

Integrated Care Sustainability: National Trends and Best Practices

2018 Indiana Primary Care and Behavioral Health Integration Conference

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The National Council for Behavioral Health is the unifying voice of America's health care organizations that deliver mental health and addictions treatment and services. Together with our 2,900 member organizations serving over 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery. The National Council introduced [Mental Health First Aid USA](#) and more than 1 million Americans have been trained.



Mental and Substance Use Disorders in America

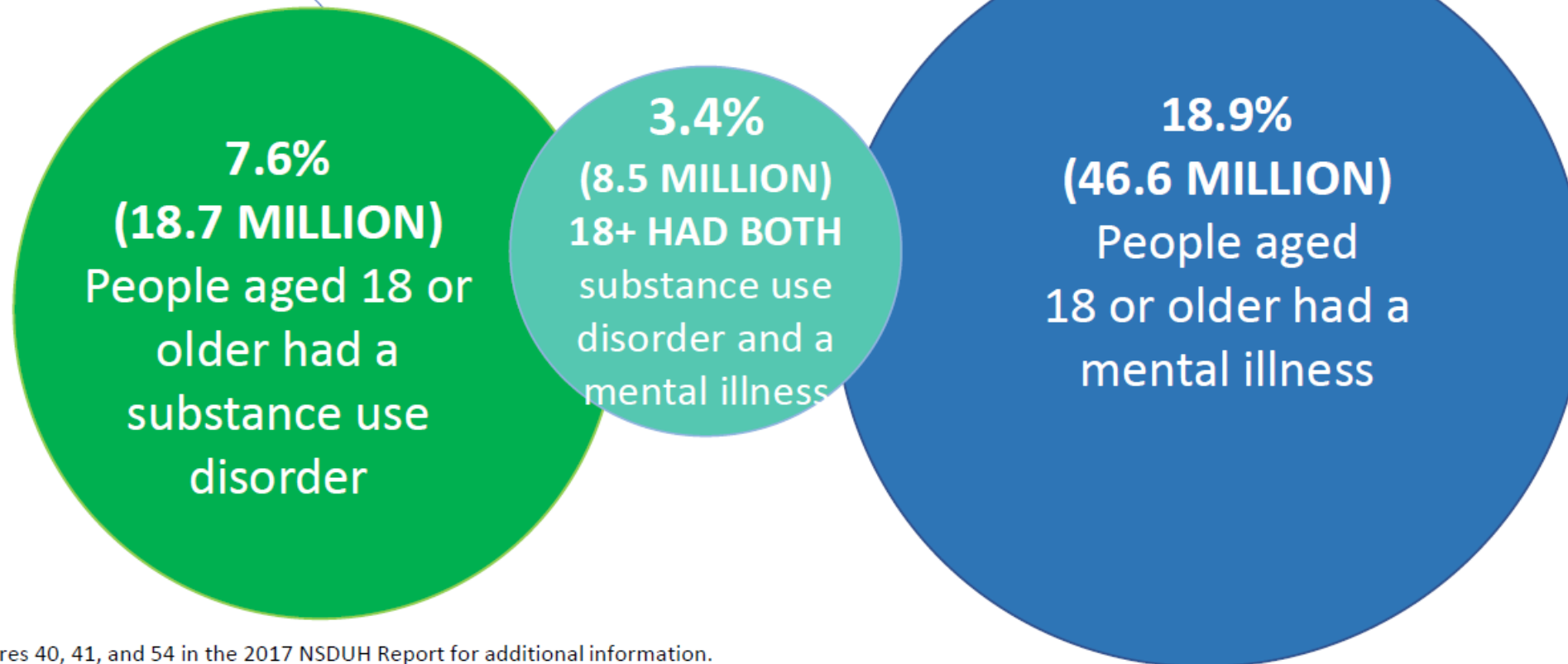
PAST YEAR, 2017, 18+

Among those with a substance use disorder:

- **3 IN 8 (36.4%)** struggled with illicit drugs
- **3 IN 4 (75.2%)** struggled with alcohol use
- **1 IN 9 (11.5%)** struggled with illicit drugs and alcohol

Among those with a mental illness:

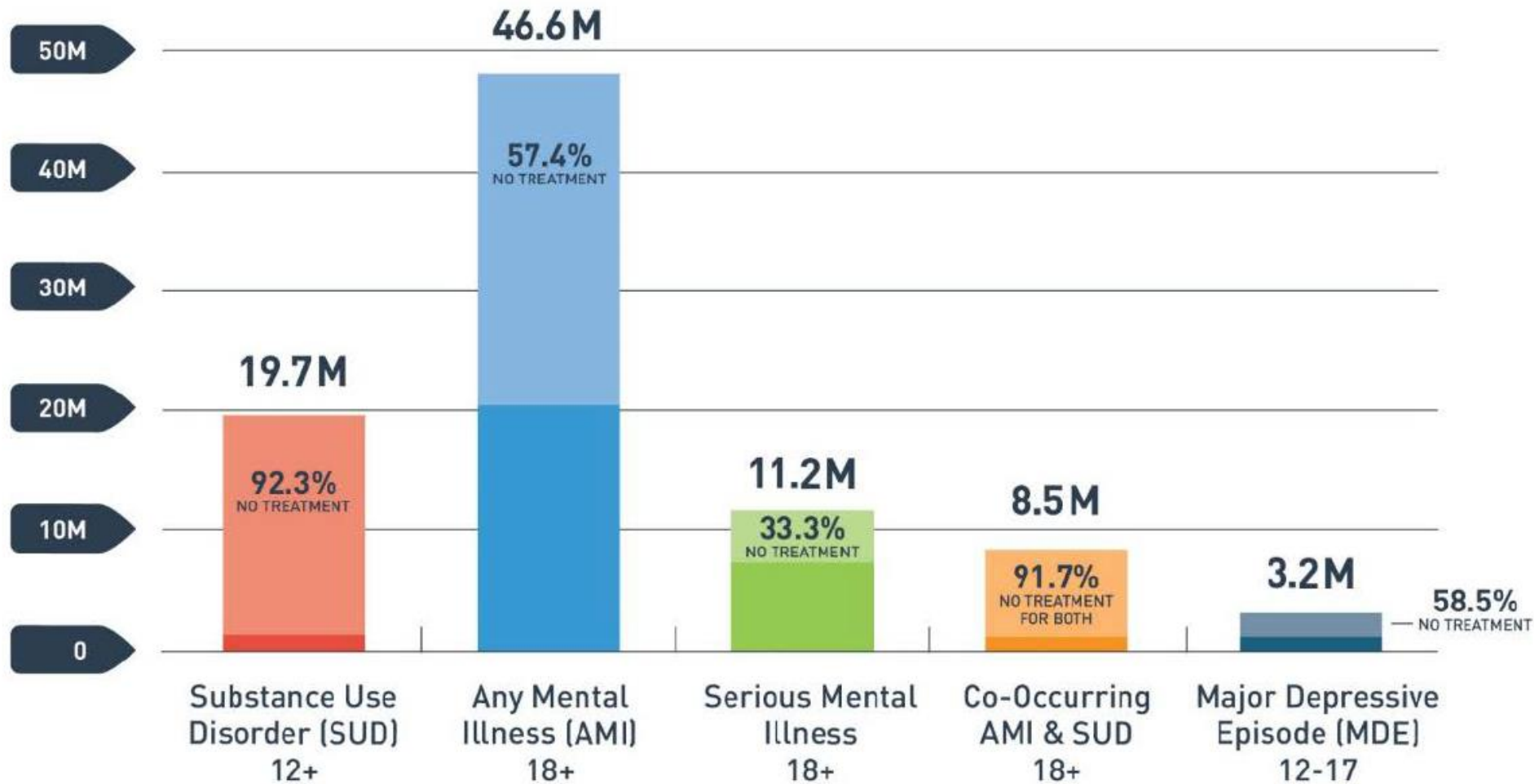
- **1 IN 4 (24.0%)** had a serious mental illness



