Wisconsin Psychiatric Association
A District Branch of the American Psychiatric Association

To: Senator Leah Vukmir, Chair, and Members
Senate Committee on Health & Human Services

From: Jeff Marcus, MD, President
Wisconsin Psychiatric Association

Date: October 13, 2015

RE: SB-293, Behavioral Health Care Coordination Pilot

On behalf of the hundreds of Psychiatrists across Wisconsin, we want to thank Senator Vukmir for bringing this legislation forward, and 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. Psychiatric practice standards are based upon 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 primarily 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. Treatment may involve psychotherapy (talking sessions), powerful medications designed to rebalance a patient's brain chemistry, or a combination of modalities.

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. 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 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.

RWHC
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TO: Senate Committee on Health and Human Services
Senator Vukmir, Chair

FROM: Jeremy Levin, MHA, Director of Advocacy

DATE: October 13, 2015

RE: SUPPORT Senate Bill 293 – Behavioral Health Proposals

The Rural Wisconsin Health Cooperative (RWHC), owned and operated by forty rural community hospitals, thanks you for this opportunity to share our thoughts on SB 293, which relates to behavioral health care coordination pilot projects, psychiatric consultation reimbursement pilot project, and access to information on availability of inpatient psychiatric beds. RWHC thanks the authors, Representatives Czaja, Kolste and Senators Vukmir, and Bewley, for introducing legislation that gives health care providers the tools for greater coordination of care, greater access to care and more efficient health care delivery for those suffering from mental illness.

RWHC believes that individuals with significant mental health conditions utilize significantly higher levels of medical (non-behavioral) care than do individuals without significant mental health conditions. We support testing new payment models designed to reduce the costs and improve the outcomes of Medicaid recipients who have mental illness. Further, using funding that had been segregated for health care purposes is reasonable.

RWHC has been working on behavioral health improvement initiatives through a Healthier Wisconsin Partnership Program Grant that we collaborate with member hospitals to implement the Alcohol Use Disorders Identification Test (AUDIT) and telehealth interventions. This collaboration is aimed to increase the number of adults receiving screening services and provide educational interventions as needed for rural residents with dependency issues.

Additionally late last year, RWHC applied for and received a three year HRSA Network Development grant to expand behavioral health services in rural Wisconsin through the use of Telehealth. The initiative involves 14 rural Wisconsin hospitals working together to develop an innovating and responsible network approach to help address the longstanding and severe behavioral health professional shortage in their communities. 2015 is primarily a planning year for us; our hope and expectation is to initiate services by early 2016.

Thank you again for this opportunity to comment on and express our support for SB 293. We encourage the Committee to act on this bill so that it might become law and more can be done to help health care providers to better serve patients in Wisconsin's underserved rural areas for their mental health needs.

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# WISCONSIN HOSPITAL ASSOCIATION, INC.

**Date:** October 13, 2015

**To:** Members, Senate Committee on Health and Human Services

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

**Subject: WHA Supports SB 293 – Mental Health Pilot Projects and Bed Tracking System**

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The Wisconsin Hospital Association (WHA) strongly supports Senate Bill 293, bipartisan legislation authored by Sens. Vukmir and Bewley and Reps. Czaja and Kolste to improve care for patients suffering from 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 suffering from 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 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 Senate Bill 293 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.

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**DRW COMMENTS AND CONCERNS ON SB 293 - 10/13/2015**

Contact: Kit Kerschensteiner, Disability Rights Wisconsin (608) 267-0214, kitk@drwi.org
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While DRW appreciates the intent of SB 293 to improve outcomes for Medicaid recipients who have mental illness, we urge a "go slow" process to allow time for discussion of these proposals and consideration of whether addition funding to support a hospital- based approach to recovery is supportive of Wisconsin's commitment to increase community based mental health services. Additionally, there has not been an opportunity for stakeholders, including people with lived experience of mental illness, advocacy organizations, and counties since they play a key role in administering mental health services to thoroughly review these proposals and provide their input.

