Human Services Research Institute

Milwaukee County Outpatient Behavioral Health Capacity Assessment

FINAL REPORT

October 27, 2015

Presented by:

Human Services Research Institute

Technical Assistance Collaborative

Public Policy Forum

Project Funders

Milwaukee Health Care Partnership

Greater Milwaukee Foundation

Charles E. Kubly Foundation

Wisconsin Department of Health Services

Rogers Memorial Hospital

United Way of Greater Milwaukee & Waukesha County

Anthem

Children's Community Health Plan

iCare

Managed Health Services

TLS Behavioral Health

UnitedHealthcare

Scope of the OCA

- Adult and child/adolescent clinical services and programs that are essential and available for a comprehensive system of care for low-income populations.
- Services assumed to be related to demand for inpatient care by functioning as an alternative to inpatient treatment in a community-based system of care.
- Excludes psychosocial and support services —also important but a separate category relevant only for a subpopulation of persons requiring outpatient behavioral health care.

Overarching Research Questions

- How many residents of Milwaukee county who are on Medicaid or are uninsured use behavioral health outpatient services?
- Where do they obtain these services?
- Are there significant gaps and/or barriers that prevent them from obtaining needed behavioral health care? If so, are these related to:

1. Lack of services or shortage of providers (gaps)
2. Inefficiency and fragmentation of the service system (barriers)

–OR–

3. Both gaps and barriers

Complexity of OCA

Challenges that make this report more complex than the Inpatient Capacity Analysis:

- More nuanced, multi-dimensional and exploratory
- More diffuse boundaries and greater diversity than inpatient treatment (BHD and private)

Complexity of OCA (cont.)

Inpatient Treatment

- Clear boundaries
- Narrowly defined clinical functions
- Comprehensive data systems

Outpatient Services

- Diverse provider organizations types and settings
  - Public, private, and faith-based
  - From large health systems to individuals in private practice
  - Broad range of services and client types vs. highly specialized
- Diverse practitioner types (including both health care and behavioral health specialties)
- Multiple, often mixed funding sources
- Multiple regulatory agencies and statutory requirements
- Multiple data systems that are nonintegrated (County and Medicaid), not comprehensive and not designed for assessment (billing systems), or not readily available (uninsured)

Complexity of OCA (cont.)

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Data Sources—Qualitative

Related to the availability and accessibility of outpatient services:

- Review of documents and previous reports
- Lists of licensed behavioral health provider organizations and practitioners
  - Interviews with stakeholders
  - BHD administrators
  - Hospital discharge planners
  - Administrators and staff of community programs and clinics (mental health/substance abuse and primary care including FQHCs)
  - Academia
  - Managed care organizations
  - Consumers (focus group)
- Simulated Patient Study

Data Sources—Quantitative

Related to service utilization:

- All Medicaid claims from July 2010 through September 2014, adult and child/adolescent enrollees with a behavioral health diagnosis registered in Milwaukee County
- Utilization data for services funded by Milwaukee County BHD for adults and children/adolescents, including Wraparound Milwaukee
- Emphasis on core clinical services vs. supportive/psychosocial services (although BHD data systems do not easily differentiate)

Topic Areas

1. Need: Treated and untreated prevalence, service gaps and barriers
2. Supply: Provider Inventory
3. Demand: Penetration and utilization (Medicaid and County-funded)
4. Recommendations to diverse stakeholders for increasing access and enhancing capacity

Provider Capacity

1. “Formal” system: Inventory of licensed provider organizations in Milwaukee County and BHD
2. “De facto” system of who is actually providing services: Provider volume (actual amount of services by providers including many outside Milwaukee County as indicated by Medicaid claims as well as BHD)

Provider Inventory
"Formal" Behavioral Health Care System

- 344 licensed Milwaukee County outpatient mental health, substance abuse and/or Wraparound provider agencies/clinics
- Includes multiple sites operated by a single organization
- Includes public, private, for profit, nonprofit, and faith-based organizations
- Does not include general health care (primary care)
- Does not include self-help programs (e.g., 12-Step)

Provider Volume
De Facto Behavioral Health Care System

- Who is actually providing behavioral health services to low-income (Medicaid) residents of Milwaukee County?
- Providers classified according to Medicaid "provider billing type" (see technical appendix for explanation)
  - Billing provider type consists of both organizations and professional specialties (authorized prescribers, who may be agency staff or private practice)
  - First 9 months of 2014—most recent data available; to capture effects of Medicaid expansion
- Services identified using CPT and DSM code algorithms

Providers by billing provider type serving Medicaid-enrolled Milwaukee County residents, Jan.-Sept. 2014

	Number of providers	Number of people served	Providers serving <10	Number people served by <10 providers
Mental health/substance abuse – individual non-prescribing clinicians	300	2,929	210	666
Physician – independent group practices	272	31,112	168	428
Physician – no affiliation identified	226	3,154	184	411
Nurse practitioner – no affiliation identified	20	49	18	49
Institutions for Mental Diseases – outpatient	8	2,459	4	8
Narcotic services	7	1,301	5	11
Crisis	11	1,611	11	10

Provider Volume Comments

- The number of providers far exceeds those located in Milwaukee County—A large number of providers that serve very small numbers of consumers, in many cases only one or two during the period.
- Conversely, a handful of large organizations serve a preponderance of individuals: the top three highest-volume providers together accounted for 40% of the total volume.

