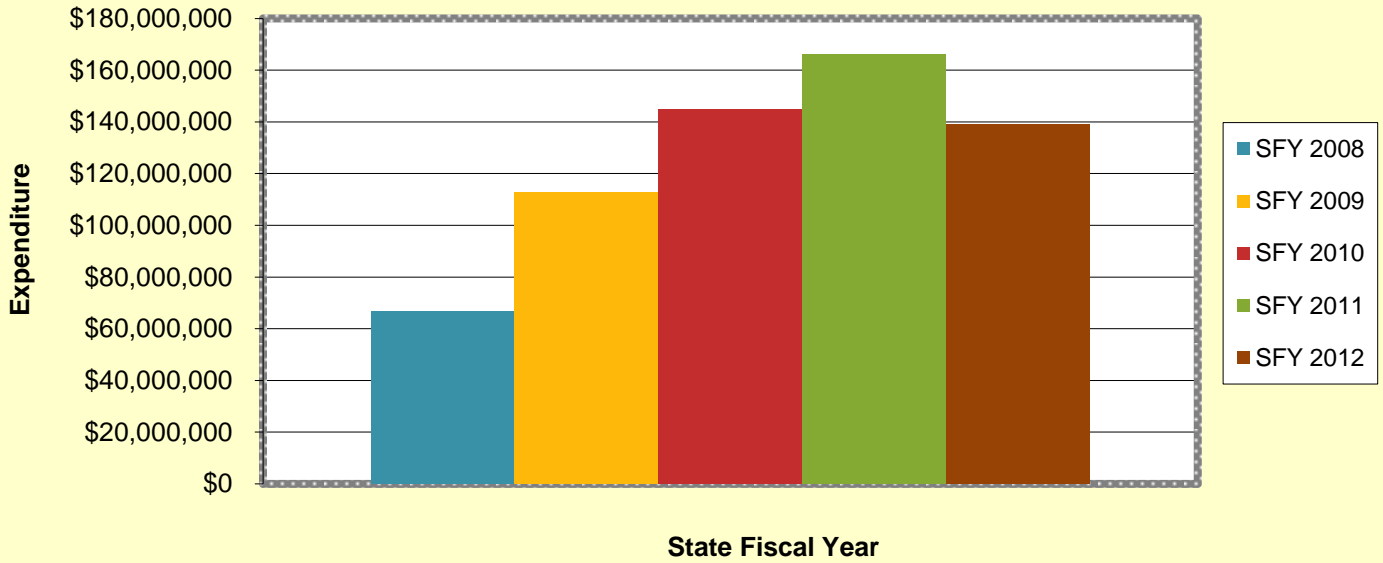


IIH Unduplicated Recipients

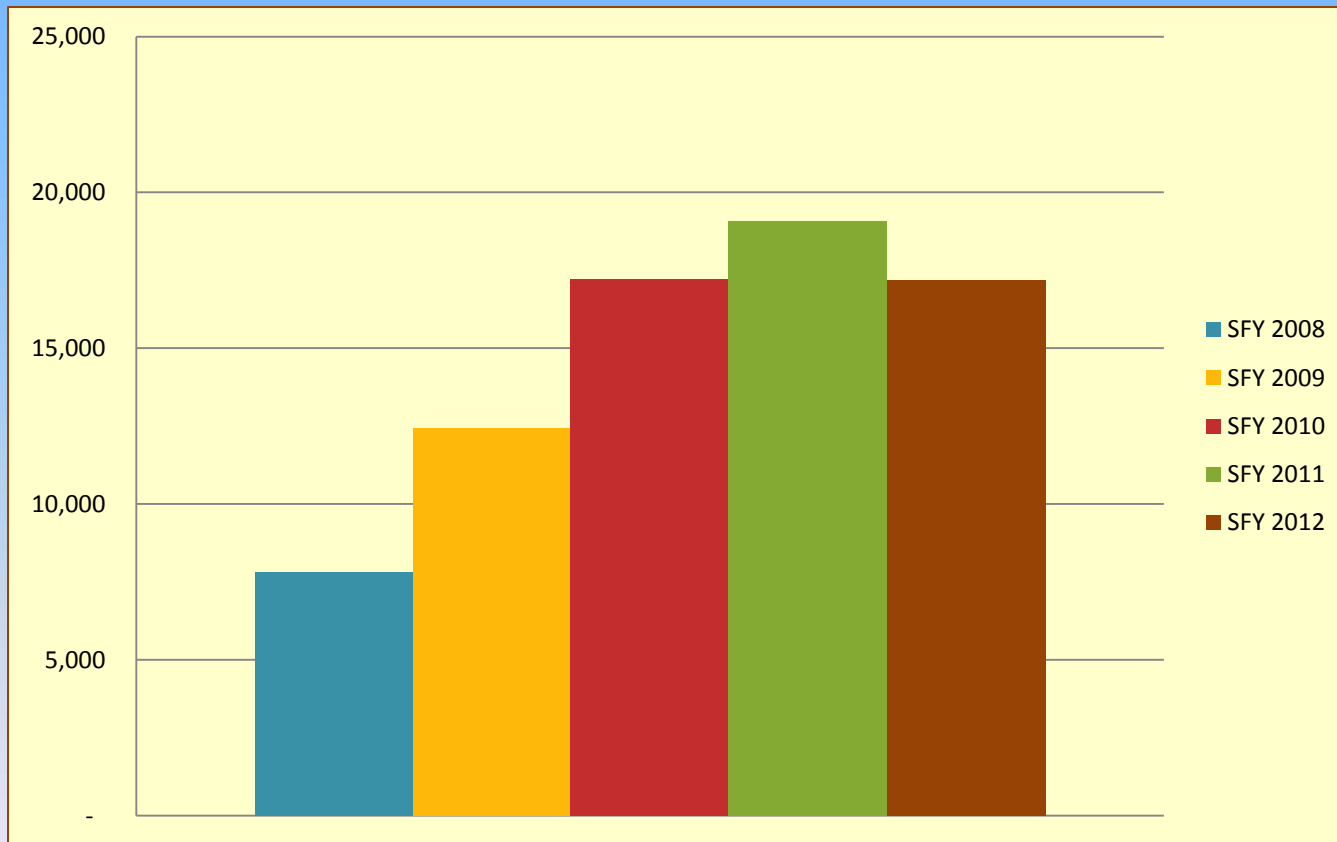