See figures 40, 41, and 54 in the 2017 NSDUH Report for additional information.

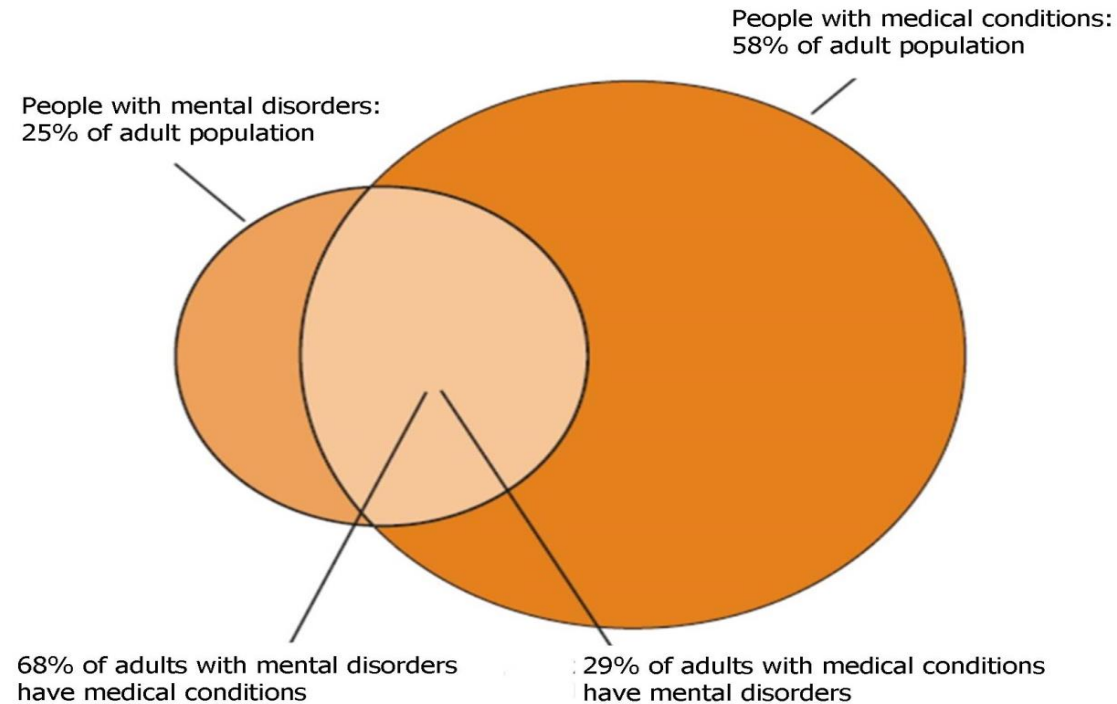
Despite Consequences and Disease Burden, Treatment Gaps Remain Vast

PAST YEAR, 2017



See the 2017 NSDUH Report for additional information.

Co-Morbidity of Mental Disorders and Other Chronic Conditions



Source: Adapted from the National Comorbidity Survey Replication, 2001-2003 (3, 83)

The “Quadruple Aim”



Population Health



Experience of Care



Per Capita Cost



Provider Satisfaction

Economic Impact of Integrated Care (Milliman, Jan 2018)

- ✓ Patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions cost **2-3 times more as those without**
- ✓ Projected costs for those with comorbid conditions in 2017 was estimated at **\$406 billion** across commercially-insured, Medicaid, and Medicare beneficiaries in the United States
- ✓ Most of the increased cost is attributed to medical services (not behavioral)
- ✓ The study concluded that “an estimated \$38-\$68 billion could be saved annually through effective integration of medical and behavioral healthcare”, with most of the projected reduced spending associated with facility and emergency room expenditures in hospitals.

How is Integrated Care Being Done in the Field?

- ✓ Screening and referral/care coordination models
- ✓ Direct hires
- ✓ Partnership models
- ✓ Virtual integration (telehealth)
- ✓ Psychiatric Collaborative Care Model (CoCM)
- ✓ Subsidiaries
- ✓ Mergers and acquisitions



How Do We Pay for It?



Basic business principle:

Costs < Revenues

Challenges to Sustainability

Often Not Reimbursable...

- ✓ Up front/transition costs
- ✓ Warm hand offs
- ✓ Brief therapy models
- ✓ Huddles/care team meetings
- ✓ Provider to provider consultation
- ✓ Peer specialists
- ✓ Health/Wellness Coach
- ✓ Care coordination/care management
- ✓ Continuous quality improvement
- ✓ Professional development/training

Other Challenges...