Provider Volume Policy Implications

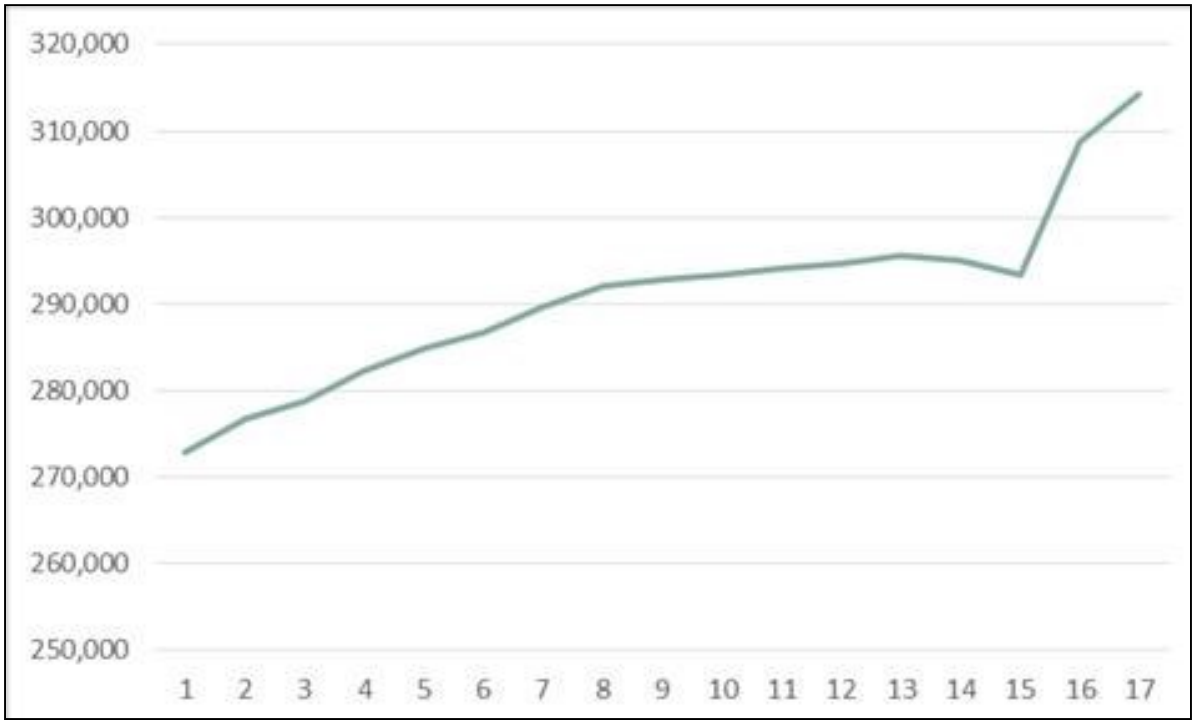
- The provider "system" is in fact bifurcated into "systems": a handful of large, high-volume providers and a large number of much smaller agencies and programs.
- Poses challenges for integrating services

–HOWEVER–

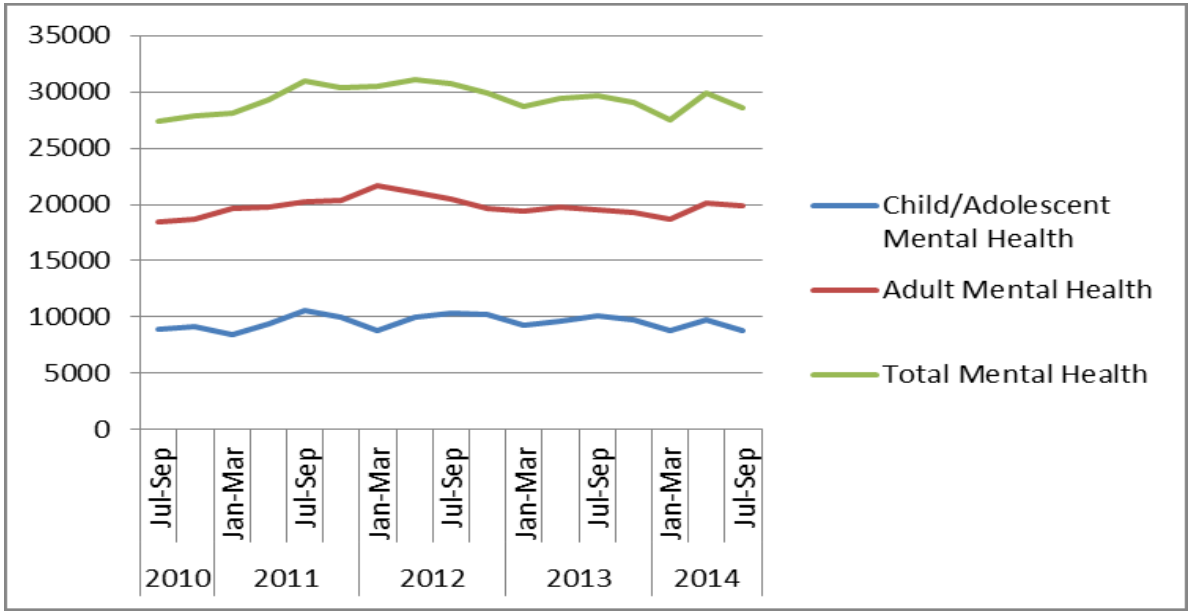
- Small providers may present opportunities for expanding capacity through outreach and integration