TDT Service Utilization

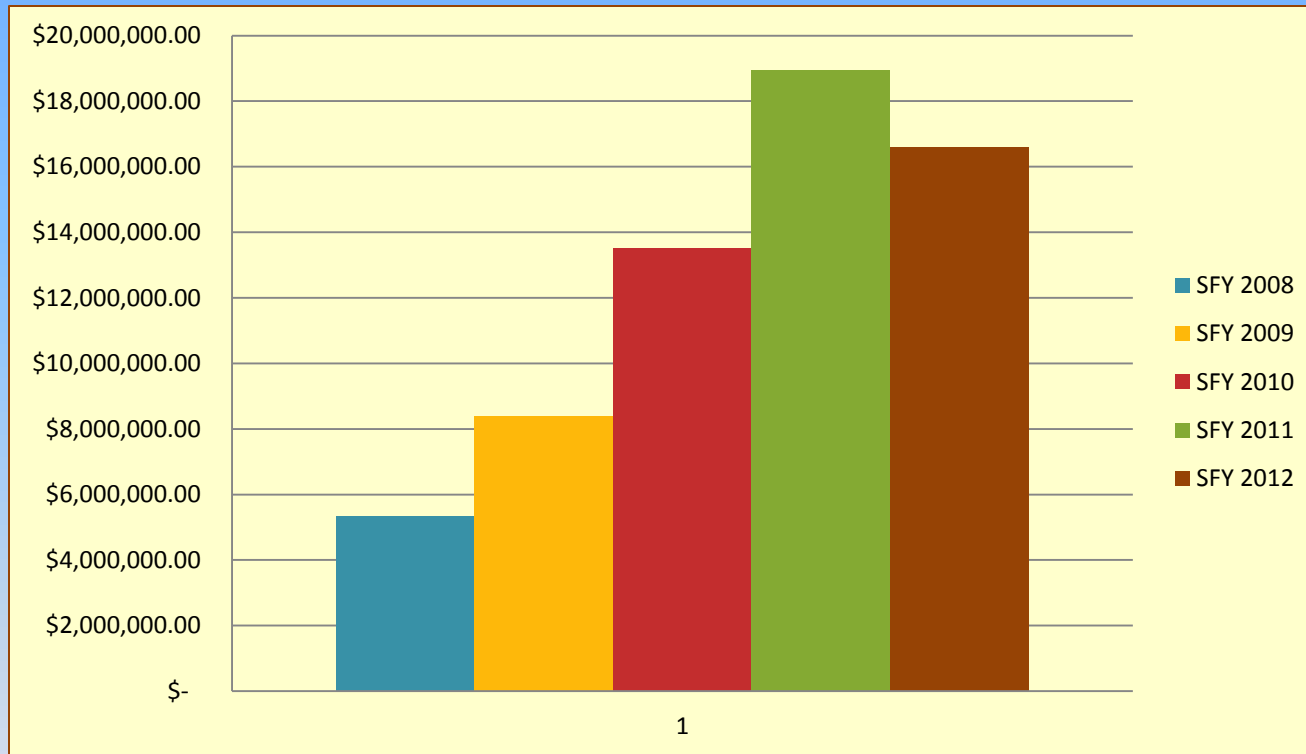
Therapeutic Day Treatment Expenditures
FY '08 Through FY '12