- ✓ Same day billing issues (real and perceived)
- ✓ Workforce shortages
- ✓ Low reimbursement rates
- ✓ Diagnostic requirements, prior authorizations
- ✓ Administrative burden

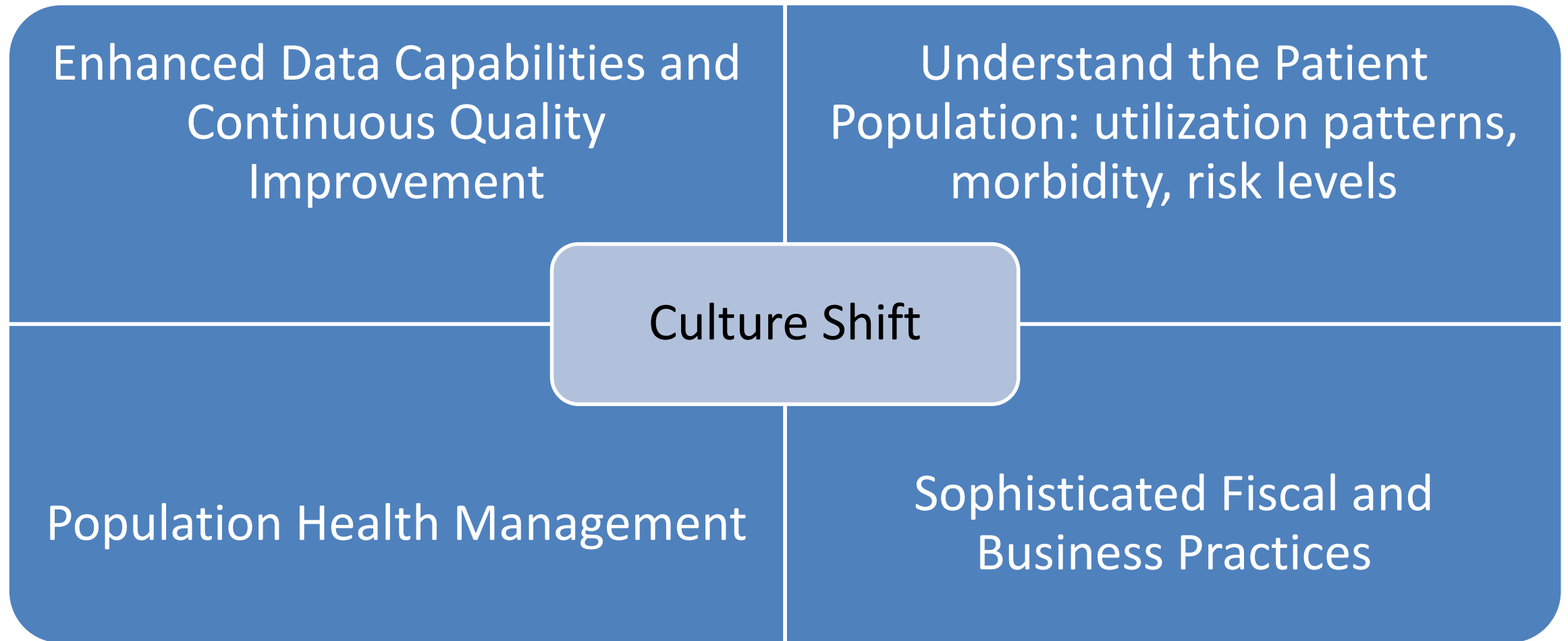


What Can Providers Do To Make Integrated Care More Sustainable?

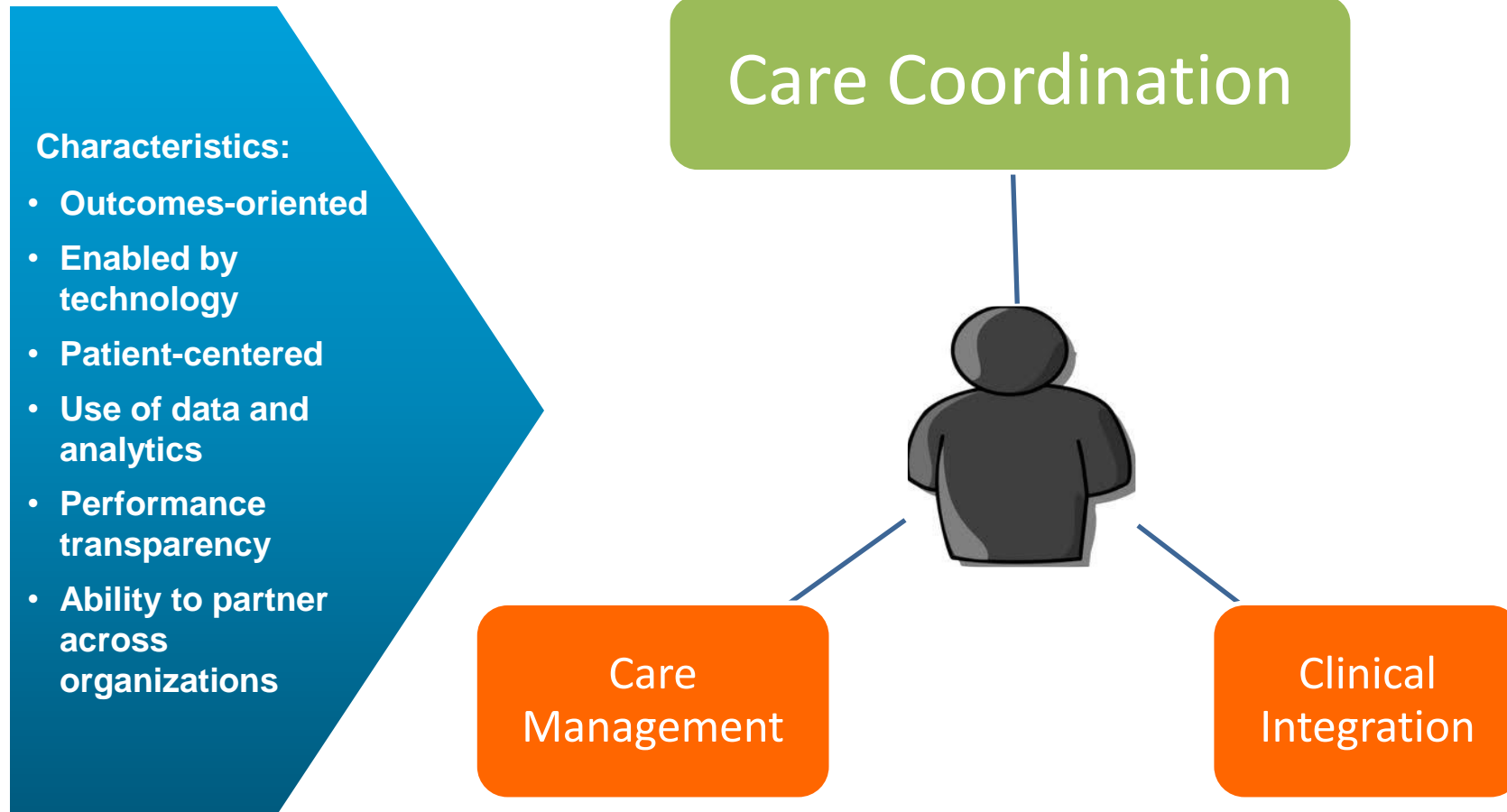
- ✓ Maximize Billing
 - ✓ Fully capture all billable services
 - ✓ Use billing and coding specialists with expertise in both primary care and behavioral health
 - ✓ Staff appropriately
- ✓ Establish and Meet Productivity Guidelines
 - ✓ Reduce no-shows
- ✓ Create Efficiencies
 - ✓ Use collaborative, concurrent documentation
 - ✓ Ensure staff are working to the “top of the their licensure”
 - ✓ Eliminate redundancies
- ✓ Diversify Funding
- ✓ Prepare for Value-Based Payment



