Sent: Tuesday, January 15, 2013 4:07 PM
Subject: Mental Health Redesign Comment Deadline

Please find the attached Dear Tribal Leader letter re: Mental Health Redesign dated December 20, 2012. This letter requested input on what the new behavioral health system should include. To date, we have received minimal input and have extended the date for submitting comments to January 30, 2013.

Please submit comments by January 30, 2013 to Colleen F. Cawston at (360) 902-7816 or colleen.cawston@dshs.wa.gov.

The comments received will be shared with the Tribal Centric Mental Health Workgroup at the meeting scheduled for Tuesday, February 5.

Please contact the Office of Indian Policy should you have any questions about this request for input.

Thank you in advance.

Teresa Guy
Department of Social and Health Services
Office of Indian Policy
PO Box 45105 Olympia, WA 98504-5105
Phone: 360-902-7706
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Email: teresa.guy@dshs.wa.gov

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Indian Policy Advisory Committee
P.O. Box 45105, Olympia, Washington 98504-5105

December 20, 2012

Dear Tribal Leaders,

In formal consultation with Washington's Tribes, the Department of Social and Health Services (DSHS) and Health Care Authority (HCA) have committed to work with Washington's Tribes through representatives of the Indian Policy Advisory Committee (IPAC), American Indian Health Commission for Washington State (AIHC), and Northwest Portland Area Indian Health Board (NWPAIHB) to develop a new behavioral health system for American Indian/Alaska Native (AI/AN) people enrolled in the Medicaid program.

The redesign will first focus on developing a new mental health service delivery system. Later, the project will be expanded to include integrated chemical dependency (CD) services as a significant component. This will insure that the new system addresses the co-occurring behavioral health needs of AI/AN people.

In July 2012 IPAC, AIHC, NWPAIHB, DSHS and HCA reconvened a workgroup to begin developing the new system. The regular meetings of the workgroup are the first and third Tuesday afternoons of the month. The workgroup identified a set of 8 near-term tasks to improve care for AI/AN people eligible for Medicaid services through the Regional Support Networks (RSN). These improvements, which are outlined in the enclosed paper, will be components in the new system. Subcommittees are now working on these tasks, which we hope to have completed by July 2013.

The workgroup also identified key components for the new system. The enclosed paper has been prepared for Tribal leaders, health directors and mental health program directors and providers to provide background information on the existing Medicaid mental health system for AI/AN people and attributes for the new system that the workgroup has identified.

We are requesting that you would provide us your ideas on what the new behavioral health system should include to better serve your members, other AI/AN people that you serve, and AI/AN people who live in other areas. We are also asking our urban Indian health program to provide us their ideas on what the new system should be.

We are requesting your input for our first meeting in January, therefore if you can send comments by January 8, 2013 to: Colleen F. Cawston, Senior Director Office of Indian Policy, colleen.cawston@dshs.wa.gov or 360-902-7816.

Sincerely,

Liz Mueller, Chair
Indian Policy Advisory Committee

Marilyn Scott, Chair
American Indian Health Commission

Enclosure

cc: IPAC Delegates
AIHC Delegates
Robin Arnold Williams, Secretary DSHS
MaryAnn Lindeblad, Director HCA
Colleen F. Cawston, OIP
Roger Gantz, AIHC
David Reed, DBHR
Deb Sosa, HCA

