

# Design of the

# Idaho Behavioral Health Plan

Report highlights

January 2016

The Legislature and the Department of Health and Welfare have successfully addressed concerns about the overreliance on psychosocial rehabilitation. The department now needs to make significant improvements to mental health program planning before taking its next steps.

## The plan

Idaho wanted to reform outpatient behavioral health for Medicaid patients.

The department planned for changes to policy, service criteria, and oversight to bring services in line with department intent.

Changes were implemented through a 3-year contract estimated at \$300 million.

## Results

A substantial decline in PSR.

An increase in other services: most notably family therapy. Despite increases in other services, total spending is down.

Savings has not come from a reduction of members served.

Intentional changes negatively affected some providers.

Investing savings in the community has proved more difficult than planned by the department.

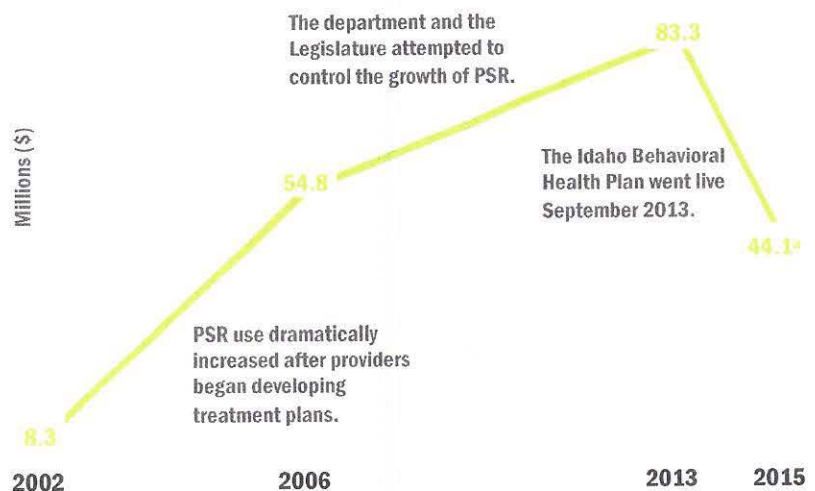
## Lessons

Clearly communicate plans and choices for new programs.

Program design should be well developed before going to contract.

Ensure sufficient expertise to align program design and vendor capabilities.

Medicaid spending on psychosocial rehabilitation (PSR) increased through 2013, a trend reversed by the behavioral health plan.



a. 2015 data extrapolated from Optum claims data. Changes in spending also reflect the department's redefinition of the service to community-based rehabilitation services in 2013.

## Recommendations

The department needs to continue taking steps to build capacity and services in the community.

The department should formally evaluate the merit of including inpatient services in the behavioral health plan.

The department should also use independent third-party expertise for assistance in evaluating the merit of including inpatient services. If it decides that including inpatient has merit, independent expertise would also be valuable for planning and designing the transition.

View the report: [www.legislature.idaho.gov/ope/](http://www.legislature.idaho.gov/ope/)



## The department's reliance on self regulation by providers led to disproportionate use of a single service: PSR.

Before making significant changes in 2002, department staff developed members' treatment plans. A member's treatment plan could include up to 20 hours of PSR per week. Before 2002, spending on PSR was stable: in 2000 spending on PSR was \$8.6 million and in 2001 spending was lower, at \$8.3 million.

During 2002 the department cut clinical staff and gave private providers responsibility to develop treatment plans. The department was concerned that the decision to give providers responsibility to develop treatment plans had allowed the uses of PSR to change. In addition to treating mental illness, PSR was sometimes inappropriately used to replace missing social services.

The department used three methods in its attempts to rein in PSR: incrementally lowering the maximum hours allowed from 20 hours per week to 4, increasing fraud prevention activities, and implementing a utilization management program.

As shown in exhibit 1, the department's policy decisions in the early 2000s led to significant growth in PSR from 2001 to 2012. In 2002 spending doubled to \$17.7 million. By 2012 the Division of Medicaid's spending on PSR had increased to \$76.1 million—more than nine times the spending in 2001.

During this time, if PSR had grown at the rate psychotherapy had grown, the department would be spending approximately \$50 million per year less on PSR than it had before transitioning to managed care. Because the department believed that other outpatient services would better treat mental illness, it wanted to reallocate resources accordingly.

See appendix D for details of the department's efforts to rein in PSR.