Provider/Organizational Readiness for Value-Based Payment



Important Provider Competencies



The Role of States in Promoting Integrated Care Sustainability

- ✓ State Medicaid programs have unique flexibility to advance behavioral health integration using a variety of purchasing, regulatory, and administrative strategies as well as delivery system and payment reform
- ✓ States can reduce fragmentation and increase alignment at the regulatory (state-agency) level
- ✓ States can work with Providers to identify and address regulatory barriers



Some Commonly Cited Regulatory Barriers

Fee-for-service, volume driven payment mechanisms

Burdensome reporting requirements

Fragmentation within state system

Facility licensing

Credentialing requirements

Scope of practice issues

Same day billing (real and perceived)

Billing codes “not turned on”

Diagnostic and/or prior authorization requirements

Limited access to claims data

Confidentiality and sharing of patient health information



How Can States Identify and Address Barriers? Case Study #1- Colorado

House Bill 11-1242 required the Colorado State Department of Health Care Policy and Financing to report on state and federal laws affecting the integrated delivery of physical and behavioral health care, as well as barriers and incentives to delivering integrated care.

The Department conducted a series of key informant interviews, focus groups, and public hearings.

The results were compiled into a “Legislative Report: Integration of Physical and Behavioral Health Care”

The report was used to help inform the Medicaid Accountable Care Collaborative and the Colorado State Innovation Model



How Can States Identify and Address Barriers? Case Study #2- New Jersey

- ✓ The Nicholson Foundation commissioned Seton Hall University School of Law to examine and clarify the state's policy environment and deliver a detailed report with findings and recommendations made available to all stakeholders, including the state.
- ✓ The Seton Hall team examined the literature on behavioral health and primary care integration and delved into the details of New Jersey's regulations on licensure and reimbursement. They also had extensive conversations with practitioners and administrators, state regulators, academics, and advocates.

State Licensing And Reimbursement Barriers To Behavioral Health and Primary Care Integration: Lessons From New Jersey

Joan Randell, John Jacobi

APRIL 7, 2016

10.1377/hblog20160407.054383



Lessons for Other States From New Jersey

- ✓ Carefully scrutinize your regulatory environment.
- ✓ Identify and involve a wide group of partners.
- ✓ Work with, and not against, government agencies.
- ✓ Focus on the needs of the patients.
- ✓ Base policy changes on clinical experience.

Source: "State Licensing And Reimbursement Barriers To Behavioral Health and Primary Care Integration: Lessons From New Jersey, " Health Affairs Blog, April 7, 2016.



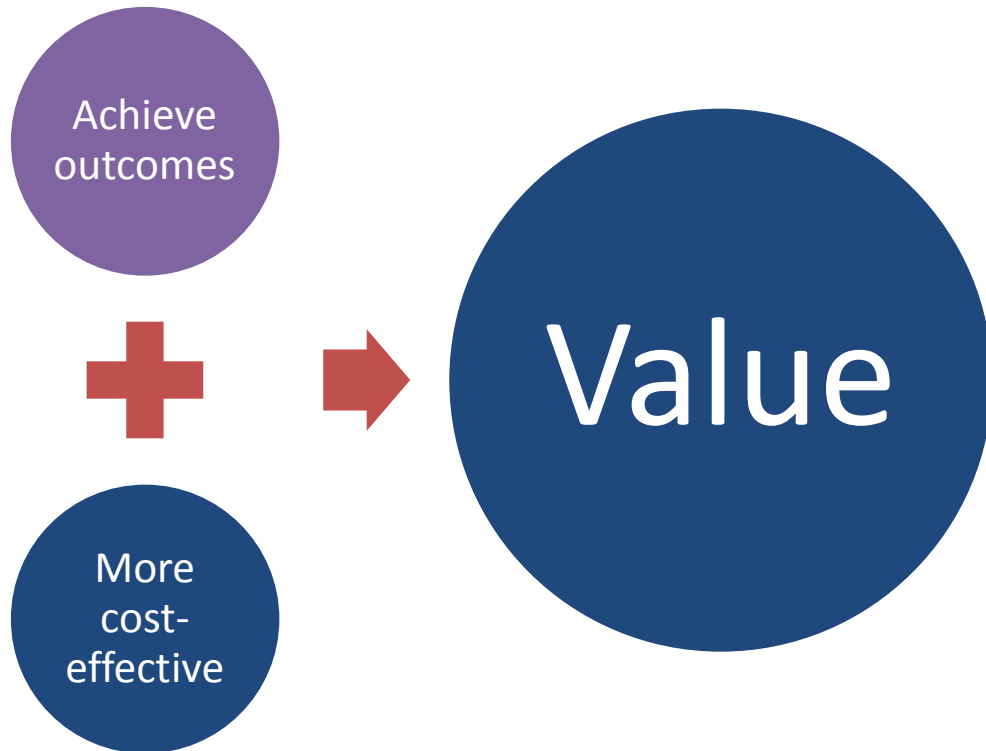
New York State Integrated Licensure Project

- ✓ Passed legislation in FY 13 authorizing the New York Department of Health, the Office of Mental Health, the Office of Substance Abuse Services to collaborate to reduce administrative burden on providers by streamlining the approval and oversight process.
- ✓ This collaboration resulted in the development of clinical and physical plant standards, staffing requirements, and a single application and review process under which providers operate and are monitored.
- ✓ The now-established Integrated Outpatient Services regulations further the core principles of the project and intend to promote increased access to physical and behavioral health services at a single site, to foster the delivery of integrated services and to establish standards for these integrated services in certain outpatient settings.

