MARY CZAJA
STATE REPRESENTATIVE • 35th ASSEMBLY DISTRICT

(608) 266-7694
Toll-Free: (888) 534-0035
Rep.Czaja@legis.wi.gov

P.O. Box 8952
Madison, WI 53708-8952

Assembly Bill 408/Senate Bill 293 – Behavioral Health Care Coordination Pilot Projects
Assembly Committee on Mental Health Reform
December 8, 2015

Thank you Chairman Tittl and members of the committee for holding a public hearing today on Assembly Bill 408. This legislation is a three-part initiative that seeks to better coordinate mental health services and to improve outcomes for Wisconsin Medicaid patients who are suffering from mental illness.

Behavioral Health Care Coordination Pilot
Current Wisconsin Medicaid enrollees who have significant or chronic mental illness often make repeated trips to the emergency room. This continuous cycle is a significant cost driver for our state's healthcare system and ultimately is not in the best long-term interest of the patient. SB 293 allows for the use of alternate Medicaid reimbursement models with the goal of incentivizing providers to manage and coordinate all aspects of care; behavioral, physical, and social services. This synchronized and preventative care can help to prevent future ER visits.

The project will provide $1.5 million in all funds ($600,000 GPR) to at least two pilot programs for up to three years. Health care providers eligible for the pilot must meet certain criteria. This pilot is based upon a similar effort in Illinois that resulted in savings of $8 million to taxpayers.

Psychiatric Consult Reimbursement Pilot for Medicaid
The second pilot program is targeted to adult Medicaid recipients who have mild to moderate mental health needs. Under current law, Medicaid does not reimburse providers who provide consultation to a primary care physician when a patient is in need of care. The purpose of the pilot is to show that proactive consults with a psychiatrist will reduce costs and lead to better outcomes.

Online Mental Health Bed Tracking System
Our state's system for tracking the availability of psychiatric care has become antiquated. Currently, when an individual needs inpatient psychiatric care, clinics have no other option than to call around to individual hospitals in an attempt to locate an open bed. An online system can display bed availability statewide in real time, saving valuable staff time and resources. The startup investment is $50,000 GPR and an annual cost to maintain of $30,000 GPR.

AB 408 has wide bipartisan support with over 70 cosponsors from both houses. The Senate companion bill SB 293 was passed unanimously on a vote of 30-0 during the fall floor session in October. The bill is also supported by the Wisconsin Hospital Association, the Wisconsin Medical Society, and Wheaton Franciscan Healthcare. Thank you and I am happy to answer any questions.

LEAH VUKMIR
STATE SENATOR

Assembly Bill 408

ASSEMBLY COMMITTEE *on* MENTAL HEALTH REFORM
Tuesday, Dec. 8, 2015

Chairman Tittl, committee members, thank you for taking the time to read my testimony on Assembly Bill 408. I'm sorry that I was not able to attend in person.

The bill before you today demonstrates Wisconsin's ongoing commitment to promote quality behavioral healthcare. I am proud to join Reps. Czaja and Kolste and Sen. Bewley — along with the broad bipartisan support this bill has in the legislature — to work on improving how we care for those who suffer from mental illness.

Wisconsin is home to one of the best healthcare systems in the country. Our state's healthcare system was recently named No. 2 by the Agency for Healthcare Research and Quality. The work our hospitals, doctors, nurses and other healthcare providers do to constantly provide the best care possible for Wisconsin citizens struggling with mental illness is a large reason why Wisconsin was granted this distinction. Our state is a leader in healthcare and addressing mental health issues — but we can do even better.

The bill contains two pilot programs to test how we can improve healthcare for those with mental illness. The first pilot program tests new payment models created to reduce Medicaid costs by integrating care and managing the costs of non-behavioral healthcare for individuals with significant or chronic mental illness. This project allows providers to test some transformative Medicaid reimbursement models to see where they can find cost savings and where they can encourage proactive care for patients with mental illness. By investing in these pilot projects now, the insights found will help us understand where Wisconsin can find efficiencies in Medicaid and how we can better coordinate care for some of our highest-need patients.

Illinois invested $500,000 into a similar pilot project that resulted in $8 million in savings to its Medicaid program. Furthermore, this pilot saw a 65 percent decrease in Medical Assistance payments for emergency room visits and an 88 percent decrease in MA payments for medical admissions. I am eager to see the savings Wisconsin will find with our investment and the better care that results from the findings.