Exhibit 1


Medicaid Mental Health Services
Medical Medicaid Mental Health Services
Tribal Medicaid Mental Health Services
RSN Medicaid Mental Health Services
Child
Adult
Psychological evaluations, neuropsych testing. Service must be provided by licensed psychologist, limited to two services per lifetime. Does not include EPSDT evaluations.
OP individual, family and group therapy. Can be provided by DOH licensed psychiatrist, psychologist, ARNP, social worker, marriage and family therapist or mental health counselor. Clinician must have at least two years clinical experience with children and youth. Service limited to one hour per day per client, maximum of 20 hours per year.
Inpatient Services are covered through RSN Managed Care System
Med Management provided by physician or psych ARNP. Not subject to duration limitations.
Psychological evaluations, neuropsych testing. Service must be provided by licensed psychologist, limited to two services per lifetime
OP individual, family and group therapy. Services can only be provided by psychiatrist. If on Managed Care, services may be provided by licensed MHPs. Service limited to one hour per day per client, maximum of 12 hours per year.
Inpatient Services are covered through RSN Managed Care System
Med Management provided by physician or psych ARNP. Not subject to duration limitations.
Fee for service model: Encounter Rate
Service scope, duration, frequency and intensity determined by medical necessity and ordered through treatment plan; no limit on benefit for medically necessary services
AI/AN consumers served by Tribal programs not required to meet Access to Care Standards or have covered diagnosis.
Encounter Rate services may only be provided by MHP
Current credential from other states is valid
Medical Necessity can only determined by an MHP.
Services must fit within mental health Rehab Section of Medicaid State Plan
Managed Care model.
Service scope, duration, frequency and intensity determined by medical necessity and ordered through treatment plan; no limit on benefit for medically necessary services
Services provided through RSN system require consumers to meet Access to Care Standards and to have a covered diagnosis
Services may only be provided by DOH credentialed MHP or MHCP, all care provided under supervision of an MHP.
Medical Necessity can only determined by an MHP.
Services must fit within mental health Rehab Section of Medicaid State Plan
Medical OP Mental Health State Plan Medicaid Services
Psychiatric Services
OP individual, family, group therapy (20 visits for children, 12 for adults)
Med Management
Rehab State Plan Medicaid Services
Medication Management
Medication Monitoring
MH Services in Residential Setting
Peer Support
Psychological Assessment
Rehab Case Management
Special Population Eval.
Stabilization Services
Therapeutic PsychoEd
Brief Intervention Treatment
Crisis Services
Day Support
Family Treatment
Freestanding E&T
Group Treatment
High Intensity Treatment
Individual Treatment
Intake Evaluation

Exhibit 2

Tribal-Centric Mental Health System
Near-Term Goals

DBHR Liaison for Tribal Access Issues

Complete by February 1, 2013.

- DBHR identify toll free number
- DBHR modify phone menu
- DBHR distribute phone number to Tribal MH providers

Outcome: ***Tribes will have access to Liaison for problem resolution.***

Culturally Appropriate Treatment Services

Completion: ongoing

- Establish a DSHS/Tribal workgroup comprised of Tribal mental health clinicians
- Review existing Indian specific mental health treatment for AI/AN
- Schedule and hold work sessions with workgroup and Tribal MH clinicians to identify other culturally appropriate promising and evidenced based practices
- Assess whether services can be covered under existing SPA treatment modalities and through IHS encounter rate
- Hold statewide meeting with Tribal health directors and their clinical staff to present service options

Outcomes: ***Tribal mental health programs adopt culturally appropriate, EBPs and promising practices.***

Access to Timely Crisis Services

Complete by February 1, 2013

- Review existing RSN contract terms regarding crisis services
- Develop alternative terms as needed to ensure Tribal access to crisis services
- Identify options for Tribal MH providers to deliver own crisis services
- Develop RSN specific, real-time procedure for notifying RSN of crisis access issues

Outcome: ***Tribal members will have access to crisis services as specified in the RSN contracts.***

Tribal Designated Mental Health Professionals

Complete by February 1, 2013

- Identify issues and develop strategies for having Tribal DMHPs
- Explore option of RSN providers hiring/contracting with Tribal DMHPs
- Explore designating Tribal DMHPs
- Determine oversight of Tribal DMHPs
- Identify steps in developing standing for ITA with Tribal Courts

Outcome: ***There will be a plan for designating Tribal DMHPs.***

Involuntary Treatment Act and Tribal Court Jurisdiction

Complete by April 2013

Identify desired outcomes with Tribal Court jurisdiction of Tribal ITAs

- Identify steps in developing standing for ITA with Tribal Courts
- Determine if statutory change is required to implement jurisdiction

Outcome: *A work group will be created with at least one member with Tribal Court expertise. By April 1, the workgroup will have created a list of tasks to move this item forward.*

Voluntary Inpatient and Appeals

Complete by March 1, 2013

- Review Medicaid voluntary hospitalization process
- Review medical necessity definition, discuss and review length of stay issues with inpatient providers
- Analyze use of voluntary inpatient across RSNs for AI/AN consumers
- Develop document describing process and client rights

Outcome: *Tribal behavioral health providers will receive training explaining Medicaid voluntary inpatient hospitalization access, their rights, and the appeal process.*

Inpatient Discharge Planning

Complete by March 1, 2013

- Identify discharge-related issues and concerns of Tribal providers
- Develop procedure for discharge planning
- Determine if amending RSN contracts would provide additional leverage
- Explore possibility of meeting with hospital association

Outcome: *Tribes will have draft Memoranda of Agreement document to sign with local inpatient facilities. RSNs will involve Tribal providers in discharge planning.*

Tribal-Centric Behavioral Health System

To develop an integrated Medical and Behavioral health system to address the needs of Medicaid eligible clients American Indians and Alaskan Natives for Rehabilitative Services.