Trends in Medicaid enrollment

Total Medicaid enrollment by quarter, Jan. 2010 – Sept. 2014



Number of Adult and Child/Adolescent Medicaid enrollees receiving mental health services, by quarter (Jan. 2010 - Sept. 2014)



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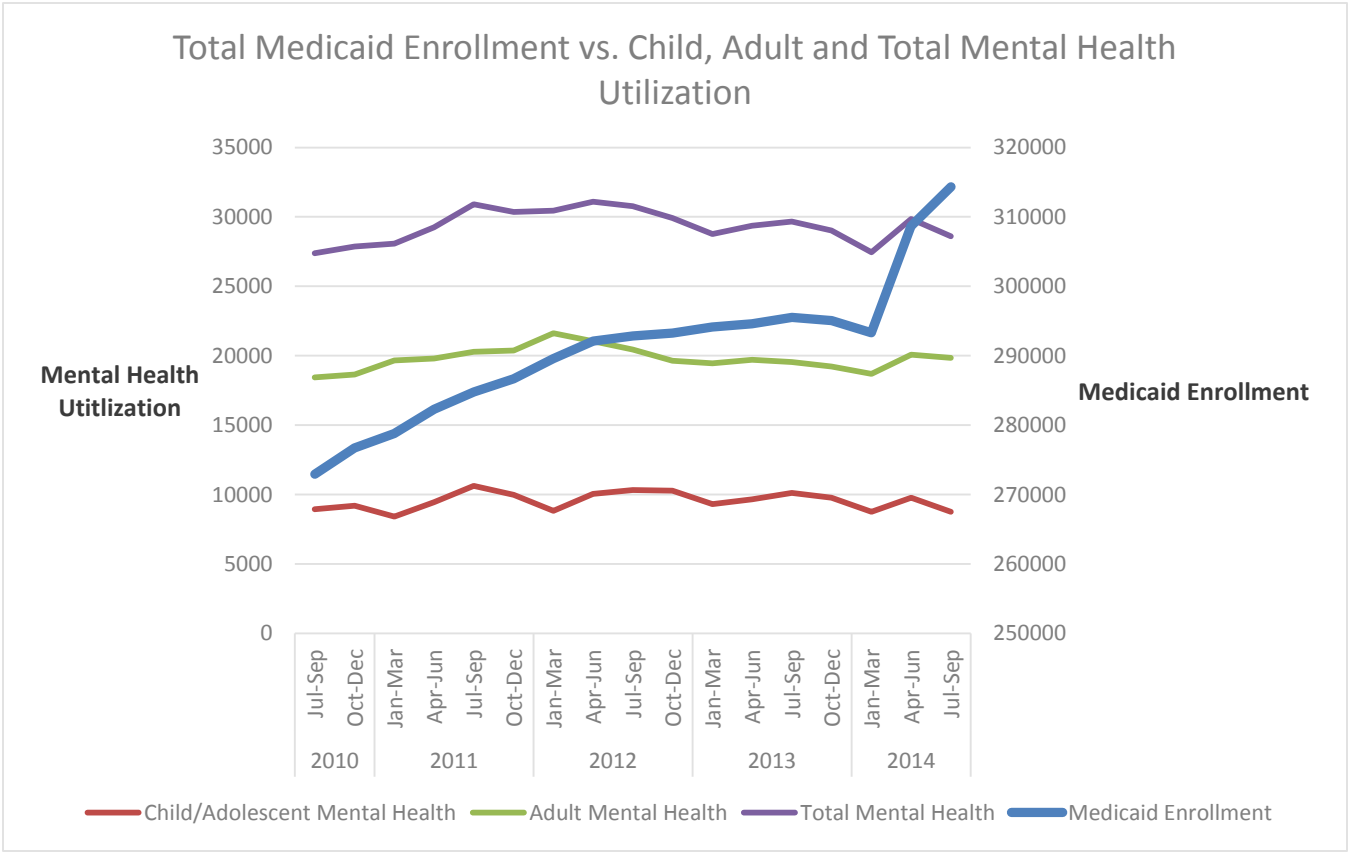
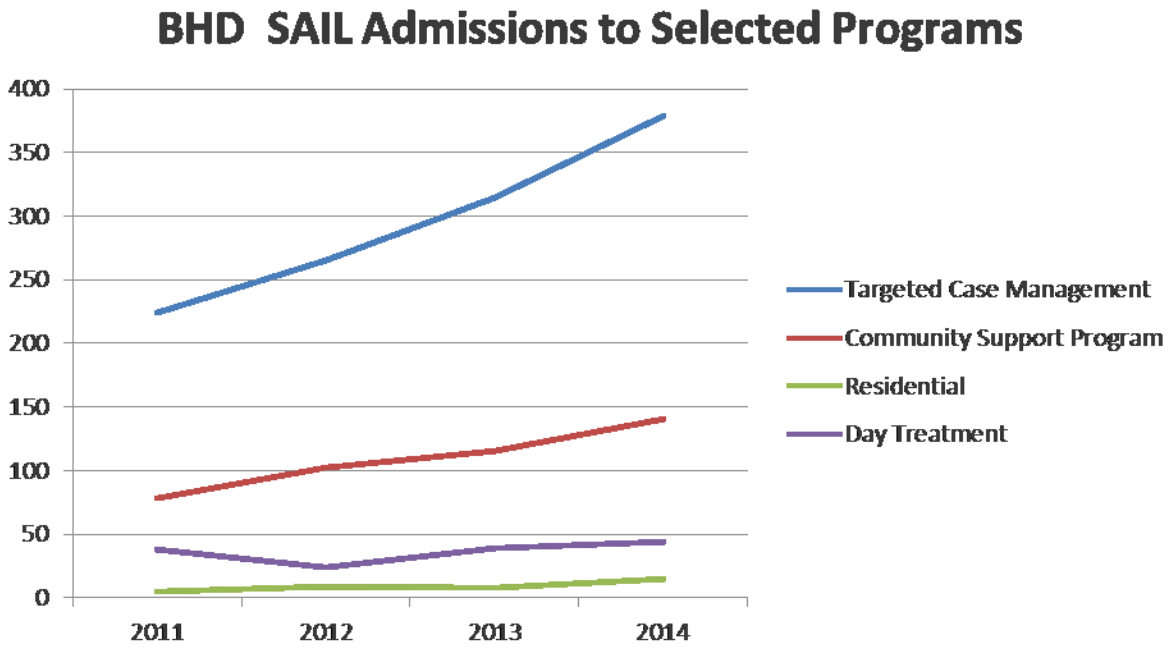


