



# Hogg Foundation for Mental Health

## Mental Health Policy Priorities 2018/2019

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### Key Issues:

- Peer Support Services
- Mental Health Parity
- Mental Health and Trauma-Informed Care for Individuals with Intellectual/Developmental Disabilities
- Mental Health Workforce Development Plan
- Strengthening the Mental Health Workforce
- Integrated Health Care
- Mental Health Funding
- State Psychiatric Hospital Beds and Infrastructure

### Peer Support Services

According to the Center for Medicaid/Medicare Services (CMS), peer support services are an evidence-based mental health model of care in which peers who have a history of lived experience with mental illness or substance use their personal recovery and specialized training to help guide other individuals experiencing a behavioral health condition in their own recovery. Research is continuing to emerge on the efficacy and outcomes of peer support services.

Peer services are cost effective and can be used in criminal justice facilities, emergency rooms, state hospitals, community clinics, and other mental health provider locations to supplement traditional mental health services and add value to treatment and recovery teams.

“Peer services” are not currently a Medicaid billable service and are not defined in statute or rules. Expanding access to evidence-based support services from certified peer specialists and substance use recovery specialists is an immediate step Texas should take to help address the significant mental health workforce shortage.

### RECOMMENDATIONS:

With input from mental health and substance use peer specialists, and other relevant stakeholders, the commission shall develop and the executive commissioner shall adopt:

1. Rules that establish training requirements for peer specialists so that they are able to provide services to persons with mental illness and/or services to persons with substance use conditions;
2. Rules that establish certification and supervision requirements for peer specialists;
3. Rules that define the scope of services that peer specialists may provide;
4. Rules that distinguish peer services from other services that a person must hold a license to provide; and,

5. Any other rules necessary to protect the health and safety of persons receiving peer services.

The commission in its rules and standards governing the scope of services provided under the medical assistance program shall include peer services provided by certified peer specialists to the extent permitted by federal law.

## **Mental Health Parity**

Per federal regulations in the Mental Health Parity and Addiction Equity Act (MHPAEA), all health plans that offer mental health or substance use benefits must provide those benefits at the same level (“parity”) as surgical and medical benefits.

In 2011, the Texas Department of Insurance (TDI) adopted rules in response to MHPAEA. As required by federal law, TDI’s rules detail that mental health and substance use benefits must be offered at a comparable level to medical and surgical benefits. The rules do not, however, address certain federal parity regulations, including non-quantitative treatment limitations (NQTLs). While quantitative treatment limitations are numerical, like the number of visits per year or the number of days covered for inpatient treatment, NQTLs include “non-numerical limitations” like step-therapy or pre-authorization. A MHPAEA rule issued in 2013 requires parity in NQTLs, but TDI rules do not yet reflect this federal update.

Although Texas has its own parity rules and regulations, many consumers continue to struggle with their health plans to receive needed mental health and substance use services. More work is needed to ensure that individuals with mental health and substance use conditions can access needed services at parity with medical and surgical benefits.

### **RECOMMENDATIONS:**

1. Require that health benefit plans offered by insurers and HMOs in the individual, small employer, and large employer markets comply with federal parity law and federal regulations pursuant to the act, including requirements related to NQTLs. NQTLs need to be clearly defined within the Insurance Code.
2. Create a Behavioral Health Access to Care Ombudsman position within the existing HHSC Ombudsman Office to handle behavioral health access to care complaints, including complaints pertaining to MH/SUD parity. This position would also be tasked with parity education for providers and consumers, reviewing current parity complaint processes, and tracking and monitoring NQTL-related complaint trends.
3. Create a Mental Health and Substance Use Disorder Parity Advisory Work Group to bring together stakeholders to work on MH/SUD parity issues in Texas. The committee would be tasked with issuing recommendations on: parity compliance, strengthening oversight of parity at state and federal agencies, improving the complaint process for consumers and providers, and increasing public and provider education about parity.
4. Direct TDI and HHSC to collect data from commercial and Medicaid health plans, as appropriate, to determine the rate at which medical and/or surgical benefits and MH/SUD benefits are subject to prior authorization or utilization review, denied as medically necessary, or subject to an internal appeal.