Sampling of Other State Strategies to Address Regulatory Barriers

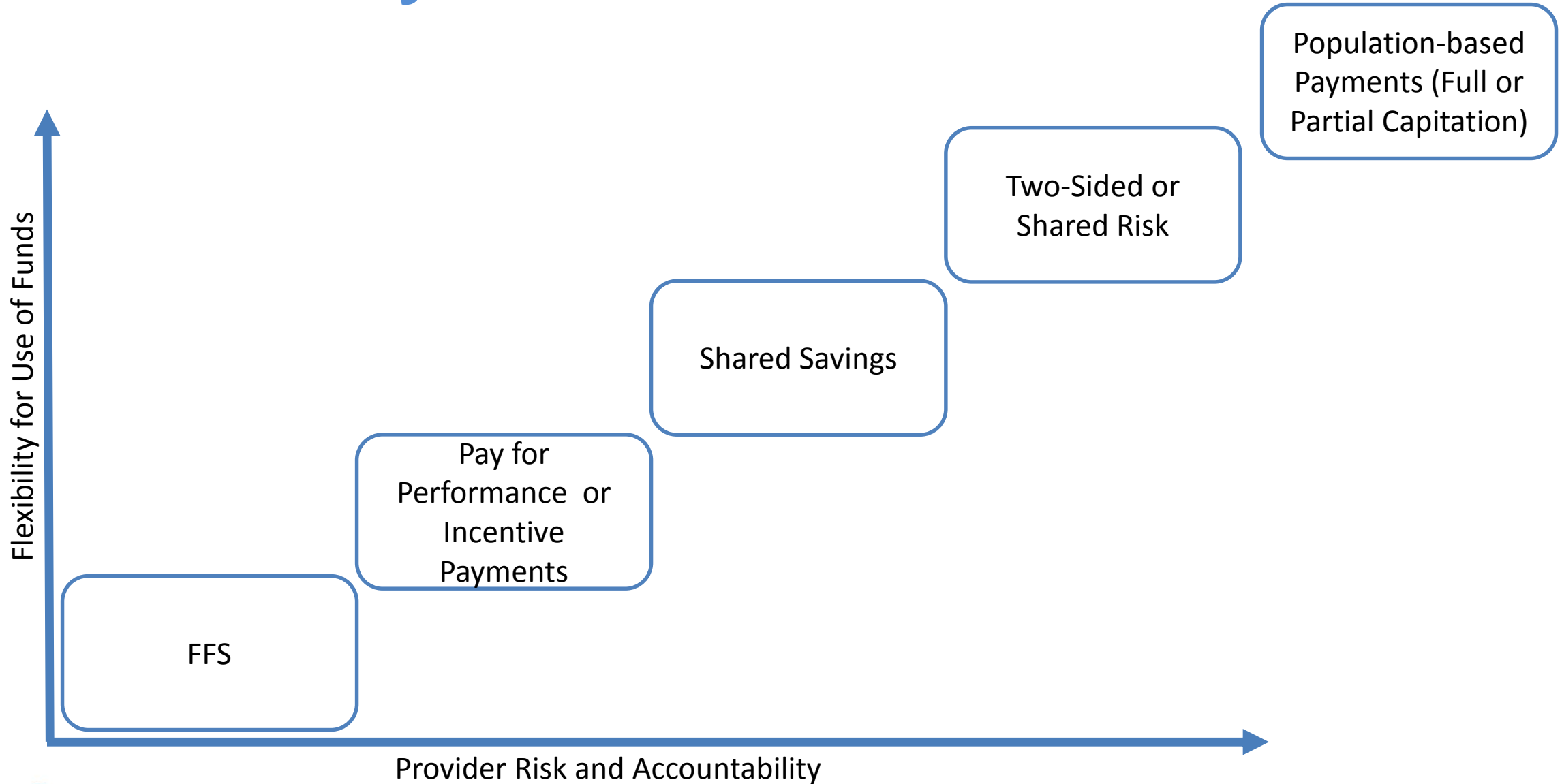
- ✓ Support information sharing
 - ✓ California State Health Information Guidance (SHIG) on Sharing Sensitive Health Information <https://www.californiahia.org/shig>
- ✓ Support workforce development
 - ✓ The Behavioral Health Education Center of Nebraska at the University of Nebraska Medical Center has a legislative mandate to collect and analyze data on behavioral health workforce needs and to administer and measure outcomes for training and recruiting programs.
- ✓ Support practice transformation
 - ✓ New York State Delivery System Reform Incentive Payment Program (DSRIP), Behavioral Health Value Based Payment Readiness Program and creation of regional Behavioral Health Care Collaboratives; Care Transitions Network
- ✓ Make claims data available and accessible
 - ✓ 18 states have created All Payers Claims Databases

What is Value-Based Payment?



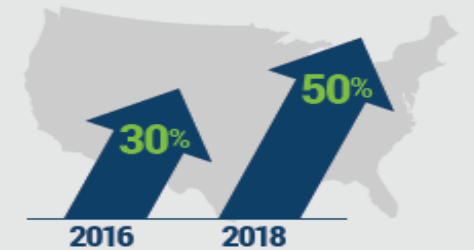
- ✓ Shifts the focus from traditional fee-for-service (FFS) systems that pay for volume of services to alternative payment models that reward high-quality, cost-effective care.
- ✓ There is a continuum of payment methodologies, with increasing levels of accountability and financial risk to the provider.

Payment Reform Continuum



APM MEASUREMENT EFFORT

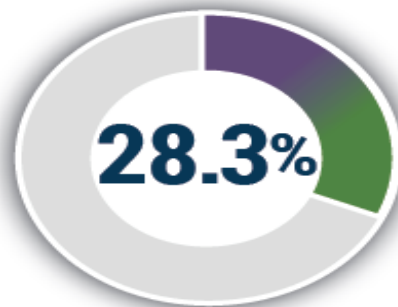
Public and private health plans, managed Medicaid FFS states, and Medicare FFS voluntarily participated in a national effort to measure the use of Alternative Payment Models (APMs) as well as progress towards the LAN's goal of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.



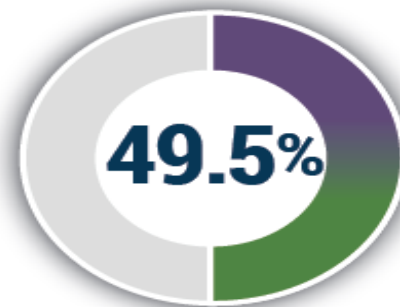
In **2017**,

34% of U.S. health care payments, representing approximately **226.3 million** Americans and **77%** of the covered population, flowed through Categories 3&4 models.

