COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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December 1, 2014

MEMORANDUM

TO: The Honorable Charles J. Colgan
Co-Chairman, Senate Finance Committee

The Honorable Walter A. Stosch
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones Cynthia Jones
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on the Impact of the Mental Health Skill Building Services Regulations

The 2014 Appropriations Act, Item 301 #2s, requires:

> *"DMAS and the Department of Behavioral Health and Developmental Services shall jointly prepare a report to be delivered by November 1, 2014 to the Chairmen of the House Appropriations and Senate Finance Committees. The report shall document the impact of the MHSS regulations implemented on December 1, 2013 and shall include an assessment of the fiscal impact, consumer and family impact, service delivery impact, and impact upon other agencies and facilities in Virginia."*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Department of Medical Assistance Services
Report to the Chairmen of the
House Appropriations and Senate Finance Committees

Impact of Regulatory Changes to Mental Health Skill Building Services
Implemented on December 1, 2013

November 2014

Report Mandate

The 2014 *Appropriations Act*, Item 301 #2s, requires:

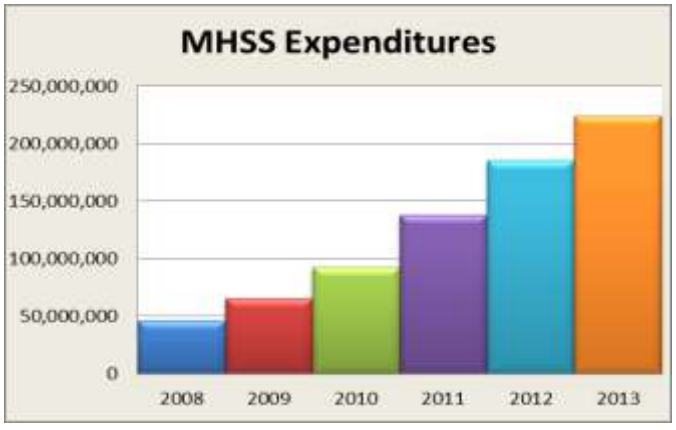
> *"DMAS and the Department of Behavioral Health and Developmental Services shall jointly prepare a report to be delivered by November 1, 2014 to the Chairmen of the House Appropriations and Senate Finance Committees. The report shall document the impact of the MHSS regulations implemented on December 1, 2013 and shall include an assessment of the fiscal impact, consumer and family impact, service delivery impact, and impact upon other agencies and facilities in Virginia."*

Background

The 2012 and 2013 *Acts of the Assembly* directed the Department of Medical Assistance Services (DMAS) to make programmatic changes and to consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. DMAS was directed to promulgate regulations to implement these changes within 280 days or less from the enactment of this date, or June 11, 2012. This language has been in place to allow for the Department to implement necessary program integrity components to ensure effective program operation.

Mental Health Support Services, or MHSS, is a Medicaid-funded community mental health rehabilitative service. Over the past several years, DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) noticed rapidly increasing costs and quality of care concerns which were documented during licensing reviews and financial audits of service providers. Chart 1 illustrates MHSS program expenditures increased by $178 million, which was an increase of 384 percent from FY 2008 through FY 2013.

Chart 1



In its responsibility to ensure the integrity and cost effectiveness of this service, DMAS used emergency regulatory authority to implement changes to MHSS on December 1, 2013. MHSS was renamed as Mental Health Skill Building Services (with the same acronym) and significant programmatic changes were made that clarified service eligibility, medical necessity criteria and the scope of allowed services.

DMAS audits and DBHDS Licensure reviews showed a considerable portion of these services were not in compliance with the requirements and purposes for MHSS. Examples of service misuse are described below.

- Licensing and provider billing patterns demonstrated many providers of children's behavioral health services shifted to provide MHSS for adults beginning in 2010. (Prior to this time, only 100 providers offered this service. By the time changes were made to MHSS, the number of providers had tripled to 312 in less than two fiscal years.)
- The reduction of IIH and TDT billing by private sector providers was immediately matched by an increase in billing for MHSS as providers rapidly pivoted from provision of these services to MHSS. An almost identical set of problems occurred with this service, including inappropriate individuals served and services being delivered with a non-clinical purpose. While there are many excellent providers and these have been the ones most active in constructive efforts to improve and regulate MHSS, some providers did grave damage to the viability and affordability of this service.
- DBHDS' participation with DMAS to limit these abuses and growth followed the same path as with IIH and TDT: clarification of eligible provider qualifications, clarifying mental health disorder and age requirements for client eligibility, and requirements for proper treatment planning and documentation.