The **Behavioral Health Coordination Pilot** proposal would fund several pilot projects to test whether there are Medicaid cost savings through the provision of hospital-based case coordination services to individuals who have a severe and persistent mental illness and are also considered high users of non-behavioral health medical services after a psychiatric inpatient stay. A high percentage of individuals with a mental health diagnosis have co-occurring chronic health conditions such as diabetes, hypertension, or asthma and could potentially benefit from additional case management of their medical care. Although an integrated model holds promise, we have several questions and concerns regarding the proposal:

- The Department of Health Services is currently working on several initiatives related to integrated care for individuals with a mental health diagnosis including the National Governor's Association Complex Care Initiative and the State Health Innovation Plan (SHIP). Is there a need for an additional pilot project aimed at high users of Medicaid dollars and how will it fit with these DHS initiatives? Will DHS have the resources to support two additional pilot projects? How many members can such a small investment fund?
- The proposed pilot primarily focuses on a medical model – hospital based care and outpatient medical care. Many of the services which are essential for the target population are non-medical services such as psycho social rehab services available in county administered benefits (CSP, CCS), as well as transportation, benefits counseling and housing. Any model for integrated care case coordination must include counties as partners and incorporate access to non-medical services. There is a brief references to coordination of social services but no details are specified.
- To develop a model of care that will be successful in engaging those served, it is essential to draw on the lived experience of members to help determine how to coordinate care which enhances the members' outcomes of improved quality of life, health, and independence. We are concerned that this proposal has been developed without input from individuals with lived experience of mental illness, or advocates with expertise in public benefits. We would recommend that the authors provide such opportunities for public input, and amend the proposal to include requirements for consumer and advocate input moving forward, in the pilot design and implementation.
- Participation in these pilots should be voluntary. Many Medicaid members have long standing relationships with their providers, including those who provide mental health care. These relationships are often the key to a successful outcome. Members should have the choice of continuing to be served by these providers and not be required to enroll in an integrated pilot.

- Many people with a mental health diagnosis have experienced discrimination from health care providers who may be dismissive of their health care concerns and inappropriately ascribe these physical concerns to mental illness or addiction. There must be a commitment by all providers in the integrated pilot to be responsive to health care concerns raised by members and to guard against the potential barrier of disability related discrimination. The role of the pilot's navigators and case coordinators is not clearly defined. The question then becomes whether hospital based these navigators would act more as gatekeepers to medical care than facilitators.

**Online Mental Health Bed Tracking System**

The proposal also includes a grant for development and administration of an internet site and system to show the availability of inpatient psychiatric beds statewide. Initially there is the general observation that this pilot facilitates the hospitalization of individuals needing mental health serves and discourages a consideration of whether there are other resources to divert an individual from an inpatient admission. The design of a bed tracking system should address the following concerns:

- Patient choice must be the determining factor in a placement out of the area. Therefore, this system should only be used with voluntary patients.
- The system should be designed to provide information about beds that are in closest proximity to the patient's home. Placements that are far from where the patient lives may not be conducive to good outcomes for several reasons.
    - Such a placement may create barriers to ensuring strong discharge planning and transition to the community. Staff at a remote hospital will not be familiar with local community services that are key to successful re-entry to the community after a psychiatric hospitalization.
    - Placing patients in a hospital far from their home will isolate them from family and friends and make recovery difficult.
    - Long transports to a hospital far away may further contribute to the trauma associated with a psychiatric hospitalization.
- Will hospitals participating in the bed tracking system have an obligation to accept patients referred from other areas? Currently one significant barrier for securing an inpatient psychiatric bed is that hospitals many not agree to serve certain prospective patients even when beds are available. There may be a number of contributing factors, such as policies related to serving Medicaid patients, other insurance coverage issues, or patient needs.
- Wisconsin's public mental health services are provided through a county-based model. There is no county involvement in this bed tracking system. They are neither consulted on an individual they may have been working with for a long time or allowed to access the tracking system.

**Medicaid Psychiatric Consult Reimbursement Pilot**

This proposal builds on the Child Psychiatry Consultation Program model, to fund consultation by a psychiatrist to primarily and specialty care providers. This was a very promising initiative and we have heard informally that there have been positive reports. We would recommend that there first be a review of the Child Psychiatry Consultation Program to evaluate its success and incorporate lessons learned before moving forward with an additional pilot. One additional issue that a number of people with mental illness experience is being" banned" by medical providers from receiving medical services. It would be helpful if this proposal also allowed for consultation on how to accommodate patients with mental illness by medical practitioners.

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Testimony on *Senate Bill 293* before the

**SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES**

October 13, 2015

**Dr. Ken Schellhase, MD – *WAFP member***

Good morning Chairperson Vukmir and members of the Committee. Thank you for the opportunity to testify today in favor of Senate Bill 293.

My name is Dr. Ken Schellhase. I am a practicing family physician, a faculty member at the Medical College of Wisconsin, and also work in a large Medicaid HMO. I am speaking today in both a personal capacity and as a representative of the Wisconsin Academy of Family Physicians.