STATE CAPITOL
P.O. BOX 7882 • MADISON, WISCONSIN 53707-7882
(608) 266-2512 • FAX: (608) 267-0367

The second program tests new payment models to encourage the collaboration of psychiatrists and primary- and specialty-care providers, building on the child psychiatry consultation program that became law last session. This will help people suffering from mental illness so when, for example, a patient visits with their primary-care provider, a caregiver could step out of the examining room and quickly call that patient's psychiatrist. The psychiatrist could then give immediate feedback on the healthcare situation, preventing the patient from needing to go to another office visit. Right now this coordination doesn't happen because psychiatrists are not reimbursed through Medicaid for this consultation. With this bill, the psychiatrist would be to be paid for his or her over-the-phone consultation, allowing for the primary-care doctor to help discover the best method of care for a particular patient in a quick manner. Ultimately, this will also prevent higher long-term Medicaid costs.

The third piece of this bill includes a bed-tracker to allow hospitals to digitally coordinate information to quickly access which hospitals have open psychiatric beds, decreasing staff time and quickening the speed at which hospitals can start caring for those suffering from mental illness. Currently, hospitals communicate this information by wasting valuable staff time cold-calling other hospitals to see which psychiatric beds are available. This bed-tracker brings inter-hospital communication into the 21st Century by providing caregivers with where the closest psychiatric beds are in their communities in real time.

Integrated care is the future of healthcare in our state and in the nation. This bill aims to discover new ways we can integrate care to promote the overall well-being of those with significant or chronic mental health issues. This will lead to financial savings for the state's Medicaid program. And, even more important, it will encourage care for patients early in the healthcare process, preventing them from going to the emergency room or having to stay in the hospital long-term.

This bill passed the full state Senate unanimously in early November. I look forward to the vote in this committee later today and hopefully to a vote from the full state Assembly in the near future.

Thank you again for taking the time to read my testimony. I encourage you to support Assembly Bill 408.

WISCONSIN
PSYCHIATRIC
ASSOCIATION

TO: **Representative Paul Tittl, Chair**
Members, Assembly Committee on Mental Health Reform

FROM: **Jeff Markus, MD**
President

DATE: **December 8, 2015**

RE: **AB 408 – Behavioral Health Coordination Pilot**

On behalf of the hundreds of Psychiatrists across Wisconsin, we want to thank Representative Czaja and Senator Vukmir for bringing this legislation forward, and to the Committee for providing us the opportunity to give some brief written comments.

Psychiatry is the specialized practice of medicine devoted to diseases and disorders of the brain that can impact an individual's cognitive, emotional, social and other mental capacities. Contrary to what many still believe, Psychiatry is based in scientific methodologies and research involving the complex science of brain chemistry and neurologic function. To a skilled practitioner, some mental health disorders may be revealed simply by interviewing and observing a patient, while others are revealed only after diagnostic testing ranging from blood chemistry tests to highly advanced electromagnetic brain scans. Mental health disorders may be relatively short lived, while others will be life long, and treatment may involve little more than psychotherapy (talking sessions) or may require long-term treatment with powerful medications designed to rebalance a patient's brain chemistry.

This complexity means that mental health disorders and disease, especially when they are not severe or grossly debilitating, can be very difficult to recognize, diagnose and treat. Left untreated or treated inadequately, even minor mental health disorders can have profound negative impacts on a patient's other physical health, leading patients to utilize other health care services they may never have needed had mental health care been rendered earlier. Family physicians, pediatricians and internists receive general psychiatric training, yet they may well be ill equipped to fully diagnose or treat more complex or more subtle mental health cases. In those cases, primary care physicians are trained to refer patients to mental health specialists.

Unfortunately, our health care system does not always lend itself to easy specialty referrals; especially in mental health cases. Whether there are enough Psychiatrists in Wisconsin is a question yet to be fully answered or addressed. Regardless, what is clear is that undiagnosed or improperly diagnosed, and untreated or improperly treated mental health disorders lead to over-utilization of other health care services, and we believe that greater coordination of care will lead to better and earlier preventative mental health care, and by extension help reduce otherwise unnecessary utilization. We applaud Representative Czaja and Senator Vukmir for bringing forward the Behavioral Health Coordination Pilot legislation to begin looking for ways to accomplish this laudable goal, and we look forward to working with her and others in this ambitious endeavor.

WISCONSIN HOSPITAL ASSOCIATION, INC.

Date: December 8, 2015

To: Members of the Assembly Committee on Mental Health Reform

From: Kyle O'Brien, Senior Vice President Government Relations
Matthew Stanford, General Counsel

Subject: WHA Supports AB 408 – Mental Health Pilot Projects and Bed Tracking System

---

The Wisconsin Hospital Association (WHA) strongly supports Assembly Bill 408, bipartisan legislation authored by Reps. Czaja and Kolste and Sens. Vukmir and Bewley to improve care for patients with mental illness and make it easier for health care providers to identify open psychiatric inpatient beds throughout the state. The pilot projects in this legislation are designed to demonstrate how our members can come to the table with ways to better manage and coordinate care for individuals with mental illness.