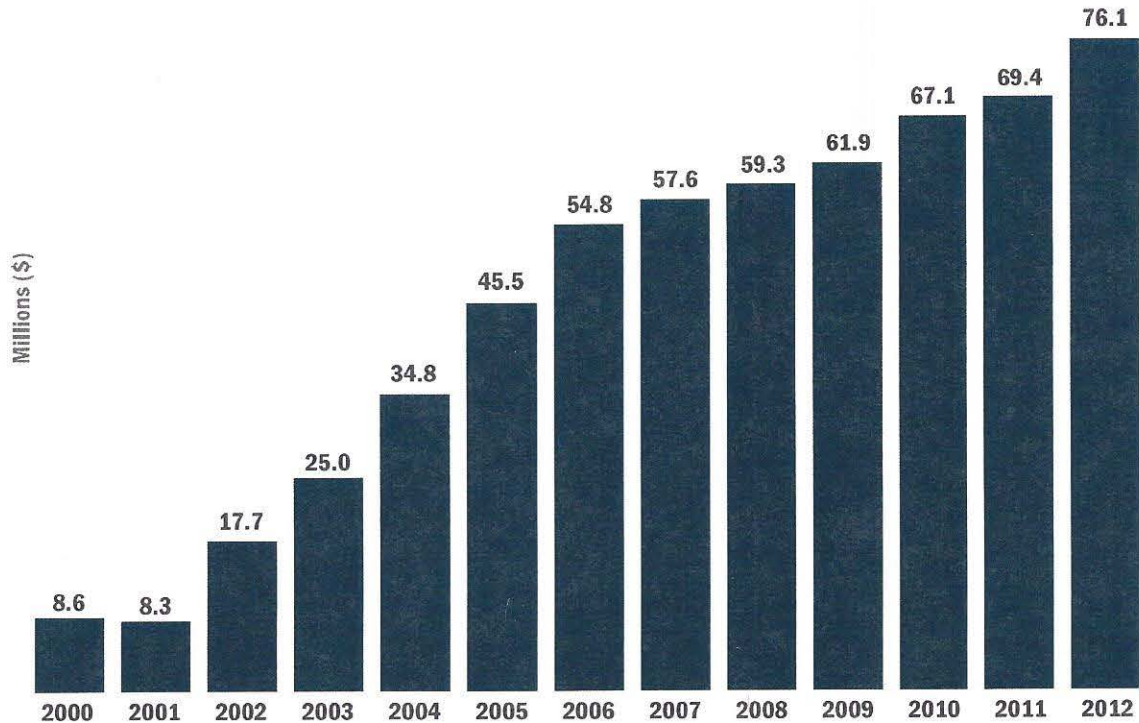
**By 2012, 65% of the division's outpatient behavioral health spending was on PSR.**

**The department was concerned that the decision to give providers responsibility to develop treatment plans had allowed the uses of PSR to change.**

**Exhibit 1**

**Medicaid spending on PSR increased ninefold from 2001 to 2012.**

The division put providers in charge of treatment plans in 2002.



**Other public health programs**

The Children's Health Insurance Program (CHIP) covers certain children in low-income families not covered by other sources. In Idaho, CHIP is administered as an extension of Medicaid. When we refer to Medicaid in this report, we include CHIP. It is jointly funded by states and the federal government.

Medicare is a program administered by the federal government that provides health coverage for the elderly and certain younger groups. No state money goes to Medicare. Medicare and Medicaid are entirely distinct, but some people are eligible for both programs.



# Psychosocial rehabilitation

Mental health rehabilitative services were introduced to the Medicaid benefit package July 1, 1994, and were called the community-support program. This history of the PSR benefit is adapted from a document provided by the Division of Medicaid.

## 1995

Initially, department regional staff conducted comprehensive assessments and developed initial service plans based on the comprehensive assessment and then referred the Medicaid participant to a community provider of the participant's choice. The community provider had to be enrolled in the Medicaid program as a rehabilitation provider. The rehabilitation provider completed the service plan by developing a task plan, which identified time-limited, measurable activities and assignments, to accomplish the objectives of the service plan.

The responsibility to review, approve, and authorize requests for prior authorization and the accompanying service plans was delegated by respective program managers to a unit supervisor, a review team, or a specifically appointed individual called the regional mental health authority. The regional mental health authority prior authorized the plan and the provider subsequently delivered the service and billed Medicaid.