Medicaid Utilization Discussion

- Downward trend in penetration rate for both adult and child/adolescent mental health services over the measurement period (similar for substance abuse)
- May signify that service capacity is increasing but not keeping pace with enrollment growth, due to:
  - Behavioral health disorders less prevalent among more recent enrollees (unlikely);
  - Lagged response to demand (possibly); or
  - Service system has reached some maximum capacity, supply not responding to increased demand, perhaps because Medicaid rates inadequate incentive (most likely)

Utilization: County-Funded Services



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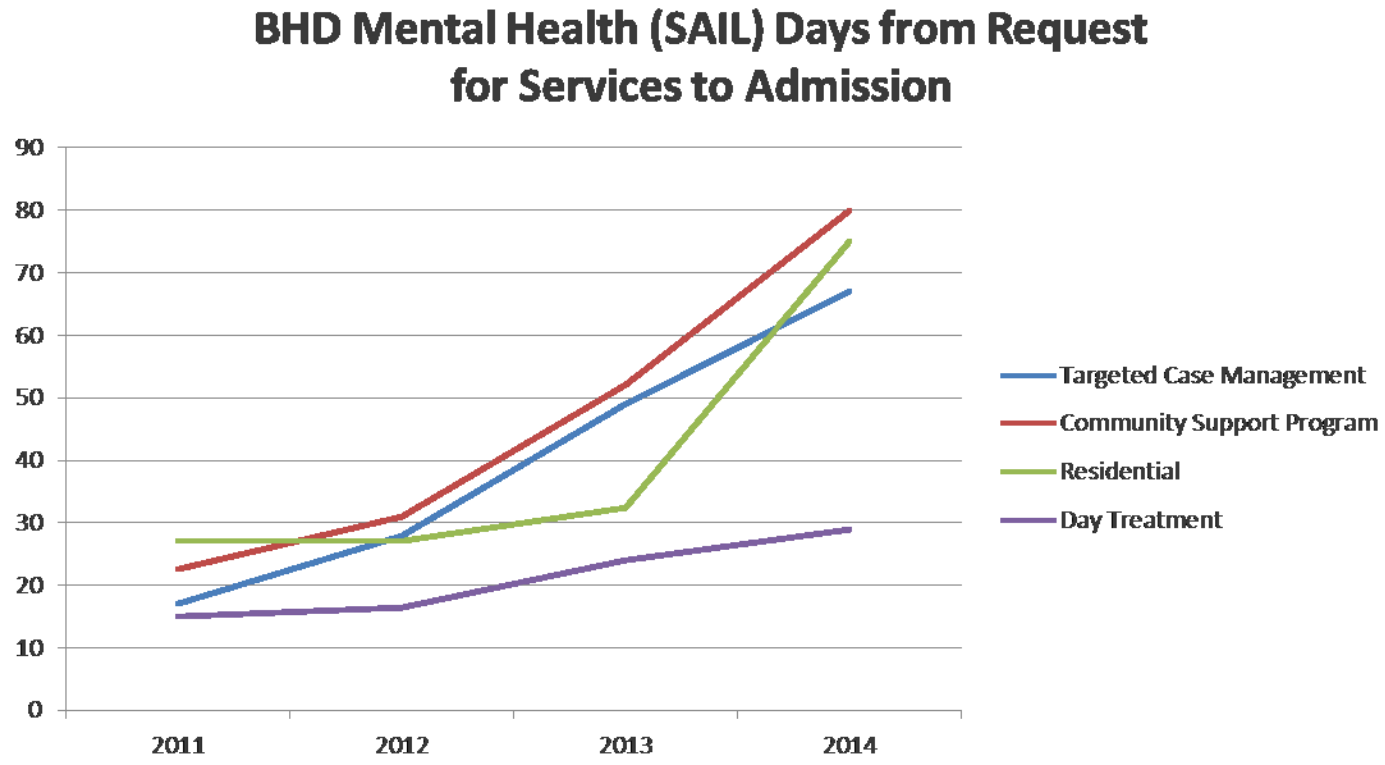

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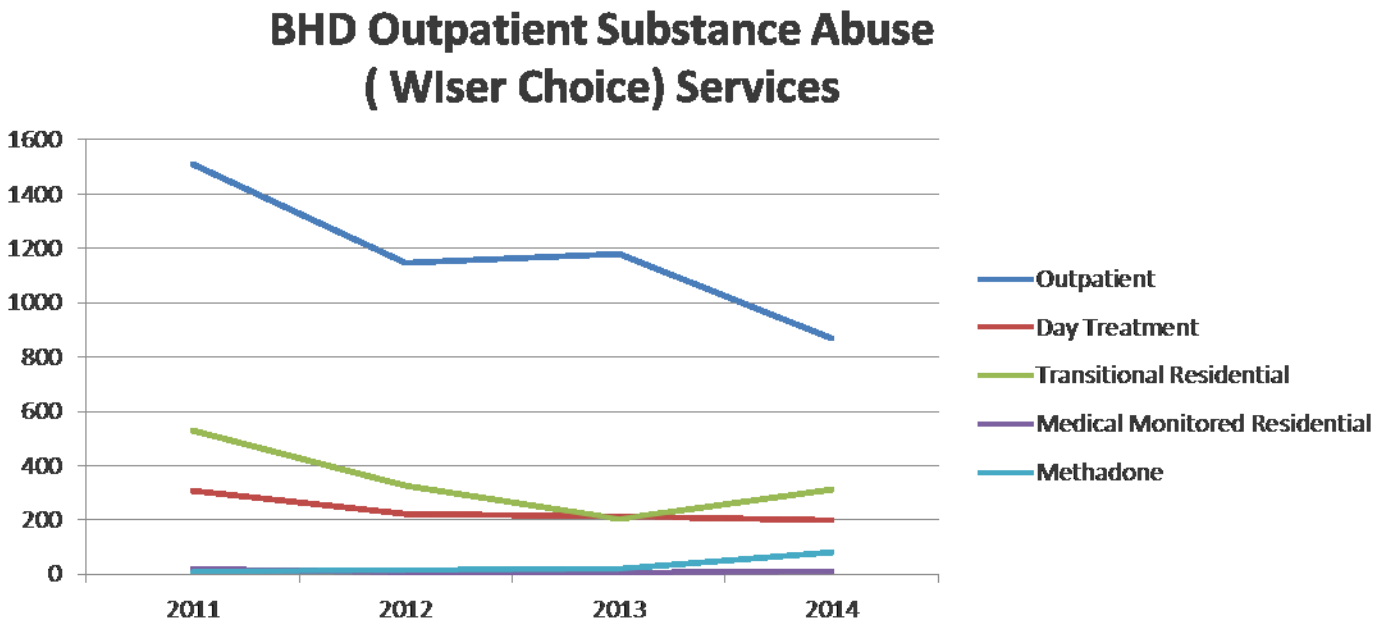