The bill will authorize two pilot programs, one to test alternative behavioral health care coordination payment models and the other to test psychiatrist-to-healthcare provider consultation payment models. The demonstration projects would both last for up to three-years and would require that the grantee report back to DHS at least twice during the project on the reduction experienced in Medicaid utilization and resulting cost savings. The purpose of this legislation is to provide lawmakers with ways to reduce costs in our Medicaid program while also providing better care for patients. Our members are eager to test these promising new care delivery and payment models.

This bill is yet another commitment that the legislature has made recently to incentivize health care providers to treat mental health and physical health together, not separately. Last year, Governor Walker signed into law bipartisan legislation that gave treating providers the ability to access information about a patient's mental health condition. This legislation, known as HIPAA Harmonization, was recommended by WHA's Behavioral Health Task Force in 2008 and presented by WHA staff to the Speaker's Task Force on Mental Health in 2013. That bipartisan legislation was applauded by health care providers all over Wisconsin who realize that it is critical to treat a patient's body and mind, together.

Our members realize that some individuals suffering from mental illness in our state Medicaid program are falling through the cracks of both our Medicaid fee for service and managed care payment models in Wisconsin. By focusing on care coordination, our members believe they can reduce Medicaid utilization and costs while improving overall health status by ensuring the patient is receiving the right services, in the right place and at the right time. In Illinois, a similar pilot program that paid health care providers a care coordination fee for 388 severally mentally ill patients was able to reduce emergency department visits by 49%, reduce emergency department costs by 65% and reduce psychiatric admissions into the hospital by 54%. Patients in the target population also experienced a 137% improvement in their quality of life scores.

Finally, the bill will also create a mental health bed tracking program that will make it easier for health care providers to identify bed availability for patients in need of inpatient psychiatric treatment. We believe that this will not only be helpful to health care providers, but also get patients to inpatient services more quickly resulting in a speedier recovery. The program is modeled after a similar and successful program in Minnesota.

WHA asks you to vote in support of Assembly Bill 408 to test alternative models of payment and care that will result in better health outcomes for patients with mental illness.

If you have any questions about details of the bill, please contact Kyle O'Brien (kobrien@wha.org) or Matthew Stanford (mstanford@wha.org) at 608-274-1820.

5510 Research Park Drive P.O. Box 259038 Madison, WI 53725-9038 P (608.274.1820) F (608.274.8554) wha.org

Testimony to the State Assembly Committee on Mental Health regarding AB 408

Tuesday, December 8, 2015

Pete Carlson, President, Behavioral Health, Aurora Health Care

Milwaukee, WI

- Aurora Health Care strongly supports AB 408, a mental health improvement bill that is comprised of two pilot projects which will test innovative approaches to providing and paying for behavioral health care, which will lead to improved care for patients, and a savings on health care costs for the State Medicaid program and the health care provider. The third component of the bill provides for a statewide inpatient bed-tracker, which will inform emergency departments and other providers around the state which facilities in the state have inpatient psychiatry beds open and available for patient referrals. This component of the bill will also lead to better care for patients in acute psychiatric crisis by reducing the amount of time it takes to find an inpatient facility with the capacity to admit a patient requiring this level of treatment.
- At Aurora Behavioral Health Services we believe that health care is evolving from a fee-for-service-based delivery model that focuses on "sick" patients to one that is value-based and focuses on prevention of illness. Prevention, in terms of behavioral health, means identifying patients that are struggling with mental health issues as early as possible and treating them before their illness becomes so debilitating as to become a barrier to people taking care of themselves in general, and, more specifically, for those with chronic medical conditions, taking care of their chronic physical health problems. This manifests itself in many ways depending upon the chronic medical condition (diabetes, high blood pressure, congestive heart failure) and the behavioral health co-morbidity (depression, anxiety, psychosis).
- The literature is clear and many studies demonstrate that patients who suffer from one or more chronic medical conditions and one or more behavioral health conditions are anywhere from two to five times more costly to care for over the course of their lifetime than a patient with that same chronic medical condition and no accompanying behavioral health condition.
- Given the advent of population health or value-based health care approaches that have been predicted to eventually become the predominant way in which health care is provided in the future, health care systems are now beginning to design and test various new models of care in an effort to prepare for this new health care paradigm. Among them are care coordination models that provide intensive amounts of case management, motivational enhancement, patient education and coaching.
- In the development of new models of care, health care systems are sometimes providing services, such as case management, that are not traditionally reimbursed. It will be critical as the new care models are developed, tested and implemented, that the payer systems partner with the provider systems to develop ways to reimburse for non-traditional services that prove to be effective.

