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February 4, 2016

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Senate Bill 293/Assembly Bill 408: Behavior Health Coordination Pilot Project, Psychiatric Consultation Pilot Project, and Psychiatric Hospital Bed Tracking

Senate Bill 293 was introduced on October 9, 2015, and referred to the Committee on Health and Human Services. On October 13, that Committee recommended the bill for passage on a vote of 5 to 0. On October 20, the Senate passed the bill on a 30 to 0 vote and messaged it to the Assembly, where it was referred to the Joint Committee on Finance.

Assembly Bill 408 was introduced on October 13, 2015, and referred to the Committee on Mental Health Reform. On December 12, that Committee recommended the bill for passage on a vote of 12 to 0. On December 22, the bill was referred to the Joint Committee on Finance.

SUMMARY OF BILLS

Senate Bill 293 and Assembly Bill 408 include three initiatives related to behavioral health: a behavior health coordination pilot project for medical assistance (MA) beneficiaries with significant and chronic mental illness; a psychiatric consultation reimbursement pilot project to facilitate consultation services for health care providers serving MA beneficiaries; and a psychiatric hospital bed tracking system to disseminate information on the availability of open psychiatric beds.

Behavioral Health Coordination Pilot Project. The bills would require the Department of Health Services to administer a behavioral health coordination pilot project no earlier than January 1, 2016, subject to the approval of the federal Department of Health and Human Services of any required waiver of federal Medicaid law or any required amendment to the state's MA plan. The bills would require the Department to develop and award at least two pilot projects to health care providers lasting no more than three years each to test alternative, coordinated care delivery and MA payment models designed to reduce costs for the care of MA beneficiaries who have significant and chronic mental illness. The Department would be required to allocate $600,000 in

state funds, plus any federal matching funds, for all three-year pilot projects, subject to federal approval. The bills would provide $400,000 GPR in the 2015-17 biennium ($200,000 GPR annually) in a newly created, continuing appropriation for the pilot projects. [Although the bills would provide $266,600 in 2015-16 and $266,700 in 2016-17 in the appropriation, the appropriation would also be the funding source for the psychiatric consultation reimbursement pilot program.] The Department would be required to seek federal matching funds for the pilot program.

The Department would be required to award the pilot projects and allocate funding only to health care providers that provide all of the following services directly or through an affiliated entity: (a) emergency department services; (b) outpatient psychiatric services; (c) outpatient primary care services; (d) inpatient psychiatric services; (e) general inpatient hospital services; and (f) services of a care coordinator or navigator for each individual in the pilot project. In addition, the health care provider must provide, either directly or through an affiliated or contracted entity, the coordination of social services fostering the individual's recovery following an inpatient psychiatric discharge.

The health care provider that is awarded a pilot project would be required to target an MA population of high volume or high intensity users of non-behavioral health medical services, such as individuals who have frequent or longer than average inpatient hospital stays, who also have chronic mental illness.

Under the program, each participating provider would receive either a MA payment on a per member per month basis for a specified pilot project population or a MA payment for a specified pilot project. The bill specifies that a per member per month payment would be received in addition to existing fee for service or managed care payment fee for MA services.

The Department would be required to require health care providers that are awarded a pilot project to submit interim and final reports analyzing differences in utilization of services and MA expenditures between individuals in the pilot project population and individuals in a control group that is agreed upon by the health care provider and the Department. An interim report would be submitted by January 1, 2017, and a final report by January 1, 2019. An additional final report would be submitted at the conclusion of the pilot project if the project concludes later than January 1, 2019. The Department would be required to provide the health care provider with MA utilization and expenditure data necessary to create the reports.

The bills would specify that the term "health care provider" would not include a health maintenance organization for the purposes of the pilot program. The Department would be prohibited from limiting eligibility for the pilot project or awards on the basis that the health care provider that is awarded the pilot project serves a target population that included individuals enrolled in an MA health maintenance organization.

Psychiatric Consultation Reimbursement Pilot Project. The bills would require the Department of Health Services to develop and award a pilot project lasting up to three years to test a new MA payment model for adult psychiatric consultations by psychiatrists to health care

providers treating primary care issues and to selected specialty health care providers to help those providers manage and treat adults with mild to moderate mental illness and physical health needs. The Department would be required to allocate $200,000 in state funds, plus any federal matching funds, for the pilot project. The bill would provide $66,600 GPR in 2015-16 and $66,700 GPR 2016-17 in a newly created, continuing appropriation for the pilot project. The Department would be required to seek federal matching funds for the pilot program.

The pilot project could be awarded only to a health care provider that is an organization that provides outpatient psychiatric services and primary and specialty care outpatient services for physical health conditions. For the purposes of this pilot project, a health maintenance organization would not be considered a health care provider. Funding could be allocated to the health care provider or to individual psychiatrists providing care within the organization of the health care provider. The Department may limit the award to specific providers or clinics within the multispecialty outpatient clinic organization. The applicant for the pilot project would be required to submit a strategy to use the pilot project funding to improve mental health access in the applicant's service are and to reduce overall MA costs.

As with the behavioral health coordination pilot project, the Department would be required to require health care provider that is awarded the pilot project to submit interim and final reports analyzing differences in utilization of services and MA expenditures between individuals in the pilot project population and individuals in a control group. An interim report would be submitted by January 1, 2017, and a final report by January 1, 2019. An additional final report would be submitted at the conclusion of the pilot project if the project concludes later than January 1, 2019. The Department would be required to provide the health care provider with MA utilization and expenditure data necessary to create the reports.

The Department would be required to implement the pilot project no earlier than January 1, 2016, subject to the approval of the federal Department of Health and Human Services of any required waiver of federal Medicaid law or any required amendment to the state's MA plan.