MHSS is a service that was designed to provide training in symptom management and use of community resources for those individuals that have struggled in the past to remain successfully in the community. The revised MHSS service model returns the program to the service model that was originally intended when it was developed. Consequently, to assure that services comply with the requirements of the services and to reduce inappropriate program use, the service descriptions eligibility criteria and other regulatory matters were adjusted – with extensive stakeholder input. The MHSS Workgroup included stakeholders from DBHDS, the Virginia Association of Community Services Boards, NAMI of Virginia, VOCAL of Virginia, various independent private behavioral health providers, the Virginia Association of Community Based Providers and the Virginia Network of Private Providers.

On December 1, 2013, Magellan of Virginia began serving as the DMAS Behavioral Health Service Administrator, the same day that MHSS' regulatory changes went into effect. The MHSS eligibility and programmatic changes along with the new BHSA care coordination processes has resulted in some decreases in the overall MHSS utilization.

Chart 2 describes the scope of the regulatory changes implemented on December 1, 2013.

Chart 2

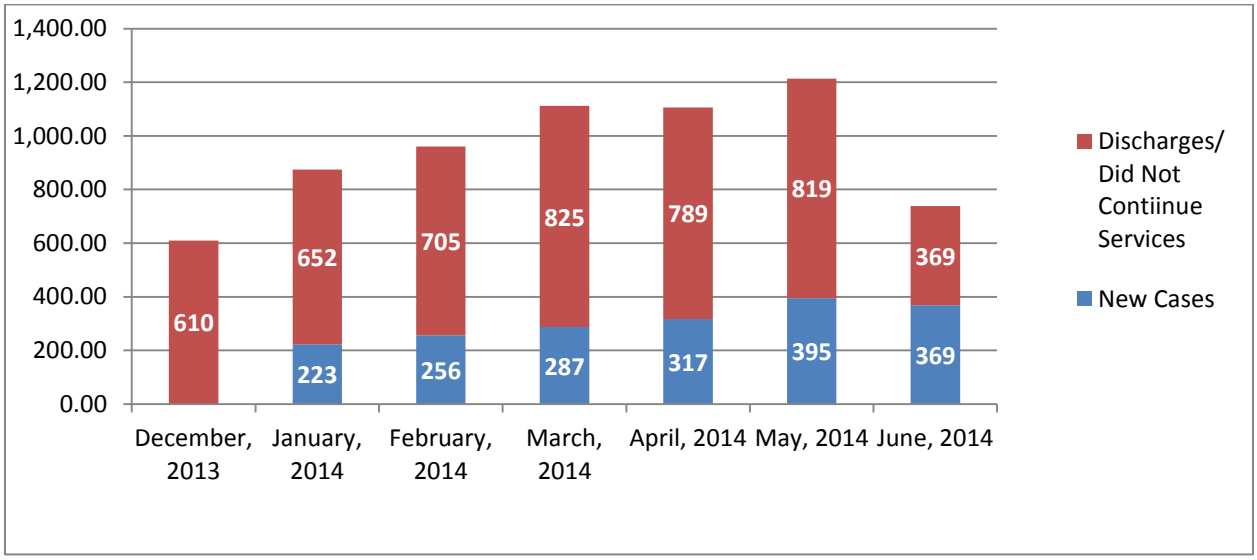
Date of Action	**Administrative Code Sections Affected**	**Administrative Code Sections Affected**
	12VAC30-50-226 (Program Scope and Definitions)	12VAC30-60-143 (Utilization/Quality Requirements)
10/10/2013 Regulatory Change 10/31/2013 Medicaid Memo 12/1/2013 Effective date	• Changed name to Mental Health Skill -Building Services, • Extensive revision of the medical necessity criteria ensures services are provided to persons with serious mental health disorders and significantly defined service histories both of which are required to qualify for the program. • Required assessing training needs and provision of training services in the services plan to qualify for reimbursement.	• Requires providers of MHSS to be licensed which has more clinical staff requirements than previous allowances • Eliminated the use of the less clinically focused In- Home Supports license • Eliminated the recognition of Supportive In Home and Intensive and Assertive Community Treatment licenses • Require that service plans and initial and ongoing assessments be conducted by an LMHP. • Disallowed MHSS from being provided by the same agency that operates the Group Home or Assisted Living Facility agency where the member resides. • Limited the provision of MHSS to persons receiving various Medicaid Waiver services. • Excluded certain diagnoses including delirium, dementia and other cognitive disorders from receiving services.