## 2002

Following budget cutbacks in 2002, the assessment and treatment planning services for what had been renamed psychosocial rehabilitation were outsourced to the community provider network. Mental health authority staff was downsized to two staff members in each region. One authorized services for the adult Medicaid participants, and one authorized services for the child Medicaid participants. This was the beginning of the dramatic increase in the use of psychosocial rehabilitation.

## 2004

In 2004 Idaho Administrative Code was updated to include more specificity for application of the PSR benefit and standards for treatment planning (IDAHO ADMIN. CODE 16.03.09.449-459 (2004)).

The PSR authorization and auditing functions of the regional mental health authorities were brought under the supervision of one unit, the Mental Health Authority, located in Boise. Authorization functions for the entire state were handled in Boise. Each region retained one clinician, now supervised by the unit supervisor in Boise, to work with adult and children PSR agencies in its region.

## 2005

The Legislature passed House Bill 385 granting the Division of Medicaid authority to establish program credentialing mental health agencies, which ensured mental health clinics and PSR providers met quality standards, utilized qualified providers, and provided appropriate services that met the needs of Medicaid participants.

## 2007

The Division of Medicaid developed a credentialing program, the goal of which was to set a minimum standard of care for all Medicaid-reimbursed mental health services, including professional ethics standards for all agency employees, whether licensed or not (IDAHO ADMIN. CODE 16.03.09.712 and 16.03.10.130.09 (2007)).

## 2008

Fifteen FTEs of the Mental Health Authority were transferred to the Division of Medicaid from the Division of Behavioral Health to promote better oversight and administration of the PSR benefit. Eight FTEs were assigned to the Medicaid central office and seven FTEs, one located in each region, were assigned to work in the new Medicaid credentialing program.

## 2009

Because of budget holdbacks, the hard limit of the PSR benefit was set to 10 hours a week (House Bill 701) (IDAHO ADMIN. CODE 16.03.10.124.05 (2008)). The Division of Medicaid discovered that only a small proportion of Medicaid participants accessing PSR were also accessing psychotherapy services.

Quality assurance processes were put in place to identify issues and to serve as an educational tool via feedback. Quality assurance results revealed that providers were applying the PSR benefit in a variety of ways significantly supporting Medicaid participants to stay out of hospitals and remain in their community roles (family, school, natural supports) and to experience recovery and resiliency from crises in their lives. Quality assurance results also confirmed that the benefit continued to be applied inappropriately by some providers.

In 2009 Idaho Administrative Code was updated to account for credentialing program rules and clients' rights to safe and appropriate treatment by competent providers (IDAHO ADMIN. CODE 16.03.09.707–718 and 16.03.10.110–146 (2009)).

On May 8, 2009, requirements again changed for PSR specialists. PSR specialists who were currently employed had until January 1, 2012, to become certified as PSR specialists in accordance with requirements of the US Psychiatric Rehabilitation Association (USPRA). To become PSR specialists, applicants had to have a bachelor's degree in primary education, special education, adult education, counseling, human services, early childhood development, family science, psychology, or applied behavioral analysis. Qualified new hires had 18 months to obtain the USPRA certification (IDAHO ADMIN. CODE 16.03.10.131.03 (2009)).

To accommodate additional Governor's holdbacks, the hard limit of the PSR benefit was again reduced on May 8, 2009, to 5 hours a week with up to 5 additional hours a week with prior authorization (IDAHO ADMIN. CODE 16.03.10.124.05 (2009)).

In 2009 a utilization management program was put in place to ensure that participants whose PSR benefit was reduced did not subsequently need to access crisis services, inpatient hospitalization, or the emergency department. No increase in the utilization of these higher-cost services occurred.

## 2011

The PSR benefit was limited to 5 hours a week. Participants who receive psychosocial rehabilitation could not also receive skill training in partial care, developmental therapy, intensive behavioral intervention, or residential habilitation services. (IDAHO ADMIN. CODE 16.03.10.124.06 (2011)).

## 2012

Because of the third Governor's holdback, the hard limit of the PSR benefit was reduced again to 4 hours per week for adults 21 years or older and 5 hours as a baseline for children up to age 21 (early and periodic screening, diagnostic, and treatment process ensured no hard limit for children). Idaho Administrative Code was adjusted to accommodate this change (IDAHO ADMIN. CODE 16.03.10.124.06 (archive 2012)). Again, there was no increase in the higher-cost services as listed above.