Inpatient Psychiatric Bed Tracking. The bills would require the Department to award a grant of $80,000 in 2015-16 and $30,000 in 2016-17 and annually thereafter to an entity to develop and operate a website and system to show the availability of inpatient psychiatric beds statewide. To receive the grant, the entity would be required to use a password-protected website to allow an inpatient psychiatric unit or hospital to enter, and enable any hospital emergency department in the state to view, all of the following information: (a) the number of available child, adolescent, adult, and geriatric inpatient psychiatric beds, as applicable, currently available at the hospital at the time of reporting by the hospital or unit; (b) any special information that the hospital or unit reports regarding the available beds; (c) the date that the hospital or unit reports this information; (d) the location of the reporting hospital or unit; and (e) the contact information for admission coordination for the hospital or unit. The bill would provide $80,000 GPR in 2015-16 and $30,000 GPR in 2016-17 in a newly created, annual appropriation for the purpose of making the grant.

FISCAL EFFECT

The bills would provide total GPR appropriations of $346,600 in 2015-16 and $296,700 in 2016-17 for the three proposed programs. Funding would be allocated as follows: (a) $200,000 annually for the behavioral health coordination pilot project; (b) $66,600 in 2015-16 and $66,700 in 2016-17 for the psychiatric consultation reimbursement pilot project; and (c) $80,000 in 2015-16 and $30,000 in 2016-17 for the psychiatric bed tracking internet website development and operation.

Behavioral Health Coordination Pilot Project. For the behavioral health coordination pilot project, the total amount of funding available for services would depending on the availability of federal matching funds. In its fiscal estimate for the bills, the Department notes that the pilot project may qualify as a "health home" under provisions of federal law. Qualifying health home services may receive a 90% federal match for the first eight fiscal quarters that a health home state plan amendment is in effect, instead of the standard federal matching percentage, which is approximately 58% for Wisconsin.

The Patient Protection and Affordable Care Act of 2010 established the health home program to encourage states to offer more intensive care coordination and management for individuals with chronic conditions, including behavioral health conditions. Among the goals of the health home service delivery model are a reduction in the use hospital emergency department services, hospital admissions, are a reduction in the use of long-term care services. The enhanced matching is available for specified services, such as care coordination, patient and family support, and referral to community support services, and not for underlying Medicaid services, such as physician and hospital services. Since the bills do not specify the types of services that would be provided under the pilot program, it is not possible to determine the proportion of state funding that would be spent on services qualifying for the enhanced matching rate. However, if all expenditures under the behavioral health coordination initiative were to qualify under the federal program, the Department could have a total of $2,000,000 annually for two years for the pilot program ($200,000 GPR and $1,800,000 FED). Without enhanced matching, the state would have approximately $482,000 available annually ($200,000 GPR and $282,000 FED).

The bills would give the Department discretion to develop a reimbursement methodology for the behavioral health coordination pilot project. If reimbursement is provided on a monthly capitation basis, then the bills specify that this payment must be made in addition to existing payments for providers, including services reimbursed on a fee-for-service basis and services provided under managed care. To the extent that the pilot project accomplishes its objectives of improving patient health and, in turn, reducing the utilization of medical services, the initiative could result in reduced expenditures for medical services. This could reduce MA program benefit expenditures if those services would otherwise be reimbursed on a fee-for-service basis. If the participating MA beneficiaries are enrolled in health maintenance organizations (HMO), any savings associated would initially accrue to the HMO, but may be factored into the determination of future capitation rates.

Given the wide range in the amount of federal matching funding that could be available for

the pilot project and the fact that many of the details of the initiative, including the services that would be provided and the reimbursement methodology that would be used, are not specified, it is not possible to determine how many MA beneficiaries would be able participate in the program.

Psychiatry Consultation Pilot Project. As with the behavioral health coordination pilot project, the bill would require the Department to seek federal Medicaid matching funds to increase the total amount of funding available for the psychiatry consultation pilot project. If the initiative qualifies for matching funds, a total of approximately $160,500 could be available annually for the three-year demonstration (assuming the standard federal matching rate applies). Currently, the MA program does not reimburse specialists for consultative services, so it is not known whether federal policy would allow for a separate reimbursement of interprofessional consultative services provided without a waiver. If no federal matching funds are available, the Department would have only the $200,000 ($66,700 annually) in state funds available over the three-year period for the program. By comparison, the Department spends $500,000 GPR annually for a child psychiatry consultation program. The Department provides this funding to the Medical College of Wisconsin to provide consultative services in Milwaukee County and several northern Wisconsin counties.

Inpatient Psychiatric Bed Tracking. The funding provided for inpatient psychiatric bed tracking is intended to support the one-time development costs, as well as ongoing operational costs, of an internet website. The amount of funding provided by the bills is based on the amount provided by the Minnesota Department of Human Services to build a similar system in 2006 ($50,000 for development and $30,000 for annual operating costs). The bills would provide the funding in an annual appropriation (unlike the appropriation for the two pilot projects, which is a continuing appropriation). Consequently, any funding that is not obligated for development or operating costs at the end of the fiscal year would lapse to the general fund.

Department of Health Services Administrative Costs. In its fiscal estimate, the Department indicates that the bills would require modifications to the Medicaid Management Information System in order to accommodate a new reimbursement system under the behavioral health coordination pilot project. The Department estimates that these changes, which would be done by the state's MA program fiscal agent, would cost $50,000, and would be split evenly between GPR and FED sources. The Department indicates, however, that the costs could be absorbed within existing appropriations. The Department also indicates that the costs associated with staff time needed to implement provisions of the bills could be absorbed within existing resources.

Prepared by: Jon Dyck