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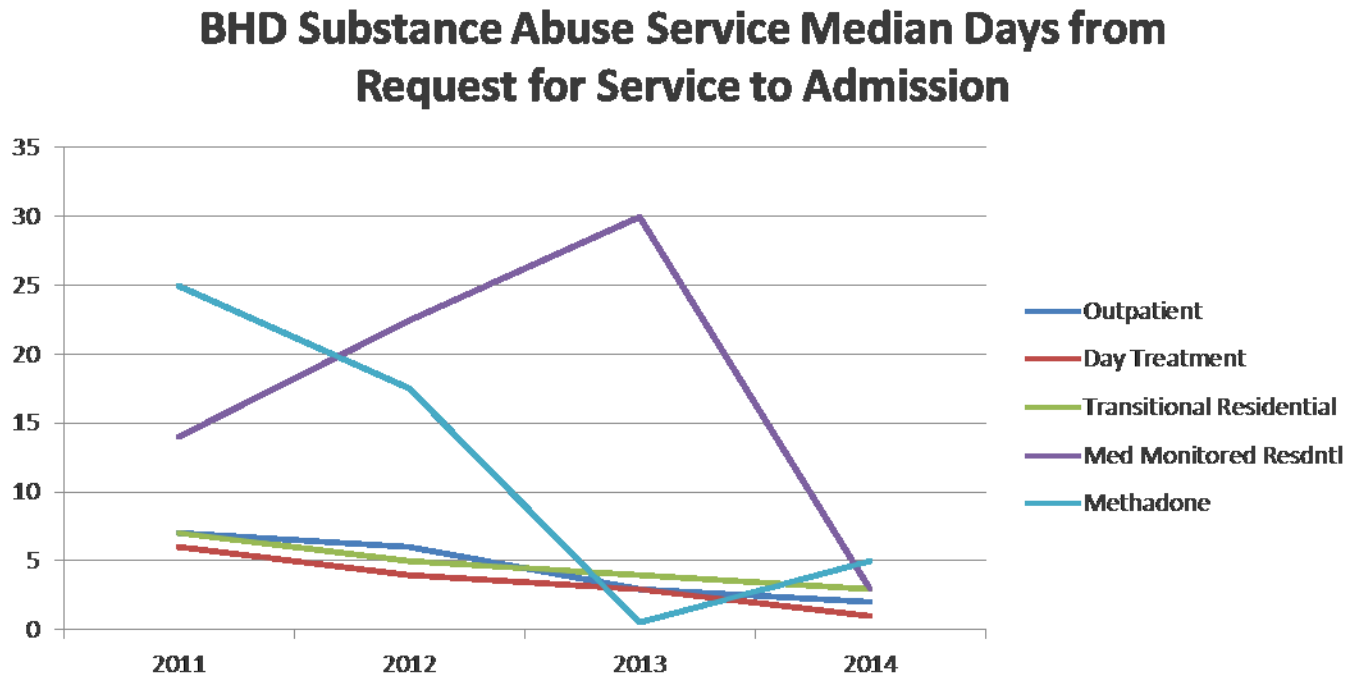

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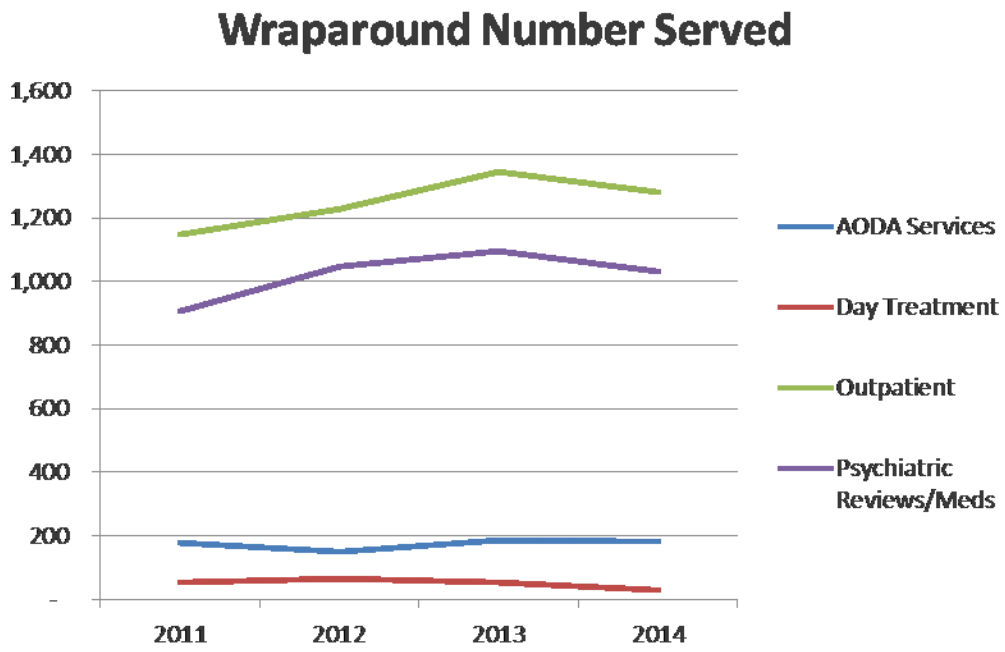

