Mental Health America
Regional Policy Council

“State of Mental Health 2016”

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Secretary
Indiana Family and Social Services Administration
Great Challenges = Great Opportunity

- Slow Evolution of “Neurosciences”
- Population shifts (“dementia generation”)
- MH Costs rising 7%/yr (GDP=4.3%)
- Poor integration into general medical care
- Slow acceptance of EBM
- Healthcare “consumers” vs patients
- “reverse stigma”
- Transinstitutionalization
- No unifying voice for patients, advocates and providers + HC systems and payors
“Frozen to inaction”
“What if we don’t change at all ... and something magical just happens?”
“Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion”
Charles Roehrig et al, Health Affairs May 2016

- Data annually collected 1996 – 2013
- Mental Disorders: 1996 (2) $79B
  - 2013 (1) $201B
  - Heart Dz ($147B) and Trauma ($143B)
- 60% civilian
- 40% Active duty Military, ECF, SOF, DOC

“increased spending is not due to rise of Alzheimers and other dementia cases (4%), ...rather it was increases in spending on depression and anxiety (7%)”
Jails and Prisons are the new State Psychiatric system

- **Indiana:**
  - 1970 = 5% prison population with SMI
  - 1980 = 10%
  - 1990 = 15%
  - 2012 = 40%

  2006 Department of Justice study
  - 24% County inmates have psychosis
  - 26 days vs 51 days
  - 41% of behavioral infractions
  - 80% assaults on deputies
  - $130/d vs $80/d for non-mentally ill
Closing so many State Hospital beds was a mistake

- Acutely psychotic:
  - Can’t be safely managed in community
  - Involuntary hospitalization
  - Prone to victimization in other settings
  - Anosognosia – AOT/Involuntary treatment
  - (2562 Hoosiers with SMI who should be in AOT)

- 2008 consensus report that 50 public beds per 100,000 is minimal needed
  - $50 \times 6.6 \text{ m (66)} = 3300$ beds in Indiana
Uninsured with Mental Illness in States That Have Not Expanded Medicaid - 2014
Healthcare Consumerism:

- Movement which advocates patient involvement in their own HC decisions
- Move from “Dr Says/Pt Does” to partnership
- Involves transfer of knowledge so that pt can be informed
- Who pays? Move from “incentivized” 3rd party to consumer
- Consumers paying more – value proposition of ownership
2014 - State-wide Assessment

- SOF’s – isolated and stuck in custodial model
- CMHC’s – running independently
- Public didn’t work well with Private
- Systems duplicating efforts
- Extreme variation in care
- Over-reliance on block grants – stuck in FFS
- Uninsured
- Slow integration
FSSA Mental Health Transformation “Playbook 2014 - 2015”

- Recognize the states role and responsibility in funding care and services
  - HIP 2.0 (370,00 enrolled in first year) – MC rates + legacy increases
  - Embrace MH/SUD Parity – expand services
- Reorganize our SOF’s as a system
  - “One Hospital System with 6 campuses”
  - Systems Integration Council – September 2014
- Modernize our public assets for the future of healthcare
  - NDI as hub – focus on Neurodiagnostics
  - Leveraging technology – Video Presence + Telepsychiatry
  - New model of care – rapid through-put, shorter LOS
- Re-establish public continuum of mental health care
  - Hospital Systems + Private practices
  - Free-standing Psychiatric facilities
  - CMHC’s
  - SOF’s
- Promote Integration of primary medical and psychiatric care
- Submit Federal waivers (1115)
  - increase Medicaid covered services
  - lift IMD Exclusion
- Address Mental Health manpower needs
Medicaid Expansion

- ACA - projected that 30m of 54m uninsured would be “covered” under MK expansion
- Supreme Court Decision - can’t force states to expand Medicaid
- President’s Challenge
  - Entice states with 100% federal match 1st - 3 years
- 28 states + DC took $ - traditional Medicaid expansion
- Indiana has the most innovative alternative
HIP 2.0 Supports Integration

• A great success for Indiana patients and providers
  • Indiana-specific solution
    ▫ Establishes consumerism in an entitlement program
    ▫ Builds off of successful program (HIP 1.0)
  • Expands coverage AND improves access
    ▫ Raises provider reimbursement
    ▫ Increases patient incentives
    ▫ Addresses disparities – including mental health
  • Consumer-directed (ownership)
    ▫ Price transparency
    ▫ Patient/provider partnership
    ▫ Focus is on healthy individual outcome
HIP 2.0 vs. Medicaid Expansion

Health Improvement

Access

Coverage

Medicaid
✓ Successful Roll Out
  • Website operational and well received
  • 700,000 applications processed
  • Eligibility Determination - 20 day average
  • All eligibility re-determinations already completed