Impact of Regulatory Changes

At the time of this report, it is early to determine the overall cumulative impact of the program changes as a majority of service authorizations that were under the old MHSS requirements did not end until June 2014. A minimum of a year's data is needed to more accurately predict the outcome of the regulatory changes. However, for the purposes of this report, a preliminary analysis was completed with the baseline measures of program growth prior to, and subsequent to December 2013 (Fiscal Years 2009 – 2014). The first quarter data for FY 2015 regarding the number of beneficiaries served and expenditures was not yet available at the time of this report.

Chart 3 shows an average of 683 persons, or six percent of the monthly members, did not pursue an extension of MHSS after December 1, 2013. During the same time period an average of 246 persons per month initiated the service as new recipients of MHSS. According to stakeholder input the reduction in persons served is largely due to changes in the medical necessity criteria/service eligibility criteria.

Chart 3 – Number of MHSS Participants Initiating or Discharging From Service, By Month



Charts 4 and 5 show the changes in the number of beneficiaries served per month and expenditures for MHSS each month prior to and after the MHSS regulatory changes.

Chart 4 - Average Monthly Total Service Cost Per Fiscal Year

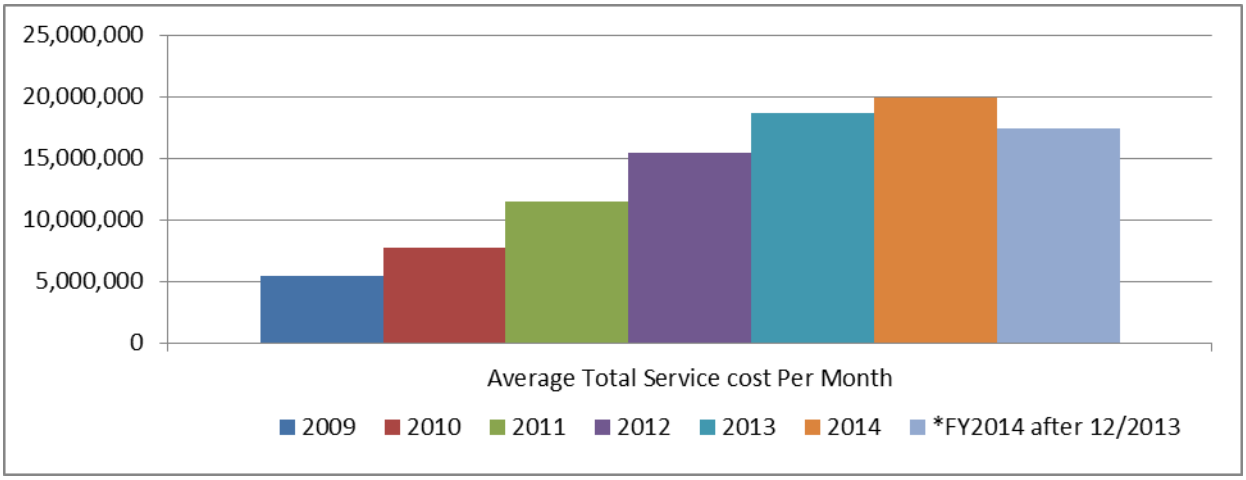
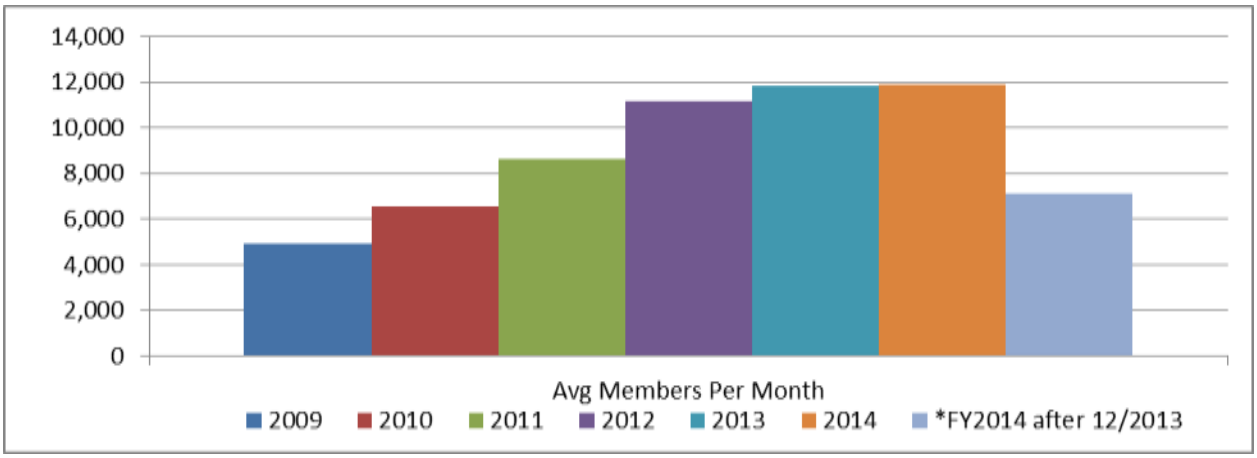