## **Mental Health and Trauma-Informed Care for Individuals with Intellectual/Developmental Disabilities**

People with intellectual and developmental disabilities (IDD) are too often defined by their behaviors – behavior challenges, behavior plans, behavior interventions. It is past time to move from "managing behaviors" to supporting individuals with IDD and co-occurring mental health conditions by providing appropriate mental health treatment and supports.

Individuals living with IDD experience abuse, neglect, bullying, isolation, institutionalization, and other forms of trauma at two to three times the rate of those without IDD. They also experience the associated depression, anxiety, post-traumatic stress, and more. Additionally, there is nothing about having IDD that makes an individual immune from the same mental illnesses that those without disabilities experience, including bipolar disorder and schizophrenia. Yet we continue to focus on managing inappropriate behaviors instead of working to heal trauma and support recovery from mental health conditions. It's time to change our focus to mental health and wellness, trauma-informed care, and recovery.

### **RECOMMENDATIONS:**

1. Develop standards for services to individuals with intellectual/developmental disabilities and co-occurring mental health conditions within the Texas Health and Safety Code. These standards should ensure access to quality mental health assessments, diagnosis, and treatment for individuals with IDD in the state health and human services system.
2. Require each Regional Education Service Center to offer teachers and other educators employed by school districts training specifically developed for children with IDD to address their mental health needs, including trauma-informed care.
3. Ensure adequate service availability and network adequacy in managed care.
4. Include individuals with IDD in the public mental health recovery-oriented system.
5. Include capacity to provide mental health services to individuals with IDD in the comprehensive workforce development plan (see above).

## **Mental Health Workforce Plan**

Mental health workforce challenges are not new to Texas or to the nation. Challenges include insufficient reimbursement rates, lack of residency slots and internship sites, an aging mental health workforce, and inadequate mental health training for primary care providers. A number of factors make it difficult to address these challenges, including the diverse Texas population, the lack of cultural and linguistic competency, the lack of license reciprocity, and the unwillingness of providers to accept patients with Medicaid.

Various legislative initiatives, agency reports, and advocacy efforts have offered recommendations for addressing workforce challenges across the various mental health disciplines. However, without a thoroughly conceived and well-developed plan for workforce analysis, policy implementation, and outcome evaluation, advances will probably be limited and difficult to measure. Although HHSC should be responsible for creating the workforce development plan, participation of other agencies providing mental health services and supports, and those training individuals to provide those services, is crucial.

### RECOMMENDATION:

1. HHSC should develop and implement to the extent possible without additional legislative direction, a comprehensive plan for developing, increasing, and improving the Texas mental health/substance use workforce. The comprehensive plan must include an analysis of existing studies, reports and recommendations, as well as implementation strategies, monitoring processes, and outcome evaluations methods. Timelines should be developed in conjunction with the comprehensive plan outlining short, mid, and long term quantifiable goals and objectives to ensure a framework for accountability.

### **Strengthening the Mental Health Workforce**

While there is a critical need to develop a comprehensive behavioral health workforce development strategic plan (see above), there are additional steps that can be taken in the short term to begin addressing the crisis. Information on these recommendations can be found in the Hogg Foundation policy brief, *The Texas Mental Health Workforce: Continuing Challenges and Sensible Strategies*: <https://hogg.utexas.edu/project/the-texas-mental-health-worforce-continuing-challenges-and-sensible-strategies>.

### RECOMMENDATIONS:

1. Evaluate and improve mental health reimbursement rates.
2. Evaluate reciprocity and scope of practice rules to ensure maximum utilization of providers.
3. Expand use of technology including telemedicine and telehealth.
4. Improve training of primary care physicians.

### **Integrated Health Care**

SB 58 (83<sup>rd</sup>) required the integration of physical and behavioral health care into managed care. Phase 1 of the integration process focused on integrating funding streams. Phase 2 should help us move to integration of care. The Behavioral Health Integration Advisory Committee (BHIAC) developed recommendations to ensure that Texas continues to move to a more integrated managed care system while developing systems and programs that use performance-based, recovery-focused metrics for use in assessing quality and determining payment.

### RECOMMENDATIONS:

The BHIAC made the following recommendations as it relates to outcome measurements in its second report to HHSC dated July 8, 2015:

1. Outcome measures should support a positive continuous quality improvement process and incentivize accountability at the state, MCO, provider, and member level. A biennial review of metrics should be considered to ensure the metrics being gathered are fostering a successful integrated health care delivery model. MCOs and providers, with the support of HHSC, must develop mechanisms to share data on common members while Health Information Exchanges (HIE) in local communities are under development.
2. Measures should be tailored to meet the needs of children, young adults, adults, and the elderly.

