

MHSS Stakeholders Meeting Minutes 8/2/2012

Introduction by Karen Kimsey, DMAS Director of Policy and Research Division, DMAS:

The intent of the proposed changes is to preserve the integrity of MHSS. The handout attached to the agenda shows the dramatic increase in expenditures for this service. DMAS wants to work with providers to look at ways to control MHSS expenditures so that the service remains available for those who need it.

Les Saltzberg, Director of the Office of Licensure at DBHDS, provided the following summary regarding MHSS trends:

1. In July, 2010 there were 75 providers; now there are 153. There are 94 companies in the application process.
2. MHSS trends over the past year:
 - a. DBHDS staff members are seeing a significant number of individuals being served who are not seriously mentally ill.
 - b. An increasing number of individuals just receive MHSS and nothing else. In the past, most individuals received other services while receiving MHSS.
 - c. Providers have little experience with providing support to the seriously mentally ill.
 - d. Services tend to be companion care rather than focused on skill building.
 - e. More providers are billing the maximum amount of hours. Seven hours a day, several times a week is too much.
 - f. An increasing number of individuals living in assisted living facilities receive these MHSS services in the facility rather than being taken by the provider out to the community. There is a concern that MHSS services are duplicating services provided by the facility.

Review of Proposed Changes –

1. Eligibility Criteria

- Is it the intent to replace the existing criteria or will the proposed changes be used in addition to current criteria? These will be primary criteria, and the current criteria will be applied in addition.

- One stakeholder expressed concern with regard to the prescription criteria. Some individuals who have not had prescriptions may still need MHSS to prevent emergency services. There are problems with access to get prescriptions. There are waiting lists to see psychiatrists.
- Another stakeholder also disagreed with the criteria. He noted a concern with having the prescription on file, and problems with individuals providing accurate history of hospitalizations.
- What are the DBHDS criteria for seriously mentally ill? These were summarized, and the criteria were emailed to stakeholders after the meeting.
- One stakeholder is a psychiatrist and has worked with individuals with mental illness and believes in trying to be a good steward of public dollars. She does not have difficulty with what is being proposed. She likes the “or” rather than “and.” Someone with serious mental illness should be on medication. She noted that DMAS should add antidepressants to the list to cover those with depression.
- A stakeholder noted that the criteria don’t consider those who refuse to seek traditional mental health treatment.
- Another stakeholder stated that some individuals don’t have the skill set to seek treatment.
- A stakeholder asked if we could increase the time frame for a prescription from 12 months to 24 months. She also asked how providers should prove that they have met the criteria (medication/hospitalization).
- A stakeholder asked how flexible DMAS will be on documenting or proving criteria (for example, an individual hospitalized out of state).
- Some stakeholders have a concern that DMAS is restricting eligibility criteria rather than dealing with providers who are not providing quality services. It is more important to preserve excellent services than to restrict eligibility criteria.
- There are very few individuals with SMI who don’t meet the proposed criteria. In addition, most individuals with serious mental illness receive additional services other than MHSS.
- One stakeholder teaches recovery classes where at least one person with SMI refuses services (medicines, hospitalization) and she has a concern with them not meeting the criteria for MHSS. She has a concern that DMAS is neglecting wellness and prevention strategies, and that the proposed approach is anti-recovery and not person-centered.

- One stakeholder stated that he had no concerns with the criteria. He said that it is extremely rare that someone with SMI will not have a hospitalization or prescription for psychotropic medicine.
- DMAS recognizes the concern about being person-centered. However, MHSS and other CMHRS services are not supportive services, they are rehabilitative services. These criteria are set by CMS, which audits DMAS. DMAS needs to assure that MHSS is a rehabilitative service.
- DMAS needs to look at provider outcomes. Also, how are providers finding resistant clients? If these individuals are resistant to treatment why are they receptive to MHSS?
- DMAS needs to look at outcomes, like it did with children's services. Also, individuals who need support may need a different type of service like recovery and wellness classes, which are not a covered DMAS service. There is a need for more services for people who don't need intensive treatment.
- Audit criteria could be identified to define services and support.
- DMAS will make a note to educate providers on the criteria of rehabilitative vs. supportive as part of upcoming training plans.
- Could crisis stabilization and crisis mobile teams be added to the hospitalization criteria?

2. Reducing units

- Some providers have recommended transitioning to an hourly rate – one unit equals one hour. This is also the preferred approach by CMS.
- An hourly rate easier to monitor. When using multiple hour units, time gets fuzzy . This stakeholder is very supportive of moving to hours.
- DMAS should allow three units on crisis days. The standard should be a maximum of two units, but if an individual is in crisis, and the crisis is documented, DMAS should allow three.
- The conversion of day support services from units to hours was difficult. Providers may already have data on the number of hours used. DMAS should look at the average number of hours that are being provided when coming up with the number of hours allowed.
- One provider stated DMAS did a survey a few years ago that found that providers were doing an average of 2 hours for each unit billed. DMAS was encouraged to look for that study.

