disabilityrights WISCONSIN
Protection and advocacy for people with disabilities.

INITIALCOMMENTS ON LRB 2586/1 and LRB 3370/1 - 9/29/2015

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While DRW appreciates the intent of LRB 2586/1 and LRB 3370/1 to improve outcomes for Medicaid recipients who have mental illness, we urge a "go slow" process to allow these proposals to be vetted and enhanced by stakeholders, including people with lived experience of mental illness, advocacy organizations, and counties as they play a key role in administering mental health services.

The **Behavioral Health Coordination Pilot** proposal would fund a pilot project to test alternative coordinated care delivery and payment models to reduce costs of Medical Assistance recipients who have significant or chronic mental illness. 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 a holistic integrated model. Although an integrated model holds promise, we have several questions and concerns regarding the proposal:

- The Department of Health Services is already 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 and how will it fit with the other 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 counselling and housing. Any model for integrated care must include counties as partners and incorporate 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 better coordinate care with the goal of improving the quality of life, health, and independence of members. 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 a 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.

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. 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.
- 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 will 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 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.

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.