Service Gaps & Barriers: Stakeholder Interviews

- **Fragmentation**: Individually, many providers deliver high-quality care, but services take place in "silos," resulting in problems with access, integration, and continuity of care.
- **BHD service access**: Assessment and referral processing by the Service Access to Independent Living (SAIL) program can result in service access bottlenecks for persons with serious mental illness.
- **Dual diagnosis treatment**: Difficulties remain in terms of access to the WIser Choice Alcohol and Other Drug Abuse (AODA) program, with continuing bifurcation and duplication of mental health and AODA services despite past efforts to develop integrated treatment.

Service Gaps & Barriers: Stakeholder Interviews (cont.)

- **Managed care organizations**: Variation in managed care organization policies, procedures, and operational protocols creates confusion for members and providers. There were also questions about the availability of providers despite the large numbers listed as available on network lists.
- **Role of FQHCs**: The potential but as yet underdeveloped role of FQHCs in providing behavioral health services was noted, as was a lack of integration with BHD and other behavioral health providers.

Service Gaps & Barriers: Stakeholder Interviews (cont.)

- **Case management**: Stakeholders expressed frustration and concern over the lack of readily accessible case management.
- **Medicaid reimbursement rates**: Stakeholders identified the low Medicaid rates for services as one of the most significant barriers to behavioral health care, with several discharge planners asserting that only a handful of providers would accept Medicaid enrollees.
- **Psychiatrist and advanced practice nurse shortages**: Barriers particularly to psychotropic medication treatment, especially for children, were widely noted, with representatives of provider organizations commenting on the challenges of recruiting and retention.

Service Gaps & Barriers: Stakeholder Interviews (cont.)

- **Primary Care Practitioners**: PCPs are a resource for treating individuals with less serious disorders, but most are reluctant to treat children, older adults, and adults with more complex behavioral health conditions, particularly with respect to prescribing psychotropic medications.
- **Telemedicine**: While several stakeholders acknowledged that telemedicine is a reimbursable service approach under Wisconsin Medicaid, only one provider was identified as offering the service.
- **Navigation and transportation**: Stakeholders reported a lack of convenient and accessible public transportation options as a significant barrier to care.

Service Gaps & Barriers: Simulated Patient

Are new patients being accepted? If so, is Medicaid being accepted? If so, what is the wait time to first appointment?

Provider type (Number contacted)	Accept new patients	% accept new patients	Accept Medicaid	% Accept Medicaid	Days to Appointment
Non-billing Clinic/Practice (27)	14	52	13	48	Mean 37 Median 30 Range 5-75
Child psychiatrist (8)	7	88	8	100	6-12 months PCP required

Conclusions

- Which approach would be most effective for reducing the extent of unmet need: simply increasing the supply of providers or addressing inefficiencies and barriers to access among the array of providers currently in place?
- Our analysis indicates that both are significant contributing factors and both need to be addressed.

Conclusions (cont.)

- While data limitations preclude definitive determinations as to the causes and effects of outpatient access challenges, several salient points are suggested by the data:
  - Stakeholder perspectives and other forms of anecdotal evidence are important for identifying areas of concern and flagging issues requiring attention, but they should not be relied upon as the sole basis for remedial action.
  - Corresponding to the fragmentation and discontinuity of the behavioral health services is a lack of comprehensive and well-integrated data systems that would provide for overall monitoring of system performance and identification of opportunities for improvement.

Conclusions (cont.)

- Services for the Medicaid population are characterized by a handful of high-volume provider organizations and a much larger number of various types of organizations and individual clinicians that serve a small number of clients, with a minimal amount of coordination.
  - Given this variability and loose structure, improvements in communication and coordination could have a significant impact capacity in addition to an increase in provider supply.

Conclusions (cont.)

- The analysis of Medicaid claims indicates that despite increased enrollment, service capacity remained stable or even shrank slightly.
  - Of several possible explanations, the most likely is that Medicaid rates are not adequate to stimulate supply in response to increased demand.