The system will create an integrated, cohesive system of care; address health equity issues; reduce the drain of administrative re-sources to obtain services; and improve clinical care for all clients

December 20, 2012

Tribal Centric Behavioral Health Design Project

Introduction.

Through formal consultation with Washington's Tribes, the Department of Social and Health Services (DSHS) has committed to work with Washington's Tribes through representatives of the Indian Policy Advisory Committee (IPAC), American Indian Health Commission for Washington State (AIHC), and Northwest Portland Area Indian Health Board (NWPAIHB) to develop a new behavioral health system for American Indian/Alaska Native (AI/AN) people enrolled in Medicaid to receive their mental health care. [1] While the project will focus initially on developing a new mental health service delivery, the project scope will be expanded to include integrated chemical dependency (CD) services as a significant component. This will insure that the new system addresses the co-occurring behavioral health needs of AI/AN people.

In July 2012 IPAC, AIHC, NWPAIHB, and DSHS convened a workgroup, including DSHS' Division of Behavioral Health and Recovery (DBHR) and the Health Care Authority (HCA), to begin developing the new system. The workgroup identified a set of near-term tasks to improve care for AI/AN people eligible for Medicaid services through the Regional Support Networks (RSN). The workgroup also identified several key components for inclusion in the new system.

The purpose of this paper is to provide Tribal leaders and Tribal health directors with the information to assist them in providing guidance on how the new system should be designed and implemented to improve care for AI/AN people. To help provide background information, the paper provides: summary of the existing Medicaid mental health system for AI/AN people; near-term tasks to improve the RSN system that the workgroup is beginning; and, set of attributes for the new system that the workgroup has identified.

Existing Mental Health System for AI/AN People.

Washington's current Medicaid mental health service system is very complex (see Exhibit 1). There are two sets of mental health benefits and three different ways that these services are provided. The services are administered by two different state agencies—DSHS and the Health Care Authority. For AI/AN people, the system is further complicated because AI/AN and their family members can receive outpatient mental health services directly from their IHS or 638 contract/compact Tribal programs, as well as through the RSN system and/or the Healthy Options program if they have elected to enroll in managed care.

1. Mental Health Service Benefits.

The Medicaid program has two sets of outpatient mental health services for AI/AN and non-native people enrolled in Medicaid. Under what is called "medical mental health services," adult Medicaid clients may access a limited mental health benefit. They have access to 12 mental health therapy visits per year plus medication management—the therapy services must be provided by a

[1] These commitments are set forth in a December 30, 2009 transmittal to the federal Centers for Medicare and Medicaid services, July 2012 Regional Support Network waiver renewal to CMS, and June 15, 2012 DSHS letter to Tribal Leaders.

psychiatrist. Child Medicaid clients may access outpatient services from a psychiatrist or other licensed mental health professional specializing in serving children. Unlike adults, children are eligible for up to 20 visits per year, including medication management. Adult and children's management of mental health drugs by physicians and ARNPs does not have limitations. The "medical mental health services" are administered by HCA.

Under what is called "rehabilitative mental health services," Medicaid clients have access to 19 different "treatment or service modalities" (see Exhibit 1). Importantly, these services include crisis services. Unlike the medical mental health benefit, these services do not have specific limits on the number of visits. Services may be provided as long as the client presents with medical necessity for care. However, persons can only get these services if they meet "Access to Care Standards" and have a covered mental health diagnosis. [2] These services are administered by DSHS through the Regional Support Networks (RSNs).

2. Mental Health Service Delivery.

Most Medicaid clients are required to be enrolled in, and receive their medical care, through managed care contracted health plans (*Healthy Options Program*). The managed care plans are also responsible for providing outpatient medical mental health services. AI/AN Medicaid enrollees are not required to enroll in a managed care plan to receive their health care. They can go directly to their IHS/638 Tribal programs, urban Indian health programs or any other health provider with a Medicaid contract. This includes medical mental health services.

While AI/AN people can get mental health services through the two urban Indian health programs, the current Medicaid program restricts the services that the urban programs can provide. In the existing system, the urban programs must contract with their local RSN to be able to provide the rehabilitative mental health services. Otherwise, they can only provide the more limited medical mental health services. Tribal programs do not have to contact with the RSNs to provide rehabilitative mental health services to AI/AN people and their non-native family members.

Medicaid clients must obtain rehabilitative mental health services through their local Regional Support Network (RSN), which is a local government managed care program. RSNs operate as Pre-Paid Inpatient Health Plans (PIHPs) and provide outpatient services to reduce the need inpatient care. AI/AN Medicaid can also go to their IHS/638 Tribal programs to obtain outpatient mental health services. They do not have to meet the RSN access to care standards to receive the services at IHS/638 facilities. Currently, AI/AN Medicaid enrollees can only access inpatient psychiatric services through their RSN. This is true for all other Medicaid enrollees.