Chart 5 - Average Number of Individuals Served Per Month Per Fiscal Year



Initial Stakeholder Impressions of Impact

This summer, DMAS reconvened the MHSS workgroup to discuss the impact of regulatory changes made on the service delivery system. Initial stakeholder thoughts are below:

- Stakeholders report an emotional impact to family members and caregivers when services are discontinued. They also described several case examples where individuals who did not meet the new MHSS level of service had few options for other services. In addition, they reported that a service like peer supports would be beneficial for this population.
- The stakeholder group also reported a few cases that experienced some instances of hospitalizations after their discharge from MHSS. However, from the examples and data provided later in this report, a direct correlation between loss of MHSS and an increase in hospitalizations cannot be made.

- Stakeholders expressed a variety of concerns about how the changes to the MHSS medical necessity criteria have produced a service that is more difficult to staff. DMAS only recognizes the DBHDS MHSS service license for this service. Providers stated this limited their ability to use individuals with different educational backgrounds.
- Providers report a more cumbersome intake assessment procedure which is needed to document the new eligibility requirements.
- The VACSB reports that the CSB system has lost staffing due to the eligibility changes for MHSS and the resulting reduction.

DMAS and DBHDS will continue to work with stakeholders to identify issues resulting from the regulatory changes and possible solutions to address them.

Preliminary Data Results – Acute and Inpatient Psychiatric Admissions and Crisis Services

Given the initial discussions with stakeholders, DMAS and Magellan analyzed the potential increases in acute and inpatient psychiatric admissions for individuals whose services were discontinued after December 1, 2013. The Medicaid data in Chart 6 below appears to suggest that, in general, the individuals who were authorized for MHSS continually after December 2013 used acute care hospital services more frequently than the individuals who were discharged from MHSS.

Conversely, persons discharged from MHSS, generally have experienced less hospitalizations than those who remained approved for the service since December 2013. This is an improvement in reducing inpatient care to those who were discharged from the service, the persons who remained active with MHSS did not experience any different admission rates pre and post December, 2013.

