



Opportunities to Design Innovative Service Delivery Systems for Adults with Serious Mental Illness (SMI) or Children with Serious Emotional Disturbance (SED)



*State Medicaid Director
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- 1115 SMI/SED Demonstration Opportunity

Background: Care Delivery Issues

- Mental health disorders usually first arise in childhood, adolescence, or early adulthood.
- Gap of 10 years or more on average between onset of symptoms and initiation of treatment.
- Individuals with serious mental illness (SMI) or serious emotional disturbance (SED) are less likely to finish high school and attain higher education.
- Adults who are homeless have high rates of SMI.
- Individuals with SMI often have co-morbid physical health conditions and substance use disorders.
- There is an elevated risk of suicide in the first year after diagnosis of SMI.
- Most adults with SMI and children with SED do not receive timely follow-up care after inpatient stays.

*Citations for these findings can be found in the Letter to State Medicaid Directors Letter #18-011 on “Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance”

Background: Statutory Requirement

- Sec. 12003 of the 21st Century Cures Act requires CMS to issue a State Medicaid Director Letter (SMDL) on –
 - Opportunities to design innovative service delivery systems, including systems for providing community-based services, for adults with SMI or children with SED; and
 - Opportunities for demonstration projects under section 1115 to improve care for adults with SMI and children with SED
- SMDL issued Nov. 13, 2018 has two parts:
 1. Strategies under Existing Authorities to Support Innovative Service Delivery Systems for Adults with SMI and Children with SED; and
 2. SMI/SED Demonstration Opportunity

Earlier Identification and Engagement in Treatment

- Strategies to address long delays before accessing treatment for serious mental health conditions and improved engagement in treatment:
 - Supporting provider outreach activities to engage individuals in treatment, e.g., by developing relationships between outpatient MH providers and hospitals, primary care, schools, jails/prisons;
 - Enabling data-sharing between schools, hospitals, primary care, criminal justice, and specialized mental health providers; and
 - Supporting team-based models of care (e.g., Coordinated Specialty Care) and recovery supports (e.g., Supported Employment/Education)

Integration of Mental Health Care and Primary Care

- Strategies to facilitate earlier identification of treatment needs, connections with treatment, and access to treatment for co-morbid conditions:
 - Encouraging screening for mental health disorders in primary care and other health care settings;
 - Supporting consultations with MH specialists and care coordinators by primary care providers (e.g., Collaborative Care Model); and
 - Implementing telehealth technologies to support primary care provider consultation with mental health specialists and care coordination

Improved Access to Continuum of Care Including Crisis Stabilization

- Strategies to improve care for MH conditions that vary in severity over time:
 - Encouraging use of evidence-based assessment tools, e.g. LOCUS
 - Increasing availability of intensive outpatient programs including --
 - Clinic programs modeled after the Certified Community BH Clinic demonstration (ending this year);
 - Assertive Community Treatment programs;
 - Establishing crisis stabilization programs including call centers, mobile crisis units, short-term crisis stabilization programs (day programs and residential); and
 - Developing the capability to track which MH providers are accepting new Medicaid beneficiaries at different levels of care

Better Care Coordination and Transitions to Community-based Care

- Strategies to improve coordination between levels of care:
 - Implementing accountability measures and payment incentives for plans and providers (e.g., Medicare Hospital Readmission Reduction Program);
 - Requiring hospitals/residential settings to contact individuals within 3 days of discharge; and
 - Hiring peer support providers to help make connections

Increased Access to Services that Address Social Risk Factors

- Strategies to help individuals with SMI or SED maintain a job, stay in school, and access stable housing:
 - Improving access to supportive services including supported employment, supported education, supportive housing; and
 - Adopting or expanding Medicaid Ticket to Work programs that allow working individuals with disabilities whose income and/or assets exceed eligibility limits to maintain Medicaid coverage, usually with a sliding scale premium or other cost-sharing

SMI/SED Demonstration Opportunity

Expectations

- Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program.
- This SMI/SED demo opportunity allows Federal Financial Participation (FFP), upon CMS approval, for services for beneficiaries who are short-term residents in an Institution for Mental Diseases (IMD) primarily to receive mental health treatment if a state also takes action to –
 - Ensure good quality of care in IMDs; and
 - Improve access to community-based care

SMI/SED Demonstration Opportunity Parameters

- States are expected to achieve statewide average length of stay in IMDs of 30 days and comply with other Medicaid laws, regulations, and Special Terms and Conditions for these 1115 demonstrations
- Budget Neutrality is required
- Exclusions:
 - Room and board in residential treatment settings unless they qualify as inpatient facilities under section 1905(a) of the Act;
 - Nursing homes;
 - Inmates receiving treatment in a psychiatric facility or unit where oversight of the individual is under the jurisdiction of the criminal justice system
- For beneficiaries aged 21 and under, existing exception to IMD exclusion and rules for that exception continue to apply