3. Prohibiting MHSS for individuals enrolled in ID or DD Waiver or personal care in any program/waiver

- The intent is not to have duplication of services by overlapping MHSS and ID or DD waiver services that are already being provided.
- Virginia is expanding the Start program [through DBHDS], and through this program, MH support services will not be needed by individuals with ID or DD waivers.
- One stakeholder has provided MHSS on a limited basis to waiver recipients, and worked with a DMAS analyst to make sure that there was no duplication on the ISP.
- It might be better to break this proposal into two sentences.
- With regard to overlaps with personal care, what are the expectations of personal care providers? Some individuals may need a personal care attendant while being taught personal care skills.
- Do ID and DD waivers have a component like mental health support services? Yes, and DMAS will send out a list of services included in the ID and DD waivers. (Relevant portions of the ID and DD waiver manuals were emailed out to stakeholders.)

4. Prohibiting MHSS for individuals residing in nursing homes and ALFs.

- A representative from DSS stated that with regard to ALFs, direct care staff perform custodial care only, and not rehabilitative training, so there is no duplication with MHSS. The facilities that DSS has worked with that include residents who receive MHSS have shown that it helps to prevent re-hospitalization.
- Many ALFs do not have licensed direct care staff other than the director. ALFs were not originally intended for residents with complex needs who were discharged from institutions.
- This issue needs a lot of thought due to the complex needs of residents in ALFs. There are many components that need to be looked at, including how this will impact ALFs.
- Maybe DMAS should consider how many hours are appropriate for an individual in an ALF. Some providers enter a group residential facility and sign up all residents for MHSS. Is there a recommended staff to client ratio that should be considered? Are there best practices?
- It is possible that the changes to eligibility and hours will impact ALFs without even considering this item. If we make multiple changes, then we don't know which change made the difference.

Maybe we should look at eligibility and limits of hours first. These two items will make significant change in the service. The ALF issue is more complicated and will take more time.

- Many individuals live in ALFs because there is not enough housing. The practice of some providers signing up everyone in an ALF is concerning. It would be helpful to know what the monitoring capacity is and if it's adequate.
- A stakeholder expressed concern about the increase in the number of providers and dollars being spent, about unsavory providers taking advantage of the system, and about preserving the integrity of Medicaid services. He asked that the focus not just be on policies and procedures but also on providers.
- Some ALFs have 100% of their residents on auxiliary grants and they take individuals with mental health disorders who no one else will take. (These facilities may be justified in having everyone receiving MHSS.)
- One stakeholder commented that it will be difficult to monitor ALFs and the MHSS providers, and agrees with the comment about starting with the eligibility changes and new limitations on units.
- One stakeholder asked if DMAS has seen ALFs where all residents receive MHSS? Yes.
- One stakeholder commented on the need to be more outcome-focused, and to develop a practice model of what the service should be, so new providers know what to do. These practice models could be developed for other services as well. The stakeholder recommended being more positive about focusing on intended outcomes rather than restrictions. With regard to evidence-based practices, providers may be keeping outcome data and it would be helpful if this data is shared.
- There are spikes in utilization in the data that can be tied back to the fiscal year-end and to the service authorization process.
- A stakeholder asked about the impact on individuals in nursing homes. DMAS responded that nursing homes are responsible for providing for all resident needs including behavioral health needs. DMAS does not dispute that the need for behavioral health treatment exists in nursing homes, but notes that the facility is obligated to provide all care. DMAS plans to identify and work with nursing homes on this issue, to let nursing homes know about the prohibition and to let the prior authorization contractor know that MHSS cannot be provided in nursing home settings.

- The Casey Foundation has a free tool for independent living skills. The stakeholder wants to know why providers are not using Casey Foundation materials.
- To follow up on outcome-focused and evidence-based practices, we need to make sure that providers understand what is expected, and need to do a better job of defining the required elements of each service. We need to correct the problem of people receiving the wrong service because it's the only available service.
- With regard to nursing homes, DMAS should consider allowing short-term (Medicare, dual-eligible) residents who are in nursing homes for rehabilitation to continue to receive MHSS services during their short stay. With regard to ALFs, MHSS providers should integrate with and train ALF staff in what the MHSS provider was working on. There needs to be better communication between MHSS providers and ALF staff.

5. Independent Clinical Assessment

- The VICAP issue is broad, and creates access issues. It would be better to start with changes to eligibility and units, and see if that helps without implementing VICAP. The VICAP process has not resolved issues in children's services.
- There are conflicts with the CSBs providing MHSS and performing VICAPs. These issues should be resolved before the VICAP is expanded. It is not clear if the VICAP is what has reduced the number of children in service. There needs to be evidence-based research on what has decreased children's services utilization. There are children who didn't get a VICAP and there are adults who will not go to get one.
- Would ALF residents need to go to CSBs for a VICAP? DMAS has not yet determined if individuals would go to an assessor, or vice versa.
- Would VICAPs be required prior to receiving services or at a re-authorization? Those are both options that could be explored.
- Can certain sectors of the population be grandfathered into the service without a VICAP? It is an issue to have adults going in to have an assessment done. It was hoped that the BHO would be in place at this point because we don't know who has good quality services and who doesn't. Maybe we should implement what we are in agreement on and move on those items first.
- With regard to how providers found the MHSS clients: with many children's services, the parents need to get services before providers can help the child. Many parents receiving MHSS were identified while providers were working with children.

Meeting adjourned at 12:05 p.m.