

1115 WAIVER RENEWAL –

KEY ISSUES FOR COMMUNITY BEHAVIORAL HEALTH PROVIDERS

Below is a list of key objectives for community behavioral health providers in the 1115 Waiver Renewal discussions. We do not know what the proper mechanisms and terms and even work groups are to achieve them but we hope that DHCS staff, consultants and other stakeholders will work with us to incorporate these concepts which all contribute to the triple aim of better healthcare, better health and reduced costs.

1. Coordinated Physical Healthcare for adults and youth with severe mental illnesses and other chronic health care problems

Among all disease categories within the MediCal population those diagnosed with schizophrenia have about the highest average physical healthcare costs. They, and other Medicaid recipients with severe mental illnesses, have several times the average rate of all major chronic physical illnesses. Most do not have a relationship with a regular primary care practitioner to provide or arrange for the care they should be getting.

Developing individual care coordination strategies are needed to provide that care for these individuals and others who are receiving extensive behavioral health care through a community behavioral health provider. That group should include all of adults they serve with a disabling mental illness and youth who have diabetes or asthma, who do not have an established successful relationship with a primary care provider.

Providing this care will represent a cost to primary care providers and to the behavioral health provider. Those costs should be more than offset through savings in physical health care hospitalizations and other high cost services.

The financing model for this should incorporate the health home option and a shared savings component. A portion of the federal and state savings being should be made available as incentives to the behavioral health and primary care providers through the physical health and behavioral health managed care entities that they each contract with and whom would have an MOU to detail how the two managed care entities would share the savings that the state realizes and the federal savings that are shared with the state.

Calculating the projected and actual savings could be based on actual claims data for the periods before the program started and for trends among similar populations who are not in these programs during the first few years when not all are in the program.

2. Screening and Initiation of Behavioral Healthcare as identified for all individuals seen in primary care or emergency rooms

Only one in three people with a behavioral health problem seek care for that condition. The result is that there is on average a six year delay between the onset of symptoms and the initiation of treatment (from a 2003 White House Commission report) with over 90% of people who enter the public mental health system having “failed first” through a hospitalization, special education, child welfare or criminal justice encounter. Mental Health America notes that it is akin to saying we ignore cancer until it is stage 4 and they have started a new B4Stage4 campaign.

Estimates are that one third to half of all Medicaid recipients who go to a physician for any purpose, also have a behavioral health problem that has not been diagnosed or treated. Many pilot programs have been developed to address this problem and the common features of all of them are the same. They involve screening everyone who enters the health care system through primary care (and through emergency rooms for those who have not recently seen a primary care provider). If the initial screen is positive and more detailed screen is performed and if that is positive then a “warm handoff” to a behavioral health clinician – ideally co-located but always reached in some manner during that same visit.

Studies of the results of these programs show that there are added costs for the primary care provider and for outpatient behavioral health. The outpatient behavioral health costs are usually offset about equally with savings in reduced behavioral health inpatient costs.

The total costs of both behavioral health and primary care are more than offset through reduced physical health hospitalizations and use of specialty care and pharmacy.

There should be a shared savings program with appropriate incentives so that savings can be shared among all involved entities- the federal, state and county governments, the physical and behavioral health managed care entities, and the physical health and behavioral health providers.

Measuring the savings probably requires analysis of past years claims, a set of projected costs and trend analysis from the current system and from populations not implementing it initially.

This should be built into the 1115 Waiver in order to capture potential federal saving that can be shared and then to develop the models for implementation through new contract terms and continuing work groups in each county as there will be challenges in creating the necessary new relationships between primary care providers and behavioral health providers.

3. Include Section 1915 (i) elements such as transportation, employment support and respite care for individuals with severe mental illnesses

The Medicaid Section 1915 (i) Home and Community Based Services Option was originally developed primarily to provide additional services not covered by the rehabilitation option to address the needs of a narrow state specified population of individuals with severe mental illnesses. However, it was written more generally and California already used that authority to serve a different population and each state may only have one Section 1915 (i) option benefit program. While there might be ways to modify the current population to include individuals with severe mental illness, those objectives can also be achieved through an 1115 Waiver following the lead of the state of New York.

The main benefits of this option is to gain federal financial participation for certain supportive services which are important in the recovery for individuals with severe mental illness but are not covered by the rehabilitation option. These include transportation to services, employment support and respite care.

These services are already part of the treatment plan for many individuals with severe mental illnesses and their inclusion helps to advance recovery and thereby reduce the extensiveness of disability. They also contribute to reducing hospitalizations which should make them a contributing factor to an 1115 Waiver. Currently these services are provided totally at county expense. The 1115 Waiver renewal provides an opportunity to gain federal financial participation and that should be made a part of this waiver.