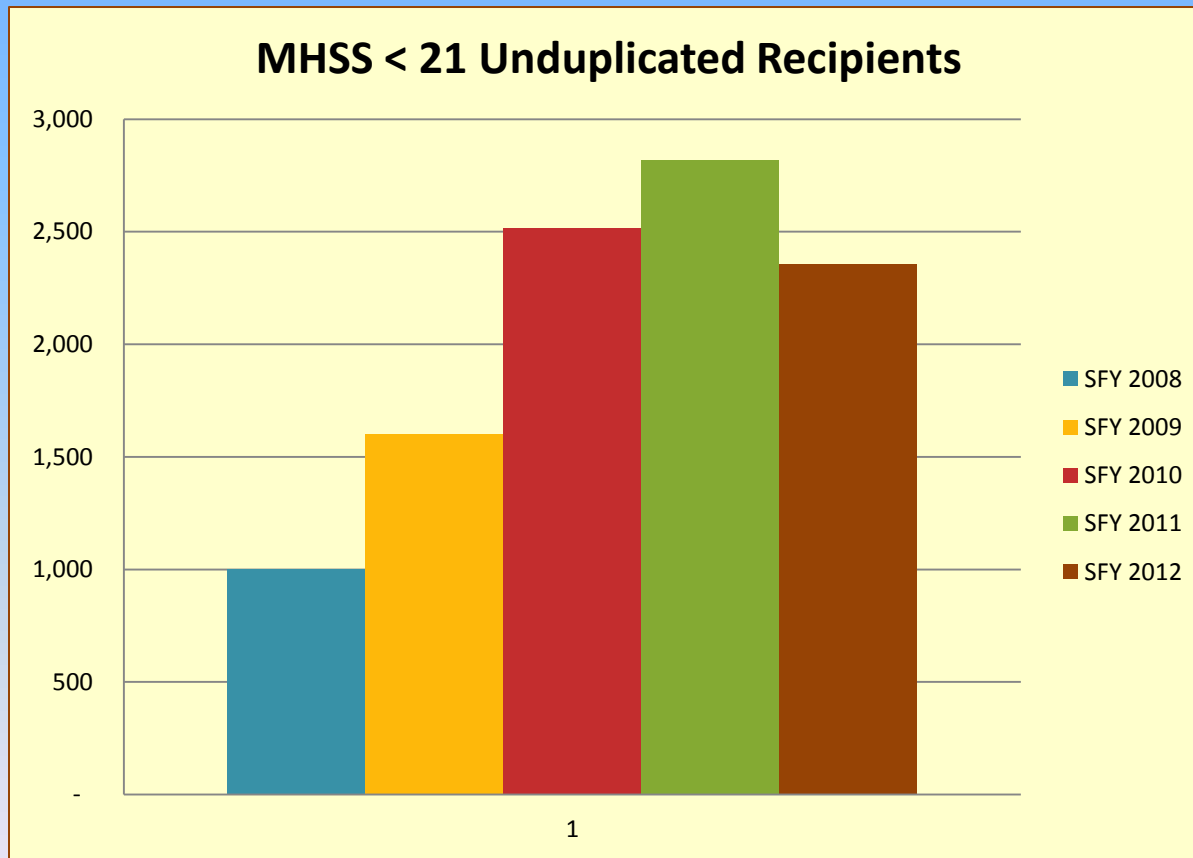
TDT Unduplicated Recipients



MHSS Utilization <21



MHSS <21 Unduplicated Recipients



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 (304.RR)

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

ICA Program Purpose

- 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

Community-based Mental Health Rehabilitative Services Affected

- On July 18, 2011, CSBs began conducting independent clinical assessments for new service requests
- Independent clinical assessments were also required for service reauthorizations, effective August 1, 2011
 - An estimated 60% of individuals who were receiving services had 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 IAH services and within ten (10) business days for other services (TDT and MHSS)

VICAP Outcomes

July 18 through June 30, 2012

- CSBs had over 42,000 calls and requests relating to Independent Clinical Assessments.
- 32,265 appointments were accepted within the time frame; 8,288 appointments were offered within the time frame but scheduled outside the time frame (due to family request); 976 appointments were outside the required time frame ($\approx 2.4\%$ of the total appointments)
- CSBs completed 28,733 assessments
- There were 11,434 families who didn't keep their appointment (no-shows) or canceled within 24 hours
 - This is a $\approx 27\%$ no show rate for scheduled appointments

Assessment Recommendations Through June 30, 2012

Intensive In-Home	8,754
Therapeutic Day Treatment	14,127
Mental Health Supports	1,800
Outpatient Therapy	14,063
Psychiatric or Medical Evaluation	13,705
Case Management	7,450
Recommended not continuing a service	2,406

ICA Implementation Issues

- A few CSBs with large demand initially struggled to respond to the volume of phone calls, requests for appointments, and difficulties meeting the required timelines for assessments
- The CSBs worked to correct these situations
- By the end of the 3rd Quarter, wait times exceeding the timeliness standards were less than 1% of all appointments offered. In the 4th Quarter of the program, only 14 total appointments (.002%) statewide were offered outside of the required timeframes