- In the case of the care coordination pilot project contained in AB 408, I believe that we have an opportunity to develop programming for a cohort of patients that are very high utilizers of health care (high cost Medicaid patients), all of whom will likely have the common denominators of being low income and having a behavioral health condition as part of their profile. In addition to whatever physical health and behavioral health problems they experience, due to their low socio-economic status, they very frequently have other psycho-social stressors that impede their ability to understand and proactively address their overall health care needs. Examples of these issues include problems with housing, transportation, employment and child care. When one is struggling with these issues, it is even more difficult for them to focus on the care they need to remain healthy, in both a physical and mental sense. Supporting a patient in resolving their psycho-social issues is often times key to getting them to focus on their long-term health needs, particularly their mental health needs. Psycho-social issues are routinely cited as the reason why there are so many missed appointments with professionals, the greatest challenge and frustration that professionals have in working with the Medicaid population.
- Although many projects have shown that using bachelors level social workers to provide case management and other care coordination services are instrumental in cost containment and improved health outcomes, they are rarely used outside of the hospital setting because they fall outside of the traditional reimbursement mechanisms.
- At Aurora, we feel that we have a unique set of assets that will allow us to work very well with an innovative, coordinated model of care for this particular cohort of patients. Having a combination of hospitals, emergency/urgent care facilities, primary care and specialty clinics, behavioral health clinics and Aurora Family Service, which specializes in case coordination and coaching activities, we believe that we can link these assets together via our electronic health record in a manner that will allow us to create an efficient model of care that significantly reduces the cost of care for this expensive cohort of patients. Similar models of care have been developed in other states with very positive results.
- In the end, the system that is created will be win-win-win. Most importantly, it will provide better care for patients, at a reduced cost to the payer and in a more efficient, cost effective manner for the provider.
- An important attribute to the long-term sustainability of the process will be the ability to test the reimbursement model from both a payer perspective as well as a provider perspective. If health systems are to maintain innovative programs that function in a non-traditional approach, it will be critical that the reimbursement system matches the care delivery model. We believe that this pilot will do just that. At the same time that we are learning about the success of the delivery model, we will also learn about the success of the reimbursement model. We will then be positioned to make needed adjustments to improve the overall system accordingly.

- We are also very excited about the second pilot project, providing a reimbursement mechanism for psychiatrists providing telephonic consultation for primary care physicians and other health care professionals.
- The current health care system has long been experiencing a significant shortage of psychiatrists, a phenomenon this is not going away any time soon. Our goal must be to expand the capacity of our current psychiatrists by expanding their expertise through other professionals, particularly those with prescriptive authority. Collectively, primary care physicians already provide as much or more mental health care than anyone, including psychiatrists. They are on the front line of psychiatry, meeting with patients that have mental health problems on a daily basis.
- Many times, due to the limited access to psychiatry, they are the prescribers of record, bridging their patients with medications the best that they can until the patient can be seen by a psychiatrist. If we can establish a reimbursement method for psychiatric telephone consultation, psychiatrists with limited time will be able to set aside otherwise billable time to provide consultation for the primary care physicians, and other prescribers, that will allow them to continue working with many patients that they previously would have had to refer.
- Frequently, the primary care provider just needs advice or ideas from a psychiatrist about diagnostic or medication questions regarding what to try next in any given situation, including when to refer the patient. The more psychiatrically mild to moderately impaired patients that the primary care provider can continue treating, the more capacity there will be in the psychiatrists' schedules for more acute psychiatric patients, those that require the psychiatrist's expertise.
- There are many ways that this particular pilot with adult psychiatric telephone consultation can be implemented, including within a large integrated health care system like Aurora or with a number of collaborating partners, like the current child psychiatric telephone consultation pilot program being implemented by the Medical College of Wisconsin with pediatricians from Children's Medical Group and the pediatricians from the Aurora Health Care Medical Group.
- Again, one of the important outcomes of this pilot is not only developing a clinical model that is effective, but also development of a reimbursement model that is effective for the long-term sustainability of the program.

- I would like to applaud the legislature for taking up these critically important pilot projects in behavioral health. Given the gradual improvements being made in reducing the stigma patients may feel accessing behavioral health services, and the greater numbers of people now accessing care for these very treatable conditions, it is crucial that we continue to focus on developing sustainable programs and services that will allow us to maximize the resources that we currently have available as a state.
- The key, in my opinion, is that we need to develop programs that are sustainable over the long-term, and that means that we need to create effective reimbursement programs to go along

with the care delivery models. We should not create programs that essentially "close when the grant ends" because there is not a way to pay for the services in the real world.

- Similarly, these pilot programs ought to be creating programs that will fit into the next generation of health care, whether that be population health, value-based care, capitation or some variety of the above. The pilot programs that we are talking about today are all programs, in my opinion, that will not only meet a need now, but in the new health care paradigm to come.
- Thank you for your time and attention to this important matter. Please let me know if you have any questions or concerns that I might be able to address. I can be reached at 414-454-6473.