RSNs are responsible for the inpatient mental health service costs for all Medicaid enrolled consumers living within the RSN. This includes Medicaid enrolled in other managed care plans, RSN enrollees and AI/AN covered by Medicaid.

[2] Rehabilitative mental health services provided by IHS and 638 contract/compact facilities are not subject to rehabilitative access to care standard. Instead, they must meet the general medical necessity standard, which is lower standard of acuity allowing for more persons to have access to this level of care.

Unless they have contracted with Tribal or urban Indian health programs, the RSN system does not culturally appropriate services for AI/AN people. In part this is due to a limited number of Indian mental health professionals, who most often work for Tribal or urban Indian programs.

Near-Term RSN Revisions.

The Tribal Centric Mental Health Design Project workgroup has developed an initial set of near-term tasks to improve the RSN systems ability to service AI/AN people (see Exhibit 2). In addition to improving the existing system, these changes are intended to be building blocks for the new system. The workgroup also has prioritized and set completion dates for the tasks.

The near-term projects are intended to improve access for AI/AN people to crisis services and inpatient psychiatric care. Tribal representatives on the workgroup have expressed concern that crisis services, which are administered by the RSNs, are frequently not available on a timely basis. This is particularly the case in more rural areas, where most Tribal reservations are located. Tribal representatives also have expressed frustration in not being able to obtain authorization for payment for hospital admission (either voluntary or involuntary) when the Tribe's mental health staff request the person be hospitalized for needed care and safety.[3]

To address these concerns, the workgroup will be working with Tribal programs to improve access to crisis services and clarify the mental health rehabilitation services that Tribes can provide and how crisis services can be provided by Tribal mental health providers. The workgroup will work with the Tribes and RSNs to clarify and enforce existing RSN contract requirements for Medicaid and non-Medicaid crisis services.

The workgroup will work with Tribal mental health programs and RSNs to get Tribal staff certified to be designated mental health professionals with the authority to detain clients to petition for involuntary psychiatric inpatient and outpatient commitment. A further area of exploration is to determine whether Tribal Courts could have similar standing as Superior Courts to make court required involuntary treatment commitments for persons needing more than a three-day involuntary hospital or outpatient commitment.

The workgroup will address concerns about AI/AN people being denied needed inpatient care, is proposing that DSHS conduct on-going training with Tribal and urban Indian mental health providers on Medicaid voluntary hospitalization criteria and the rights and appeal process for persons denied access to inpatient care.

The workgroup heard concerns that hospitals often discharge a Tribal member from inpatient care without informing the Tribes' mental health program or sharing the discharge plan. This can result in the person not being timely linked back to needed outpatient and support services in their community. In part, this may be due to AI/AN members being able access mental health services through their Tribe and not through the RSN system. The workgroup is proposing to work with the RSNs and Washington State Hospital Association to develop a cooperative memorandum of agreement on how discharge planning and release will be coordinated with Tribal programs.

[3] Admit decisions are made by hospitals. RSNs do not have power to direct admit.

Finally, DSHS is implementing a new DBHR liaison position for Tribal RSN access issues, including those outlined above. The Tribes will have access to a dedicated person who will help resolve problems with RSNs and community hospitals that provide inpatient psychiatric care. The liaison will be in place by the end of October 2012.

New Tribal Centric Mental Health System

The Tribal Centric Behavioral Health Re-Design Project workgroup has been tasked to help shape and design a new mental health system. To date, the work group has identified 10 elements for the new system. It should be noted that some of the ideas for the new system are things that Tribes may be able to do today.

1. New Fee-For-Service Delivery System.

Most AI/AN people receive their mental health services through their Tribal mental health programs, urban Indian health programs, private mental health providers and the RSN managed care system. Under the new system, AI/AN people would receive all of their care through the Medicaid fee-for-service (FFS) system. AI/AN people wanting to remain in the RSN could do so. This may be the situation in some urban or rural areas where there are not Tribal or urban Indian health programs are not available.

In the new FFS system, AI/AN people would obtain medical and rehabilitative mental health services directly from IHS or 638 contract/compact Tribal programs, urban Indian health programs and other providers contracting with the State Medicaid program. For example, this could include community mental health agencies (CMHA) that also are RSN contractors.

There will be at least two key challenges in developing this new system. Based on available data, most AI/AN Medicaid clients do not reside on reservation land. According to the American Community Survey (ACS) data nearly one-half of Washington's AI/AN population resides in urban areas. This will require DSHS and the Tribes to build a statewide FFS network of providers, particularly in urban areas, that does not exist today.