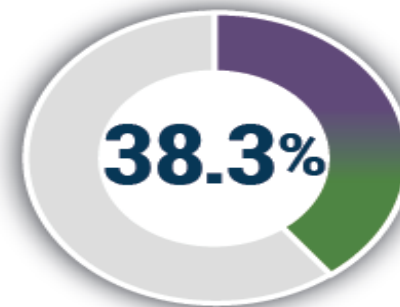
In each market, Categories 3&4 payments accounted for:



COMMERCIAL



MEDICARE
ADVANTAGE



MEDICARE
FFS



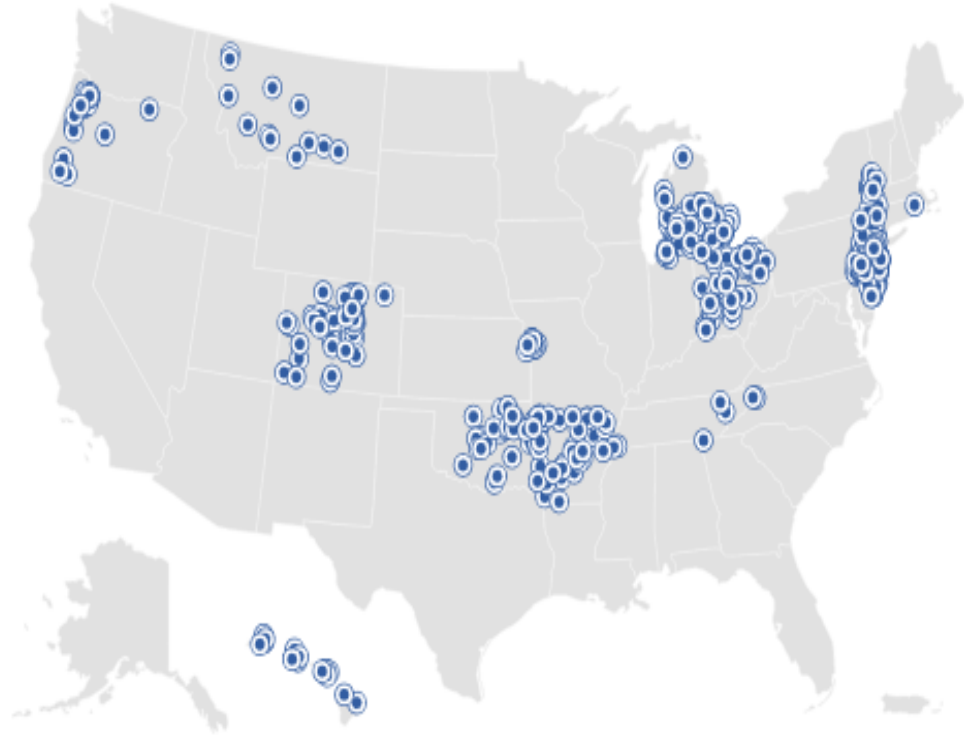
MEDICAID

Representativeness of covered lives:

Commercial - 63%
Medicare Advantage - 70%
Medicare FFS - 100%
Medicaid - 50%

Comprehensive Primary Care Plus

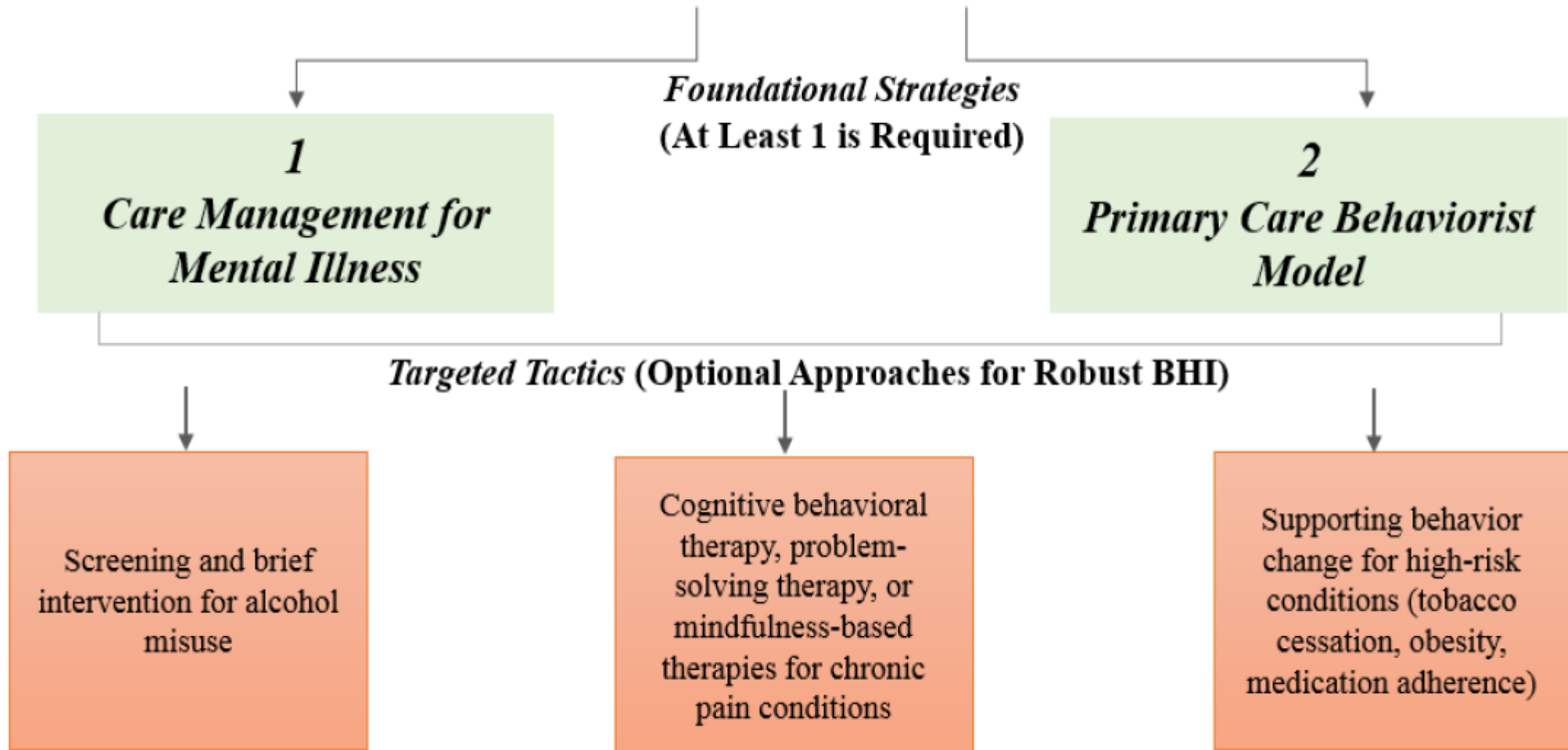
- A national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.
- Participants receive a care management fee, performance-based incentive payment, and Track 1 (FFS) or Track 2 (APM) Medicare payments