✓ Expanded Coverage **AND** Access
  • Total enrollment over 389,000
    o 68% in HIP Plus
  • 6300 new providers/locations joined IHCP

✓ Advertising campaign well received (14% increase)
✓ Eyes of the country on our experience
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Indiana Administrative and Legislative Actions to promote PCBH Integration

• Goal: To lower barriers
  ▫ HEA 1269 (2015) – allows PC billing in CMHC’s
  ▫ Telepsychiatry Coverage (2014-16)

• Goal: To expand access
  ▫ APN MK panels (500) – including CMHC’s
  ▫ 1115 SUD Waiver – add services
CMHC’s may bill for PC services

- **IC 12-15-11-8** allows CMCHs to bill Medicaid for primary health services provided to patients being treated for a mental health condition or addictive disorder.
- Allows primary care services and behavioral health services to be reimbursed for the same date of service when services are rendered by the appropriate provider and the visits are for distinct purposes.
- For more information, please see Indiana Health Coverage Programs provider bulletin **BT201587**. The bulletin, published on December 29, 2015, can be found on IndianaMedicaid.com.
Tele-psychiatry

• 2014
  ▫ Lifted the 20 mile restriction
  ▫ Pays the same fee as face to face
  ▫ Opens access for the FQHC/RHC PPS system

• 2015
  ▫ HEA 1269 – Parity provisions for telepsych

• 2016
  ▫ HEA 1263 - Can initiate an Rx remotely without first seeing patient face to face
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1115 Waiver proposal

**GOAL:** To fill in the gaps in the SUD continuum of care to improve treatment success rates by effectively transitioning individuals between levels of care and ultimately into sobriety.

<table>
<thead>
<tr>
<th>Proposed New SUD Waiver Services*</th>
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<tbody>
<tr>
<td><strong>1.</strong> Add Residential Treatment Services</td>
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<tr>
<td>• Include allowance of short term IMD stays to ensure adequate number of providers to provide new service</td>
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<tr>
<td><strong>2.</strong> Add “Addictions Recovery Management Services”</td>
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<tr>
<td>• Recovery Education</td>
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<td>• Peer Recovery Support Services</td>
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<td>• Housing Support Services</td>
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<tr>
<td>• Recovery Focused Case Management</td>
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<tr>
<td>• Relapse Prevention</td>
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<tr>
<td><strong>3.</strong> Expand Medicaid Coverage of Urine Drug Screening</td>
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* SEA 297 requires Medicaid to expand coverage of inpatient detoxification services for opioid or alcohol dependence in accordance ASAM or other criteria determined by the office. These expanded services will be added outside the waiver.
A Two Prong Reform Approach

1. Waiver to Build the Continuum of Care
   - Add SUD services to the Medicaid benefit package
   - Waive the IMD exclusion for the provision of short term IMD stays

2. MRO Reform
   - Replace fee for service reimbursement with bundled rates for some MRO services
   - Emphasis on habilitation over rehabilitation for long term MRO recipients
   - Greater oversight of MRO enrollment (MRT review, State review of diagnostic criteria)
MRO Payment Reform

• Move from Volume Based Purchasing to Value Based Purchasing
  ▫ Phase out fee for service reimbursement
  ▫ Replace with bundled rates to CMHCs for specific MRO services

• Pilot Program to Test Payment Reform
  ▫ Bundled MRO payments for individuals diagnosed with schizophrenia
    • Bundled payment to cover all MRO services required over a three month period for a member with schizophrenia
    • Transition period to ease transition to full risk bundled payment
Bundled Payments

• What is a bundled payment?
  ▫ Provides a single payment for all the services required for an entire specified clinical condition.

• How are bundled structured?
  ▫ Retrospective Payment Option
    • The provider will continue to bill on a FFS basis through the payment period.
    • At the end of the payment period, the aggregate expenditures are compared to the target price and then reconciled between the State and the provider.