Overarching Goals of SMI/SED Sec. 1115 Demonstration Initiative

- Participating states expected to take a number of actions and report information regarding progress on the following set of goals:
 1. Reduced utilization and lengths of stay in emergency departments (EDs) while awaiting access to specialized MH treatment;
 2. Reduced preventable readmissions to acute care hospitals and residential settings;
 3. Improved availability of crisis stabilization services;
 4. Improved access to community-based services to address the chronic mental health care needs; and
 5. Improved care coordination, especially continuity of care in community following hospital and residential treatment stays

Four Milestone Categories for SMI/SED

1115 Demonstrations

- Participating states expected to achieve specific milestones in the following categories:
 1. Ensuring good quality of care in psychiatric hospitals and residential settings;
 2. Improving care coordination and connections to community-based care;
 3. Increasing access to a continuum of care including crisis stabilization services; and
 4. Earlier identification and engagement in treatment including through integration
- Implementation Plan required for FFP to be available to IMDs

Milestone Category 1: Ensuring Quality of Care in Inpatient Hospitals & Residential Settings

- a) Participating hospitals and residential settings must be licensed/certified and accredited prior to participating;
- b) State oversight process (including unannounced visits) ensuring licensing/certification and accreditation requirements are met;
- c) State utilization review entity to ensure appropriate levels of care, types of care, lengths of stay;
- d) State compliance process for program integrity requirements; and
- e) State requirement that inpatient & residential settings screen for co-morbid conditions and facilitate access to treatment.

Milestone Category 2:

Improving Care Coordination and Transitions to Community-Based Care

- Ensure inpatient & residential settings provide intensive pre-discharge planning including:
 - a) Community-based providers are engaged in care transitions;
 - b) Assessment made of beneficiaries' housing situations and coordination with housing services providers;
 - c) Contact beneficiaries and community-based providers within 72 hours post discharge;
- State strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED; and
- State plans to enhance interoperability and data-sharing between physical, mental health, and SUD providers

Milestone Category 3:

Increasing Access to Continuum of Care Including Crisis Stabilization

- a) Annual assessments by states of availability of mental health and crisis stabilization services across the state;
- b) Commitment by states to a financing plan to increase availability of community-based crisis stabilization and on-going mental health services;
- c) Improvements to state's capability for tracking available inpatient and crisis stabilization beds; and
- d) State requirement to use an evidenced-based, publicly available patient assessment tool to determine appropriate level of care and length of stay

Milestone Category 4: Earlier Identification and Engagement in Treatment

- a) Implementation of strategies for identifying and engaging beneficiaries in treatment sooner, e.g., with supported education and employment;
- b) Increased integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment; and
- c) Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI

Process for Submission, Review, Approval, and Implementation

- States should follow the usual process for submitting section 1115(a) demonstration proposals as outlined in the federal regulations at 42 CFR 431.412 and 42 CFR 431.408.
- For this SMI/SED demo opportunity, states also should include in their applications:
 - Commitment to on-going funding for outpatient community-based services; and
 - Assessment of availability of mental health services throughout the state.
- Implementation Plan
 - CMS approval required for FFP prospectively for services provided to beneficiaries in IMDs that are accredited and licensed/certified

Monitoring and Evaluation: Process

- Monitoring Protocol – regarding state reporting on performance measures and other information
 - developed in consultation with CMS
 - after approval of the demonstration
- Three quarterly reports and 1 annual report - every year
- Mid-Point Assessment - performed between years 2 and 3 on state progress regarding milestones and performance measure targets
- Interim Evaluation - with renewal request or one year prior to the end of the demonstration
- Summative Evaluation - 18 months after the end of the demonstration period

Additional Tools

CMS is developing additional tools & guidance for states on the following topics:

- Implementation Plan (including the Financing Plan);
- Maintenance of Effort;
- Assessment of Current Availability of Mental Health Services;
- Annual Assessments of Availability of Mental Health Services;
- Monitoring;
- Evaluation; and
- Budget Neutrality

For Further Information

- The SMI/SED SMD Letter is posted here:
<https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>
- For questions about the SMD Letter, please e-mail
Kirsten.Beronio@cms.hhs.gov
- For states that have an approved section 1115 demonstration, please contact your CMS project officer.
- For states that do not have an approved demonstration, please e-mail 1115demorequests@cms.hhs.gov

Questions