Source: Centers for Medicare & Medicaid Services

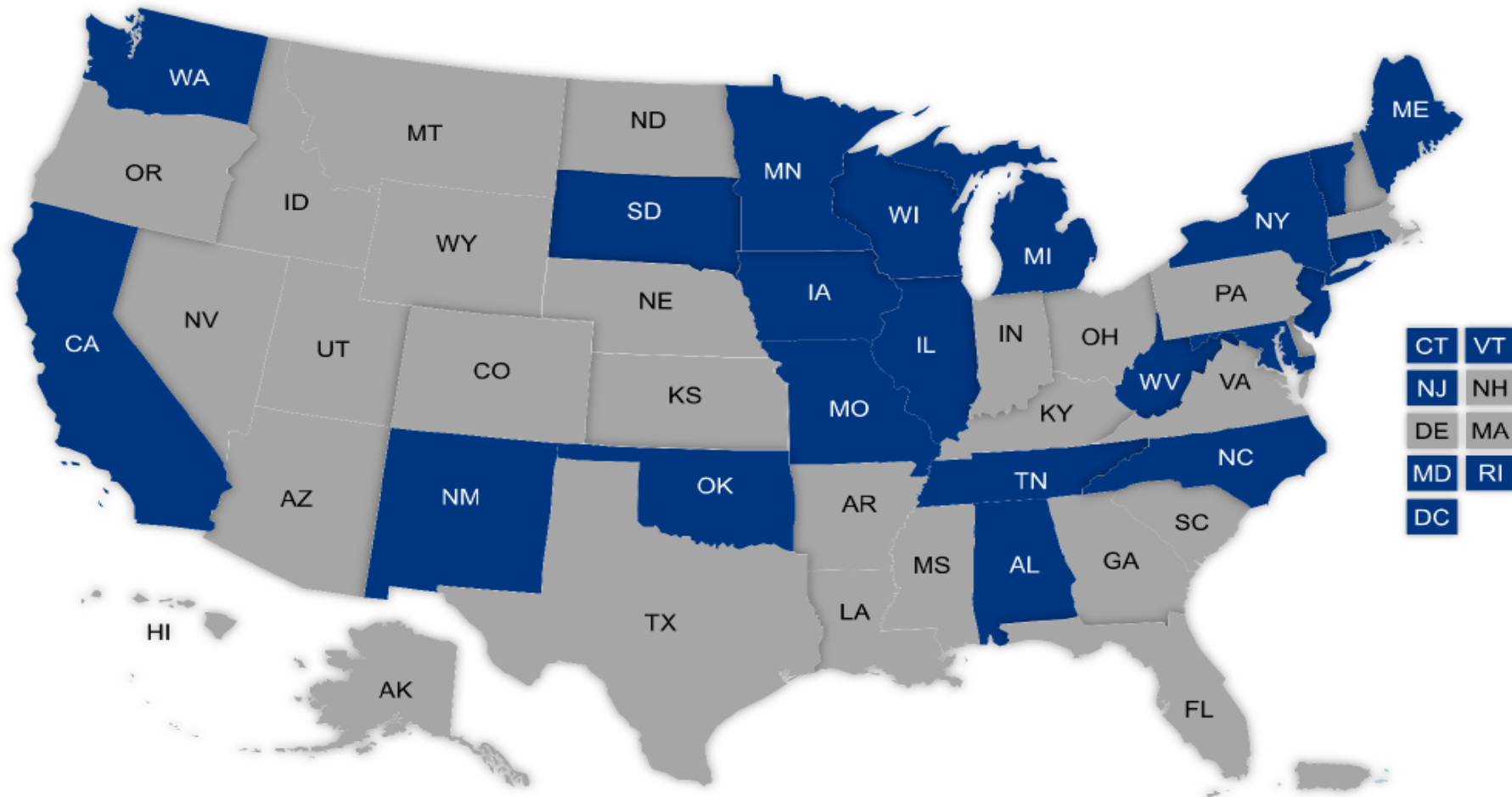
There are 2,900 primary care practices currently participating in Comprehensive Primary Care Plus (CPC+) in 18 regions: Arkansas, Colorado, Hawaii, Greater Kansas City Region of Kansas and Missouri, Louisiana, Michigan, Montana, Nebraska, North Dakota, Greater Buffalo Region of New York, North Hudson-Capital Region of New York, New Jersey, Ohio and Northern Kentucky Region, Oklahoma, Oregon, Greater Philadelphia Region of Pennsylvania, Rhode Island, and Tennessee.

CPC+ Behavioral Health Integration Menu of Options



Medicaid Health Homes for Persons With Chronic Conditions

- ✓ Section 2703 of ACA Medicaid Option - 2014
- ✓ Patient Eligibility – **HOTSPOT** - 2+ chronic conditions or SMI/SED/SUD
- ✓ Payments
 - ✓ PMPM to Provider
 - ✓ Enhanced Federal Match to State Medicaid for 8 Quarters
- ✓ Six Required Services – Care Management, Care Coordination, Transitions of Care, Health promotion/Preventive, Patient and Family Support, Access Community Services
- ✓ Accreditation – The Joint Commission and CARF
- ✓ Certified by each State



As of September 2018, 22 states and the District of Columbia have a total of 35 approved Medicaid health home models.

States with Approved Health Home SPAs (number of approved health home models)	Alabama, California, Connecticut, District of Columbia (2), Illinois, Iowa (2), Maine (3), Maryland, Michigan (2), Minnesota, Missouri (2), New Jersey (2), New Mexico, New York (2), North Carolina, Oklahoma (2), Rhode Island (3), South Dakota, Tennessee, Vermont, Washington, West Virginia (2), Wisconsin
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Note that Idaho, Kansas, Ohio, and Oregon have terminated their Medicaid health home state plan amendments and are no longer providing services under a 2703 SPA.