3. All MCOs should assess their baseline level of integration, identify strategies to address areas needing improvement, and periodically assess integration improvement and its quality. (This measurement should not be used to determine performance or payment.)
4. Member, provider, and MCO satisfaction measures should be monitored and openly distributed to facilitate feedback and transparency.
5. HHSC's philosophy in outcome reporting should be a public, transparent process to increase dialogue on integration, track changes over time, identify strategies to increase integration, and describe what is happening in a community.

In addition to the above recommendations, the BHIAC would like to make the following recommendations for the Health Home Pilots as well as for an integrated managed care Medicaid system for Texas:

1. HHSC should create an environment and philosophy of what matters most: the outcomes of the care delivered. To that end, measuring the results of treatment that Medicaid members' experience has four main purposes: to learn about members, to improve performance, to illustrate and explain superior performance, and to enable and facilitate value-based payment.
2. Medicaid managed care should be organized through a continuous quality-improvement framework to ensure real change and real improvement are achieved.
3. There are three main categories for quality metrics to achieve clear and measurable successes as part of a team-based integrated health care approach, and they are as follows:
  - a. Long-term Outcomes: (to be tracked and reported)
  - b. Cross-cutting Measures: (to be tracked and reported)
    - Weight screening and follow-up
    - Medical assistance with smoking and tobacco cessation
    - High blood pressure screening and follow-up
    - Depression screening and follow-up: Patient Health Questionnaire (PHQ-9)
    - Diabetes screening and follow-up
    - Outpatient hospitalizations
    - Risk-adjusted emergency department utilization
  - c. Diagnostic Specific Metrics: (optional, no tracking or reporting)
4. The BHIAC recommends the use of the (a) Long-term Outcomes and the (b) Cross-cutting Measures to develop quality benchmarks which determine pay for performance awards and/or earn shared savings. HHSC should bring together Medicaid members, MCOs, and providers to help plan and provide feedback on specifics during and after implementation.
5. The BHIAC also highly recommends the development of a technical assistance center to assist the MCOs and providers with all aspects pertaining to the health home pilots.

## **Mental Health Funding**

Both the 83<sup>rd</sup> and the 84<sup>th</sup> Legislatures appropriated significant increases in behavioral health funding. While it is essential to ensure that the dollars invested are being spent effectively, there remains significant unmet needs – both gaps in services and populations not being adequately served.

### RECOMMENDATIONS:

1. Develop consumer-directed services pilots to illustrate how mental health funds can be used cost effectively to purchase services and activities that promote an individual's efforts to achieve recovery.
2. Evaluate 1115 waiver projects to identify cost-effective projects exhibiting strong recovery outcomes. Determine how to continue projects with positive outcomes while reducing or eliminating those not demonstrating positive results.
3. Appropriate funds needed to increase access to peer support services through Medicaid. HHSC has estimated the cost for FY 18/19 to be \$3.5 million.

### **State Psychiatric Hospital Beds and Infrastructure**

Many discussions are taking place, and will continue to evolve, with respect to inpatient psychiatric services in Texas. A variety of proposals have been suggested that range from upgrading current facilities, to building new facilities, to combining state mental health hospitals and state supported living centers. In addition to the infrastructure discussions, there are also a number of proposals that address the actual management of the state mental health hospital system, including continued public operation, privatization, public-private partnerships, academic partnerships, and more.

Prior to determining the type of buildings needed and the management structure to operate them, it is critical for policymakers to rethink our residential care goals and objectives and build a system that is person-centered and recovery oriented. This includes considering the service and support needs of a continuum of clients focusing on both mental health and substance use treatment, as well as needed social services such as housing, employment, ongoing support, and much more.

### RECOMMENDATION:

1. The Texas Legislature should create a planning commission to determine cost-feasible, person-centered, recovery-oriented options for individuals currently using inpatient forensic or civil commitment services. Options should address the need for a continuum of services and supports and not be limited simply to determining the number of beds needed. The planning commission should make recommendations on future facility requirements and management structure with an emphasis on continuity of care throughout the system.

**For additional information, please contact:**

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