ICA Implementation Issues

- DMAS follows up on every complaint or issue reported and works to resolve the situation with the CSB or the Service Provider
- The number of complaints received by DMAS significantly decreased over the fiscal year as CSBs, families and providers grew more used to new process

Revisions and Changes

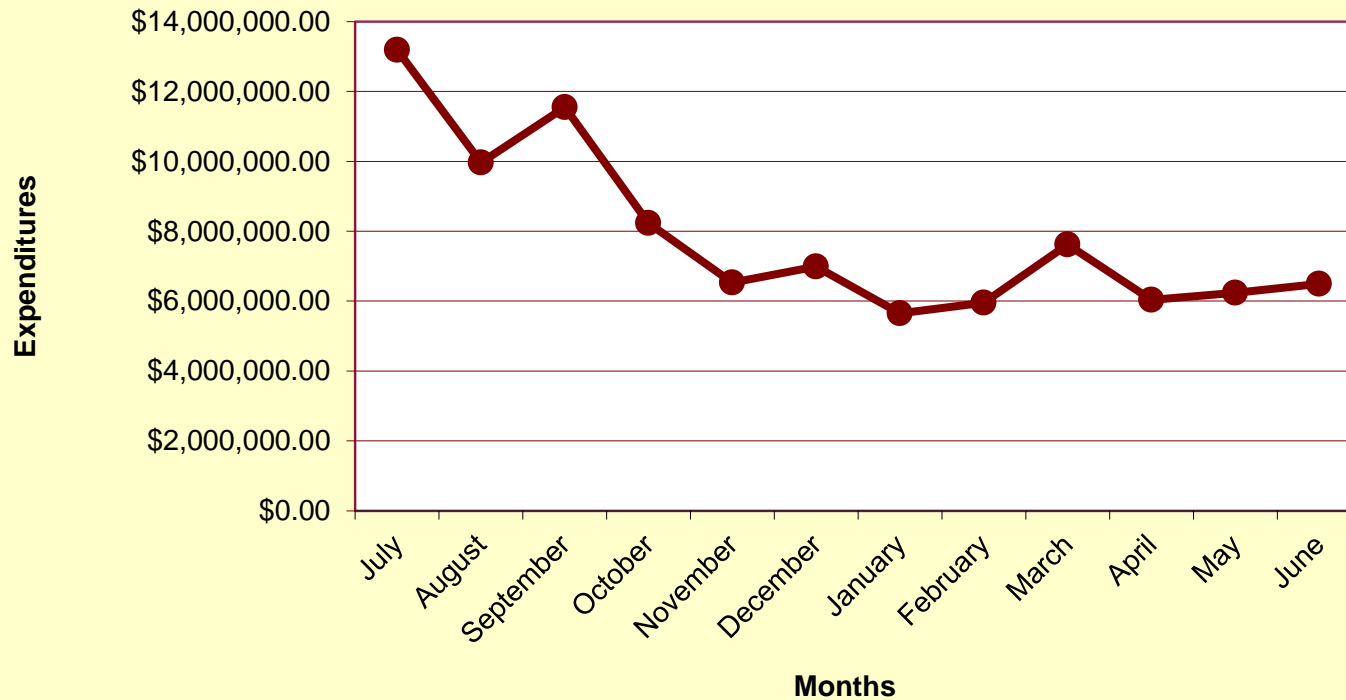
- Ongoing review and input from CSBs and Service Providers for process improvement opportunities, including:
 - Monthly (more often if needed) meetings with CSBs
 - Meetings with private providers and families
 - Trouble shooting as individual situations occur

ICA Program Impact

- 24,925 number of assessments were reimbursed by DMAS for SFY 2012. Assessment expenditures were \$6,272,431 million dollars for SFY 2012 (\$252 per assessment)
- Intensive In-Home and Therapeutic Day Treatment are showing a downward departure from trend starting in October 2011 which signaled the potential for realizing general fund savings