The Wisconsin Academy of Family Physicians represents over 2,500 members statewide and is the single largest physician specialty group in Wisconsin. We are committed to promoting high professional and ethical standards in the practice of Family Medicine and improving the quality of medical care across the state.

The WAFP believes Senate Bill 293 is a huge step in the right direction – one that recognizes the need to increase access to mental health care; understands the benefits of coordinated care; and acknowledges the need to reform the conventional health care payment model.

There is no question psychiatric problems are a major health issue in Wisconsin and across the country. Mental health disorders create significant medical and societal costs, and are the leading cause of disability in the United States. As such, I applaud the Legislature for exploring creative policies to address this growing problem. I'm particularly pleased that SB 293 looks to further integrate mental health care with primary care.

We know that up to 70% of primary care visits stem from psychosocial issues. Furthermore, the majority of patients with mental health issues access the health care system

through primary care. Fortunately, primary care physicians are trained to manage the majority of patients with mental health issues and have great potential to fill the mental health workforce gap.

The WAFP is strongly supportive of the behavioral health care coordination pilot program created by SB 239. The Academy has long advocated for transforming – and ultimately thereby improving – the health care delivery system thorough integrated and coordinated care.

Research tells us that individuals with mental health disorders suffer at a higher rate from preventable chronic illnesses like diabetes and cardiovascular disease. By coordinating general medical services with behavioral health care, we can provide the best opportunity for good outcomes for patients with multiple healthcare needs. Coordinated care can also significantly reduce unnecessary hospital visits and lower overall health care costs.

However, care coordination and the integration of behavioral health and primary care requires extensive patient support and management provided by physicians. For the coordinated care model to be successful, physicians must be compensated for these value added services.

The WAFP is pleased SB 293 recognizes the need to compensate providers for time spent coordinating care by requiring a per member, per month Medicaid payment for patients in the pilot. Unfortunately, the legislation directs the additional payment to the health care organizations awarded the pilot program. The bill does not require any of the payment to flow down to the individual physicians providing and supervising the coordinated care. The WAFP would ask the committee to consider an amendment that directs at least a portion of the payment to the individual physicians participating in the pilot.

In closing, I would like to offer the WAFP's support for SB 293 and its forward-looking approach to improving the delivery of health care in Wisconsin. I appreciate the opportunity to testify and would be more than happy to answer any questions.

# MARY CZAJA

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**Senate Bill 293 – Behavioral Health Care Coordination Pilot Projects**
**Senate Committee on Health and Human Services**
**October 13, 2015**

Thank you for holding a public hearing today on Senate Bill 293. 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.

SB 293 has wide bipartisan support with over 70 cosponsors from both houses. 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

# Senate Bill 293

SENATE COMMITTEE *on* HEALTH & HUMAN SERVICES
Tuesday, Oct. 13, 2015

Vice Chairman Moulton, committee members, thank you for taking the time to hear my testimony on Senate Bill 293.

It is appropriate that we are discussing behavioral health issues this week. Saturday marked World Mental Health Day, and people worldwide spent the day promoting behavioral and mental health — exactly what this bill does. SB 293 demonstrates our continued commitment to promoting quality, coordinated behavioral healthcare in Wisconsin. I am proud to stand with Reps. Czaja and Kolste and Sen. Bewley — along with the broad bipartisan support this bill has in the legislature — to talk about how our state can improve how we care for those who suffer from mental illness.

Currently, 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. Collaboration between our hospitals, doctors, nurses and other healthcare providers who strive 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 provides funds to test new payment models created to reduce Medicaid costs by integrating care to help manage the costs of non-behavioral healthcare for individuals with significant or chronic mental illness. This project allows providers to test new, transformative Medicaid reimbursement models to see where they can find cost savings and where they can encourage proactive, synergistic care for patients with mental illness. By investing in these pilot projects now, the insights found in the results 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 eventually resulted in $8 million in savings to its Medicaid program. Furthermore, this resulted in a 65 percent decrease in MA 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.

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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. For example, when a patient visits with their primary-care provider, that 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 type of consultation. With this bill, the psychiatrist would be to be paid for his or her real-time, over-the-phone consultation, allowing for the primary-care doctor to help discover what the best method of care is 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 with 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 what psychiatric beds are available. This bed-tracker brings inter-hospital communication into the 21st Century by providing caregivers with real-time information of where the closest psychiatric beds are in their communities.

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 behavioral health issues. This will lead to financial savings for the state's Medicaid program. But, even more importantly, 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.

Thank you again for listening to my testimony. I encourage you to support SB 293, and I will be happy to answer any questions you may have.