A second challenge is the limited availability of inpatient hospital capacity. This is an equal problem for the existing RSN system and all Medicaid clients in the state. When compared with all states, Washington ranks in the bottom five in terms of inpatient psychiatric capacity.

2. Fee-For-Service Payment Rates.

Under the new system, mental health providers would continue to be reimbursed for services using existing Medicaid payment policies. IHS or 638 contract/compact Tribal programs would continue to receive IHS encounter rate payments and urban Indian health programs would receive their existing FQHC payments for services. Hospitals would be paid under the existing Medicaid program's hospital payment system. There will be a need to develop FFS payment rates for private providers and certain services, specifically for crisis service and CMHA providers.

3. Fee-For-Service Mental Health Capacity.

Under the new system, DSHS would contract with licensed mental health providers for services needed by AI/AN people who do not have timely access to IHS or 638 contract/compact Tribal programs, or urban Indian health programs. HCA currently contracts with providers for medical mental health services. However, DSHS would likely need to expand this capacity. This could include CMHA providers who are currently under contract with the RSNS.

4. Tribal Program Capacity.

Based on a recent Northwest Portland Area Health Indian Health report, Tribal programs provide a number of, but not all, outpatient medical and rehabilitative mental health services. Under the new system, Tribes with existing mental health programs could contract with other licensed mental health providers for services not currently available. There remains an issue to be decided as to what rate these contracted providers would be paid. [4]

Currently, 27 Tribes have Medicaid mental health contracts. There are 33 clinic sites, plus the two urban Indian health programs providing mental health services. With the new FFS system, the other tribes could elect to start their own mental health programs.

5. Crisis Services Capacity.

The existing RSN system is responsible for providing 24-hour/7-day crisis services for all residents s of the RSN's catchment area, including all AI/AN people living within the RSN. Under the new system, Tribal and urban Indian health programs would be responsible for these services for Medicaid consumers. If they did not have the capacity, DSHS would have to contract with the RSNs or other entities to provide these services. This will also require developing a new payment system for these services (see above). The issue of how Tribal programs could provide and be paid for crisis services to non-Medicaid consumers remains to be explored.

6. Inpatient Hospital Services.

The RSN system is responsible for authorization of payment for inpatient services and financially responsible for the payment to hospitals for the service. Because RSNs are paid a monthly capitation payment for all services, they are at risk if inpatient hospital costs exceed the amount assumed in the capitation payment.

Under the new system, DSHS would pay hospitals for inpatient psychiatric services. [5] There would need to be an entity that would authorize these services and conduct utilization management. This could entail a joint contract relationship between DSHS, the Tribes and an authorization/ utilization management entity.

[4] The resolution of this issue is based in part on whether the contracted entity is an employee of the Tribal program and where the service is provided.

[5] This should not be a major problem because DSHS currently pays hospitals for RSN inpatient services and then bills the RSN to recoup its expenses.

While not resolved, it is assumed that DSHS would be at-risk for hospital care and not individual Tribes. However, DSHS may consider performance payments to Tribes for lower utilization of hospital care.

7. Tribal ITA Courts.

In the new Tribal centric mental health system, both Tribal Courts and Superior Courts would be responsible for involuntary treatment commitments and Conditional Releases from Inpatient Commitment. The near-term project described above, will be a model for Tribal Courts involvement.

8. Regional Residential Treatment Facilities.

As described above, the Tribal centric behavioral health system will face an inpatient care capacity problem. One option to address this would be for the Tribes to jointly develop regional residential treatment facilities that would be able to provide culturally appropriate serves to AI/AN people. Ideally, these facilities would have short-term inpatient care capacity to evaluate and treat persons in crisis. They also would be able to provide residential chemical dependency treatment for AI/AN with co-occurring needs.

9. Health Homes for Persons with Chronic Mental Health Conditions.

In the new system, IHS, 638 contract/compact and urban Indian health programs would be reimbursed for services to strengthen their ability to be health homes for persons with chronic mental health conditions. This could include payment for: comprehensive care management; care coordination and health promotion; transitional care from inpatient to other settings, including appropriate follow-up; individual and family support; and, referral to community and social support services.

10. Culturally Appropriate Promising and Evidence Based Treatment Practices.

The new system could be expanded to include culturally appropriate promising and evidence based treatment practices that are not currently reimbursable. The workgroup has already begun a review of the existing rehabilitative mental health treatment modalities to determine whether some promising practices could be reimbursed under the existing system.