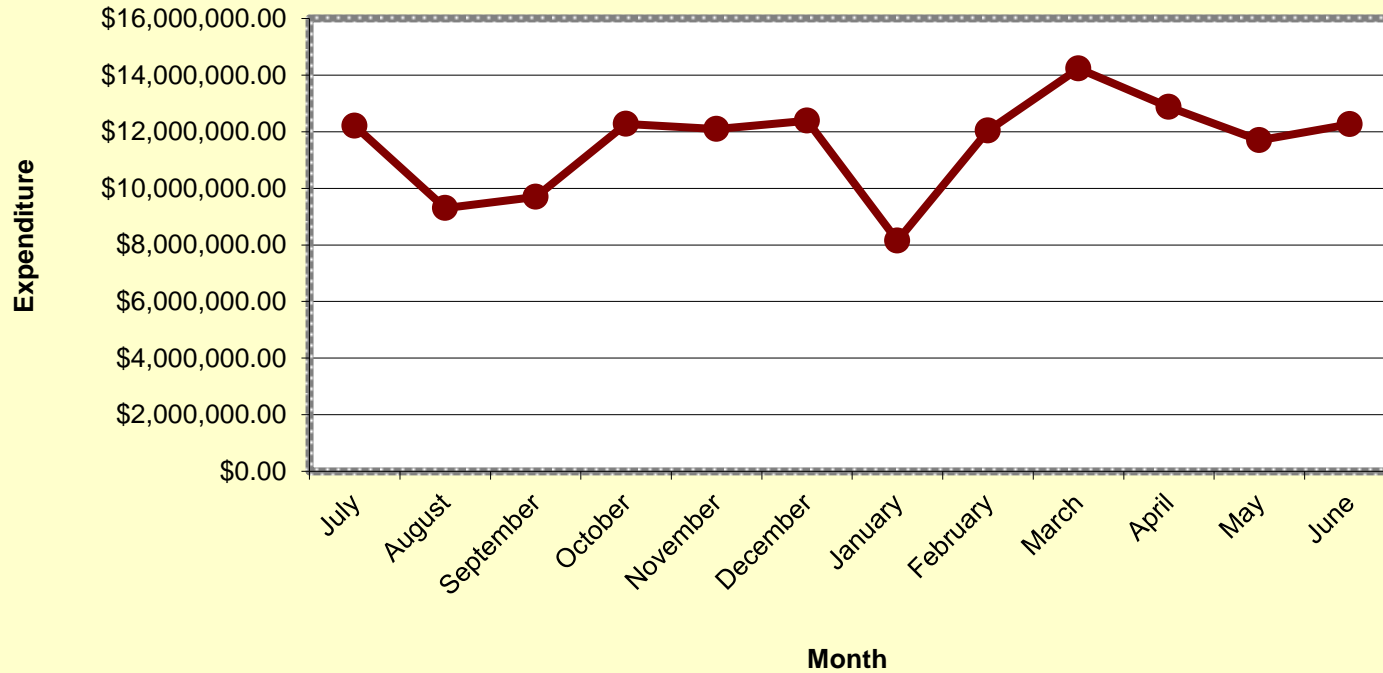
IIH Monthly Expenditure Changes

Intensive In-Home Expenditures
FY '12
13,121 Recipients



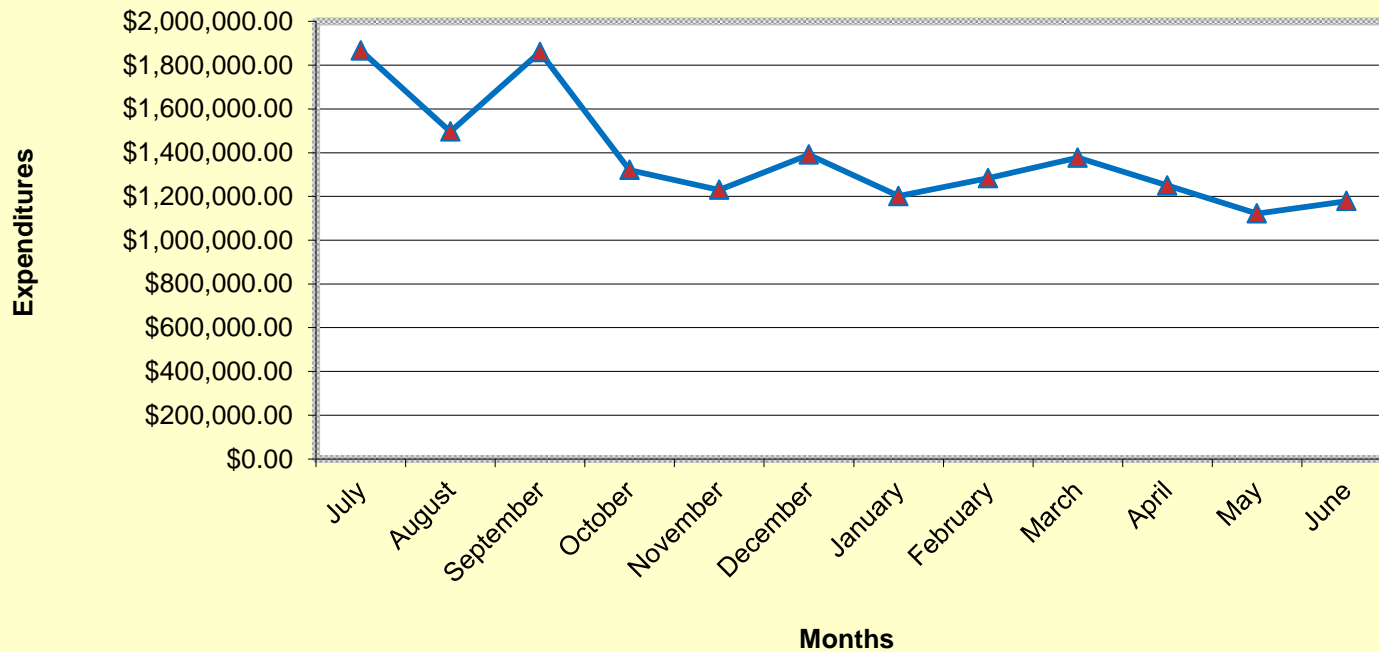
TDT Monthly Expenditure Changes

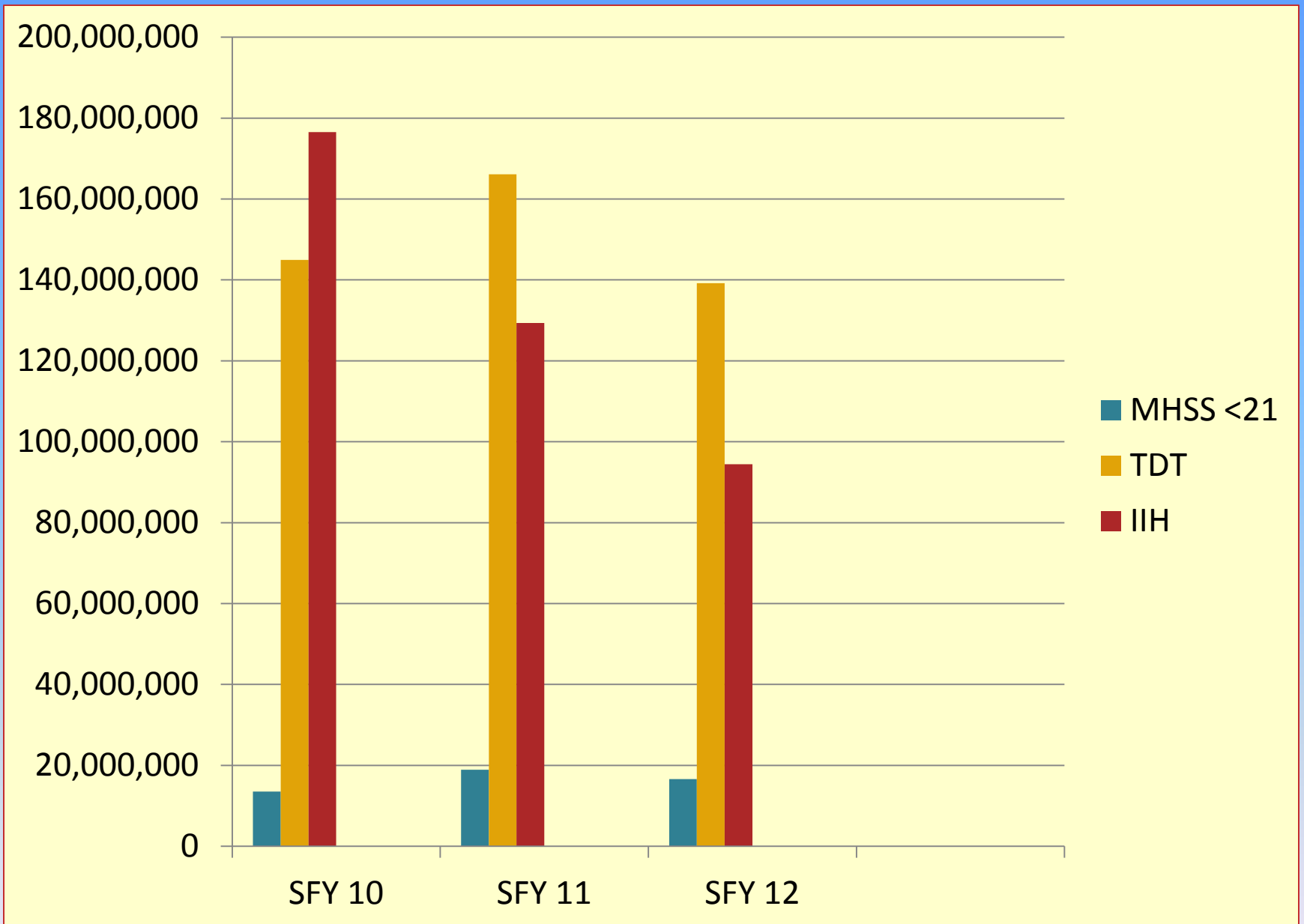
Therapeutic Day Treatment Expenditures
FY '12
17,181 Recipients



MH Support Monthly Expenditure Changes For Children

Mental Health <21 Support Expenditures
FY '12
2,355 Recipients





Change in BH Service Patterns Post ICA

ICA Lessons Learned

- As of 6/30/12, **28,733** independent assessments were completed
- Based on claims received for SFY 2012, overall utilization for these services is down by 20%
 - IIH is down almost 27%;
 - TDT is down approximately 16%; and
 - MHSS (recipients under age 21) is down approximately 20%
- For the three targeted services (IIH, TDT, MHSS), the number of recommended services closely matches the number of paid claims in DMAS claims data. This suggests that the majority of recipients were able to access the recommended service following the independent assessment
- In the 4th Quarter of the program, only 14 total appointments (.002%) statewide were offered outside of the required timeframes