Chart 6 - Average Monthly Acute Care Inpatient Admissions Discharged Cases

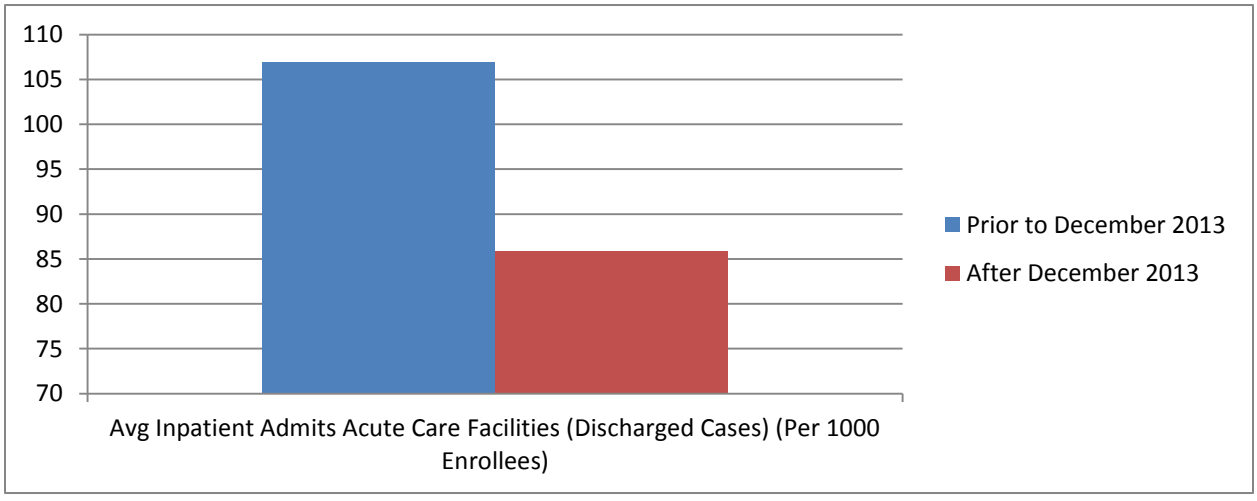
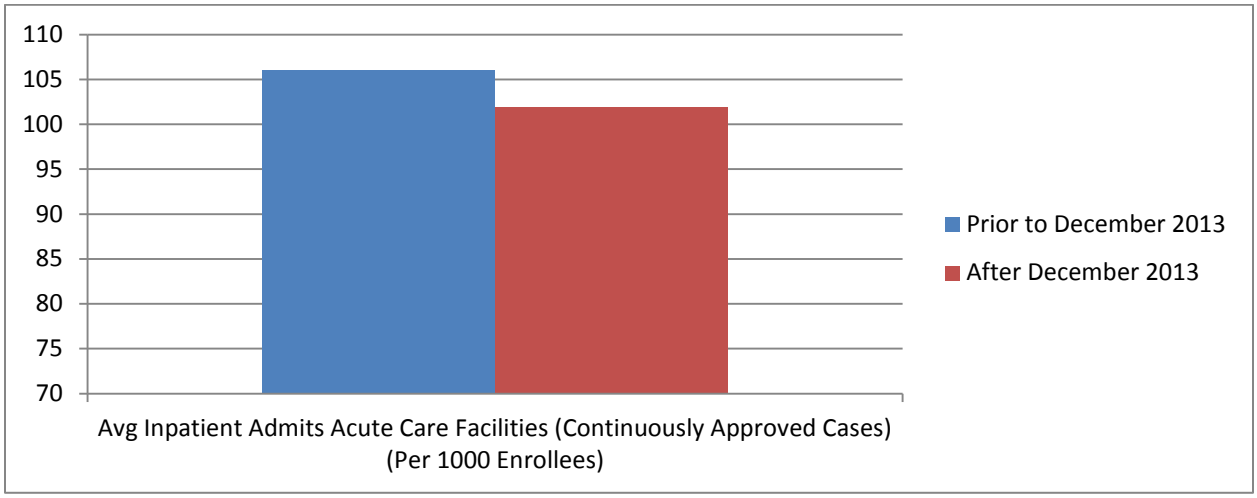
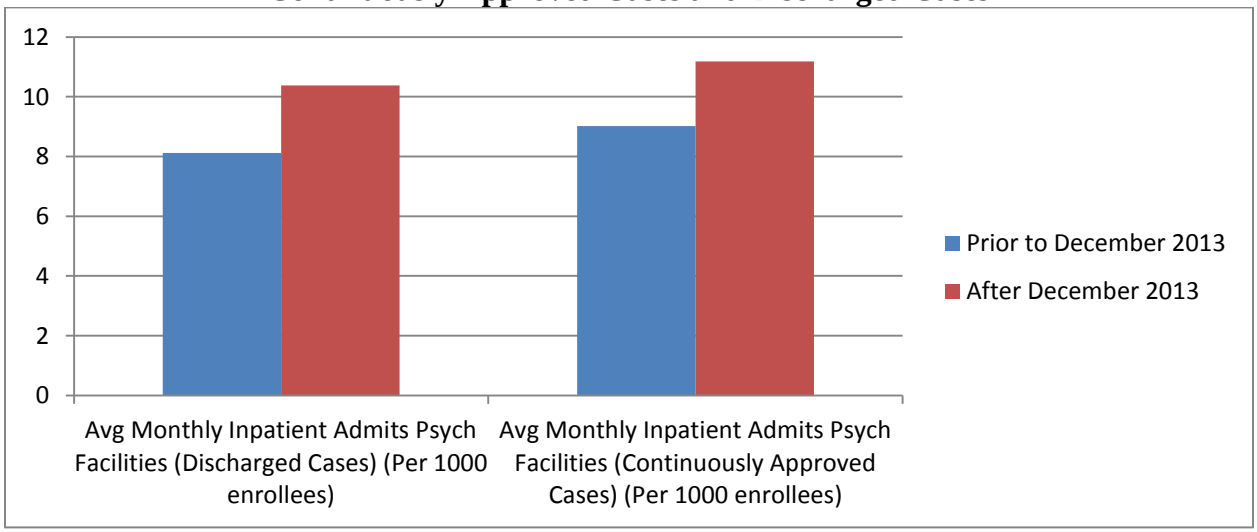