  ▫ Prospective Payment Option
    • The state pays a single, prospective pre-established bundled rate to cover the full episode of care at the beginning of the defined payment period.
Other MRO Reform Considerations

• Habilitation
  ▫ Data suggests that long-term MRO recipients tend to use more MRO services than new recipients
    • This is contrary to the rehabilitation model
    • Transition individuals no longer progressing with MRO services to Adult Mental Health Habilitation (AMHH) waiver

• MRT Oversight
  ▫ Significant MRO utilization variances across all CMHCs
    • State Medical Review Team review of member placement

• Diagnostic Criteria & Standards
  ▫ Individuals with an ADHD diagnosis make up about 1/3 of total cost of MRO spending
    • State to review ADHD diagnostic criteria
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Historical – Indiana

• 1960 – 6000 beds in 13 SOF’s (130 beds/100K)
• 2010 – 880 licensed beds in 6 SOF’s (13 beds/100K)
  – $160M ($200,000/bed)
  – ALOS exceeds 2 years
• 25 CMHC’s
  – Gatekeeper (1970’s)

• Deinstitutionalization has become “Transinstitutionalization”
  – IDOC – 30,000 inmates (40% Axis I / 80% have SUD)
  – Police have become Crisis Mental Health workers
  – Municipal/County jails – detox/stabilize
  – ER’s
  – ECF’s
  – Homeless
Modernization

- **New facility** to replace LaRue D. Carter Memorial Hospital, titled the **Neuro-Diagnostic Institute and Advanced Treatment Center (“NDI”)**

- Designed as a **state-of-the-art facility** to provide an **modern** model of advanced diagnosis and assertive mental health care in Indiana

- First State Facility built in a generation
“New Model”

- **Focus on getting the Diagnosis Right**
  - September *Institute of Medicine* Report (10% deaths)
  - Neurodiagnostics and Genetic Testing + structured tools/interviews

- **Full Medical Integration**
  - No longer remote - tertiary and specialty medical care
  - Attached to large ED

- **State-wide Center of Excellence**
  - Tele-management
  - ECHO model of consultative care in home community

- **No longer require “Gatekeeping”**
  - Eliminate need for commitments
  - Referrals from Health Systems

- **Rapid Through-put**
  - ALOS 30 – 45 days
  - Build network of step-downs
    - Dedicated SNF units for medically ill
    - ECF for cognitive challenged
    - Residential
    - Home community-based programming
About Our Location and “Partner”

• Partnership with *Community Health Network*, co-located on the campus of *Community East Hospital* in Indianapolis (co-located model addresses the need for access to a primary care facility)

• Immediate and proximal acute medical intervention availability for NDI patients

• Synergy of Community East’s campus redevelopment and Community Health Network’s exhibited commitment to mental health in Indiana
Policies of the “Future”

- Move from “Transactional” to “Transformational”
- Modernize payment systems to drive incentives towards healthy competition and better outcomes
- Reduce expenditures on programs that “don’t work” and invest those resources in to programs that produce desired results
- “Re-slicing” the payment pie will be painful but will build sustainability
- Involve all relevant provider groups in the development of policies – end users make it work!
- Require creative collaborations and novel partnerships (NDI)
Integration Initiatives through DMHA

• DMHA identified integration as a priority in its 2012 SAMHSA Block Grant (combined Mental Health and Addiction application)

• Partnered with Indiana State Department of Health to create a State Integration Team (SIT)

• Formation of Statewide Stakeholder group

• Created five stakeholder lead sub-committees;
  • Data/Technology, Workforce Development, Funding/Reimbursement, Quality, and Policy/Future opportunities

• Developed and established PCBHI Strategic Plan, Implementation strategies, and Operations Manual
PCBHI Certified Providers

Eligible for State certification for agencies providing \textit{integrated care} across public healthcare systems:

- Community Mental Health Center (CMHC)
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)
- Community Health Centers (CHC)
PCBHI Infrastructure

- Operations Manual - nuts and bolts
- Integrated Care Entity (ICE) Certification process linked to Medicaid Specialty Type
- Data/Technology Infrastructure Tool selected
  - Case Management Technologies (CMT) – ProAct
  - data analytic tool
- Quality measures selected – link to Quality Bonus and/or Pay for Performance (value-based)
Certified Community Behavioral Health Clinic (CCBHC) Planning Grants

- One year planning Grant – SAMHSA and CMS Partnership for Planning and Demonstration
- Indiana received $982,373
- Leveraged PCBHI/ICE design and framework to develop application for CCBHC planning grant
- Designed CCBHC infrastructure to align with ICE infrastructure- (certification process, key data elements, performance/quality measures, data analytics, and most standards)
Three sites (two urban/one rural) have been identified as Indiana CCBHC sites.

- Regional Mental Health Center (East Chicago)
- Porter Starke Services (Starke County Office)
- Eskenazi Health/Midtown CMHC (Indianapolis site)
CCBHC Status

- Cost Reports have been submitted by all 3 selected CCBHC sites
- PPS Rate Development is under way through state actuary vendor
- Data Sharing and Infrastructure Development is underway. FSSA DTS in collaboration with vendor CMT using their ProAct data analytic tool.
- Certification – State meets with each site monthly and together every other month; site visits will begin in June 2016
- CCBHC Demonstration Grant Application due fall 2016