ICA Lessons Learned

- The services that were recommended most frequently were TDT, non-physician Outpatient Counseling, and Outpatient Psychiatry/Medical Evaluation. Approximately 2% of children were not recommended for any professional service
- Assessments performed for re-authorization and continued care purposes resulted in over 2,400 instances in which continued care at the same level was not recommended
- Only 27% of individuals cancelled or failed to attend the appointment with less than 24 hours notice
- The appeal rate for CMHRS service denials has not shown any significant changes since the implementation of the independent assessment program

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- Concerns & Proposed Changes to MHSS***

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MHSS Service Description

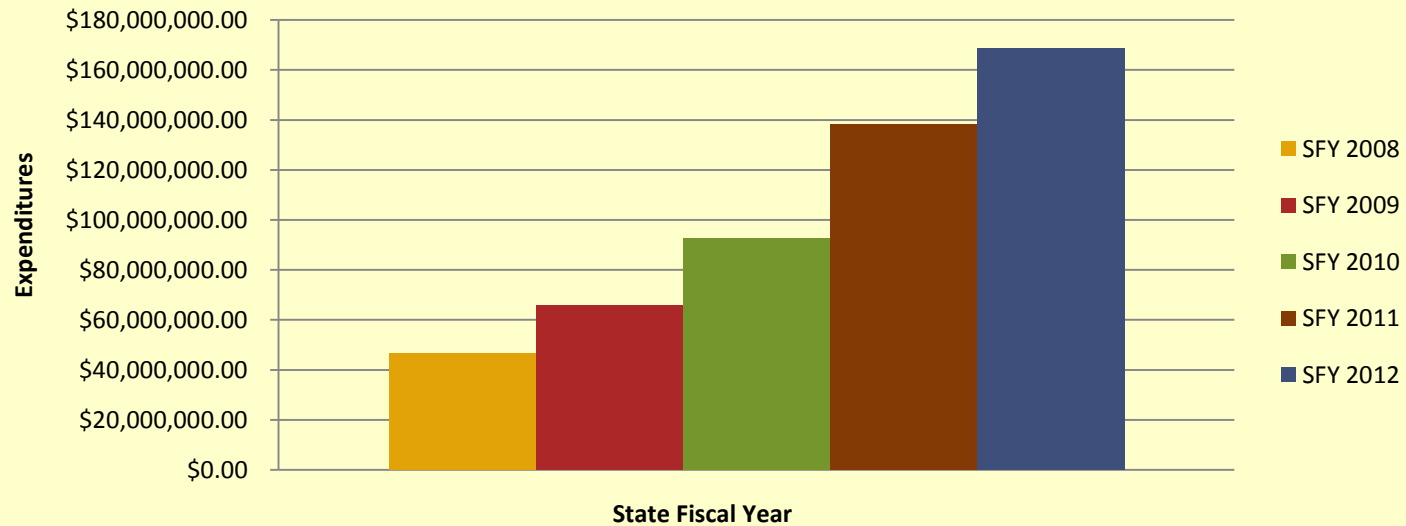
Agencies must provide training in or reinforcement of functional living skills and appropriate behavior related to the individual's:

- ◆ health & safety
 - ◆ activities of daily living
 - ◆ use of community resources
 - ◆ assistance with medication management,
- AND
- ◆ monitoring health, nutrition & physical condition