Chart 7 - Average Monthly Acute Care Inpatient Admissions
Continuously Approved Cases



In addition, Chart 8 below indicates that individuals who were authorized for MHSS continually after December 2013 generally used psychiatric hospital services more frequently than the individuals who were discharged from MHSS. It should be noted that inpatient utilization increased at the same rate for both groups in equal amounts; however, the continuously approved group remained as the higher users of inpatient psychiatric services. This data does not take into account inpatient admissions with State Mental Health hospitals but that will be analyzed with DBHDS over the next year.

Chart 8 - Average Monthly Psychiatric Inpatient Admissions
Continuously Approved Cases and Discharged Cases



One point to note is the data indicates after December 2013, the individuals who were discharged from MHSS used crisis stabilization services more frequently than the individuals who were continually authorized for MHSS. However, the data also seems to show that the persons who were continually authorized for MHSS also used crisis services significantly more before December 2013 than after MHSS program changes were implemented. It cannot be determined if there is a direct correlation to the use of crisis stabilization services due to discontinued use of MHSS, as there has been an overall increase in the use of crisis stabilization services over the last three fiscal years.

Conclusion

MHSS regulatory changes made in December 2013 to address program integrity and cost effectiveness concerns appear to be reducing the number of individuals who are using the service and the expenditures associated with it. Since the changes took effect, the average number of persons receiving MHSS decreased to approximately 6,600 per month compared to 11,900 per month prior to December 2013. This number is now close to the average number of people who were being served prior to the dramatic growth that began after 2009. However, it is premature to conclude significant meaningful inferences on the total impact of the program changes at this time. The following issues are the primary topics DMAS will consider with DBHDS to determine if further action is warranted based on the available stakeholder input:

1. The revised medical necessity and service eligibility criteria created a situation where some individuals who previously averted inpatient care or crisis services may no longer qualify for MHSS. It was reported that MHSS was the core service that prevented them from being admitted to a higher level of care. DMAS is encouraging providers to notify Magellan or the Department when such situations occur and there is a concern for an individual's health and safety.
2. The revised medical necessity criteria created a service that is targeted exclusively to a higher need population. The MHSS workgroup achieved its goal of returning the program to its original intended purpose, to serve those individuals with severe mental illness. However, a gap remains in available support services for individuals with SMI which needs to be addressed or there may be potential to experience increased inpatient and crisis service utilization.
3. Stakeholders expressed a desire for DMAS to develop a new service to address the gap created by the revised service eligibility criteria. There should be lower level of care available to adults who meet the diagnostic criteria and demonstrate significant functional impairments but do not qualify for the MHSS level of care.

DMAS, DBHDS and Magellan of Virginia will continue to collaborate with stakeholders to assess the needs of specific cases and consider potential changes to the MHSS eligibility criteria as well as the possibility of the system's need for lower level services, such as peer supports.

The Department will also continue to analyze and monitor MHSS program data to determine the full impact of the December 2013 program changes.