Recommendations: Seizing the opportunity to guide and support system redesign

- Goals of system redesign:
  - Expand community-based services
  - Improve quality
  - Control costs
  - Support recovery
- Recommendations emphasize an opportunity for BHD to take a leadership role as coordinator/facilitator, but also require action by various other stakeholders.
- Here, we suggest “key implementers” and suggested initial actions & metrics—however, the report does not specify as these need to be established by relevant stakeholder

BHD Leadership and Facilitator Functions

(MOST ALREADY AT SOME STAGE OF DEVELOPMENT)

- Acting as the County Behavioral Health Authority, work with providers and other stakeholders to establish accountability for achieving specific strategic plan objectives
- Continuing development of the BHD strategic plan, with clearly articulated goals, objectives, action steps and timelines for achieving the vision
- Providing tools and resources to support the envisioned change
- Creating performance and outcome measures to incentivize and assess change
- Identifying and addressing potential concerns as they emerge, to prevent disruption in progress

Processes and Policies to Improve Access to Outpatient Care

Coordinate and communicate behavioral health outpatient services capacity: identify and allocate existing capacity

- Assess current low-volume providers' willingness and capability to increase number of Medicaid clients
- If results are positive, develop means of communicating availability throughout the system

Improve intake processes for BHD services

Key Implementer(s): BHD

Suggested initial action steps/metrics:

1) Potential under-utilized Medicaid providers identified, contacted to determine potential for increased capacity
2) Continue measurement of mean and median time to admission
3) Outliers reviewed, strategies to address problem cases developed

Processes and Policies to Improve Access to Outpatient Care (cont.)

Expedite private provider intake policies and procedures

- Increase use of patient reminder technology
- Track missed appointment to identify patterns
- Increase use of modern scheduling methods especially for complex patients
- Develop inter-agency “warm hand-off” procedures

Key implementers(s): Providers in coordination with MCO’s with monitoring by BHD for persons with SMI and SED.

Suggested initial action steps/metrics:

1) Mean and median amount of time until appointments received
2) Outliers reviewed, strategies to address problem cases developed

Processes and Policies to Improve Access to Outpatient Care (cont.)

Increase the use of health information technology

- Broaden participation in Wisconsin Statewide Health Information Network (WISHIN) Pulse, especially for coordination of behavioral and physical health care

Key implementer(s): BHD (coordinating with MCO's, DHS and providers)

Suggested initial action step/metric:

1) Number of providers participating in WISHIN

Strategies to Increase Outpatient Service Capacity

Recognize and embrace FQHCs and similar health centers as participants in the outpatient behavioral health system

- Expand utilization of FQHC patient-centered medical homes
- Maximize advantages of prospective payment systems

Key implementer(s): BHD in coordination with FQHC's

Suggested initial action step/metric:

1) Number of adults and children receiving integrated health and behavioral health services at FQHC's

Strategies to Increase Outpatient Service Capacity

Support the replication of Medicaid health homes initiatives

- Monitor and learn from existing and proposed models for complex populations (SPA for Persons with HIV/AIDS, TLS High Acuity Behavioral Health Medical Home)

Key Implementer(s): Wisconsin DHS in coordination with BHD

Suggested initial action steps/metrics:

1) Behavioral health medical homes established in Milwaukee County
2) Number of persons enrolled in behavioral health medical homes

Strategies to Increase Outpatient Service Capacity (cont.)

Fully implement Medicaid-covered services

- Continue efforts between BHD and DHS to resolve barriers to maximum implementation and utilization of Medicaid reimbursable services such as CCS and CRS

Key implementer(s): BHD supported by Wisconsin DHS

Suggested initial action step/metric:

1) Number of consumers transferred from County to Medicaid funded services

Strategies to Increase Outpatient Service Capacity (cont.)

Facilitate collaborative workforce recruitment and retention strategies

- Rather than competing, behavioral health and primary care providers develop collaborative approaches for recruiting and retaining staff

Key implementer(s): BHD as coordinator of joint efforts by private providers and MCW.

Suggested initial action steps/metrics:

1) Formation of study group/task force
2) Development of system wide strategic recruitment plan

Strategies to Increase Access to Psychiatric Capacity

- Expand the use of telepsychiatry
- Build on the success of the Medical College of Wisconsin's Child Psychiatric Consultation (CPC) program and adopt a similar program for adults

Key implementer(s): BHD (with system-wide collaboration)

Suggested initial action step/metric:

1) Number of telepsychiatry contacts

Addressing Gaps in Substance Use Disorder Treatment

- Recruit and incentivize providers of medication-assisted treatment to promote greater access to Buprenorphine and Suboxone

Key implementer(s): Wisconsin DHS supported by BHD

Suggested initial action steps/metrics:

1) Number of practitioners authorized to provide MAT

2) Number of low-income persons receiving MAT

Increase Medicaid Provider Supply

- Increase Medicaid rates for behavioral health outpatient services
- Engage Medicaid managed care organizations in addressing gaps in outpatient care

Key implementer(s): Wisconsin DHS, coordinating with MCO's

Suggested initial action steps/metrics:

1) MCO provider networks reviewed by DHS

2) DHS-MCO contract language regarding network adequacy review, modified as indicated

3) Existing pay-for-performance measures

Action on recommendations of the Outpatient Capacity Analysis

- BHD assumes facilitator/coordinator role, acting as a behavioral health authority
- BHD organizes an Outpatient Behavioral Health Services work group with other key stakeholders (including DHS) to:
  - Identify a primary implementer/coordinator for each recommendation
  - Develop action steps, performance metrics, assigned responsibilities, and monitoring procedures