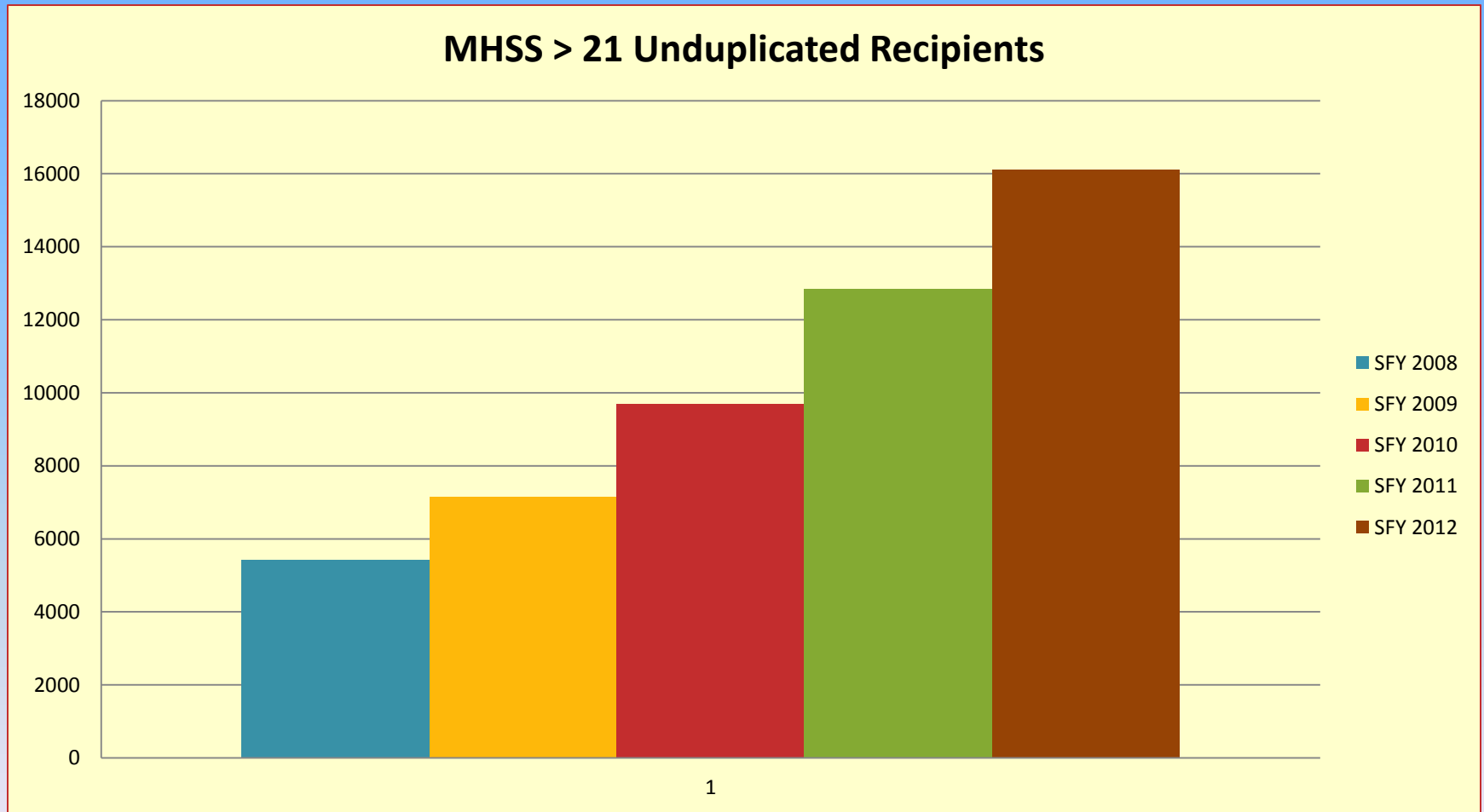
MHSS Utilization

16,113 Adults in FY '12

Mental Health >21 Support Expenditures
FY '08 through FY '12



MHSS >21 Unduplicated Recipients



Identified Concerns with MHSS

- ◆ Vague Medicaid eligibility criteria have allowed individuals who may not have a serious mental illness as defined by DBHDS to receive Mental Health Support Services
- ◆ DBHDS licensing specialists and DMAS auditors report that MHSS services are becoming more like companion care, and less like mental health treatment with a rehabilitative focus
- ◆ In the last three fiscal years, there has been a **\$102 million** increase in the cost of this service

Proposed Changes to MHSS

- “VICAP” for Adults: This option was initially on the table but this will be delayed until the effectiveness of the other changes can be determined
- Restricting MHSS eligibility to individuals with a DSM-IV diagnosis of serious mental illness, or serious emotional disturbance (such as schizophrenia, schizo-affective disorder, and bipolar disorder) using DBHDS criteria, that has been diagnosed or confirmed within the last 12 months, and who also meet both of the elements below:
 - prior history of psychiatric hospitalization; residential crisis stabilization services, or PACT services; and
 - a prescription for psychotropic medications within the past 12 months. (For these purposes, psychotropic medications shall be limited to antipsychotics, antidepressants or mood stabilizers)

Proposed Changes to MHSS

(continued)

- Other changes include:
 - Exclusion of MHSS:
 - Simultaneously with in-home residential services for individuals who are enrolled in ID or DD Waivers or personal care services (unless justified in MHSS record)
 - For individuals who reside in nursing homes or other institutional settings.
 - Change units allowed per day
 - Move to hourly rate
 - Re-authorization of MHSS within 90 days of implementation to ensure recipients meet new requirements

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Concerns & Proposed Changes to MHSS

Update - Care Coordination for Behavioral Health Services

Care Coordination: Behavioral Health Services

- DMAS developed a Request for Proposal for an Administrative Services Organization (ASO) to coordinate these services
 - The ASO is a non-risk model where a Behavioral Health Services Administrator (BHSA) is paid a fee to coordinate non-managed behavioral health services (similar to dental contract)
 - It is fully intended that the principles articulated in the item 304.RR of the 2012 Appropriations Act will be applied under the ASO model (the RFP served as the “blueprint”)
- The RFP was released December 16, 2011; BHSA Proposals were received by DMAS January 27, 2012

Care Coordination: Behavioral Health Services

(continued)

- DMAS is currently in the procurement process for the BHSA vendor
- However, the original implementation date of July 1, 2012 has been delayed due to legal issues affecting the procurement
- Once the legal issues are resolved and a contract is awarded, it is anticipated the BHSA vendor will assume the administrative functions within six - nine months of contract award