Certified Community Behavioral Health Clinics (CCBHCs)

✓ Demonstration States:

Minnesota
Missouri
New York
New Jersey
Nevada
Oklahoma
Oregon
Pennsylvania

✓ SAMHSA 2018 Grants:

50 providers nationwide

- ✓ Section 223 of the Protecting Access to Medicare Act of 2014 established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs).
- ✓ These entities, a new provider type in Medicaid, provide a comprehensive range of addiction and mental health services to vulnerable individuals while meeting additional requirements related to staffing, governance, data and quality reporting and more.
- ✓ In return, CCBHCs receive a Medicaid reimbursement rate based on their anticipated costs (Prospective Payment System).
- ✓ CCBHCs must ensure that all clients receive basic primary care screening and monitoring of health risk for selected chronic conditions.
- ✓ CCBHCs must establish formal care coordination partnerships with primary care providers in their community.



State Efforts: Arizona

- ✓ In 2015, Arizona gave the state's Medicaid director responsibility for both physical and behavioral health services after it merged its Medicaid agency, named the Arizona Health Care Cost Containment System (AHCCCS) and its Department of Health Services' Division of Behavioral Health Services (DBHS).
- ✓ The Medicaid agency assumed a new level of leadership in integration with goals of increased attention to behavioral health integration across the state, strategic purchasing of both physical and behavioral health services, and streamlined regulation, consistent policy, enhanced communication, and increased cross sector collaboration.

How Arizona Medicaid Accelerated the Integration of Physical and Behavioral Health Services

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ABSTRACT

ISSUE: In most states, one agency has responsibility for Medicaid enrollees' physical health services and at least one other agency has responsibility for their behavioral health services. Apportioning responsibility for the physical and behavioral health of Medicaid beneficiaries into different agencies inevitably leads to different—and sometimes misaligned—policy goals, program priorities, and purchasing strategies, thereby impeding the delivery of integrated care.

GOAL: To describe the rationale, process, and impact of Arizona's 2015 consolidation of its physical and behavioral health services agencies into its Medicaid agency.

METHOD: The study is based on published research, Arizona Medicaid agency materials, and interviews with 34 individuals, including representatives from the current Medicaid agency and previous behavioral health services agency, health plans, primary care and behavioral health providers, consumers, the justice system, and the health information exchange.

FINDINGS AND CONCLUSIONS: Consolidation has led to increased attention to behavioral health services and behavioral and physical health integration, enabled more strategic purchasing and streamlined regulatory processes, and enhanced communication, collaboration, and mutual trust across sectors. Arizona's experience offers lessons to policymakers as they consider how best to integrate physical and behavioral health services and ensure that Medicaid is an efficient and effective purchaser of health care services.

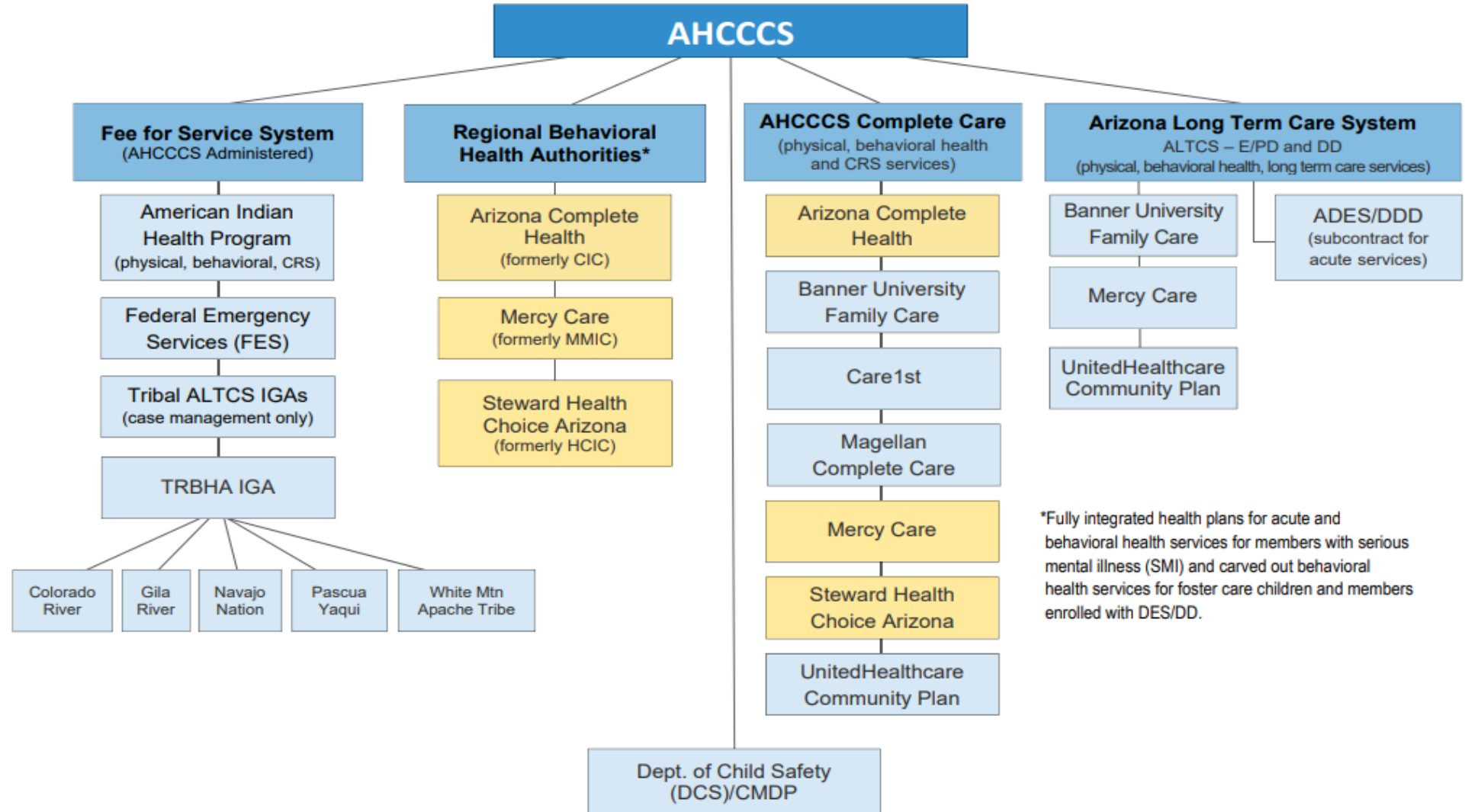
KEY TAKEAWAYS

▶ Many states have separate agencies responsible for Medicaid enrollees' physical and behavioral health services, which can lead to misaligned policy priorities and purchasing strategies

▶ Arizona's consolidation of its physical and behavioral health services agencies into its Medicaid agency offers lessons to other states in how to achieve agency integration as a means to accelerating delivery system integration in Medicaid

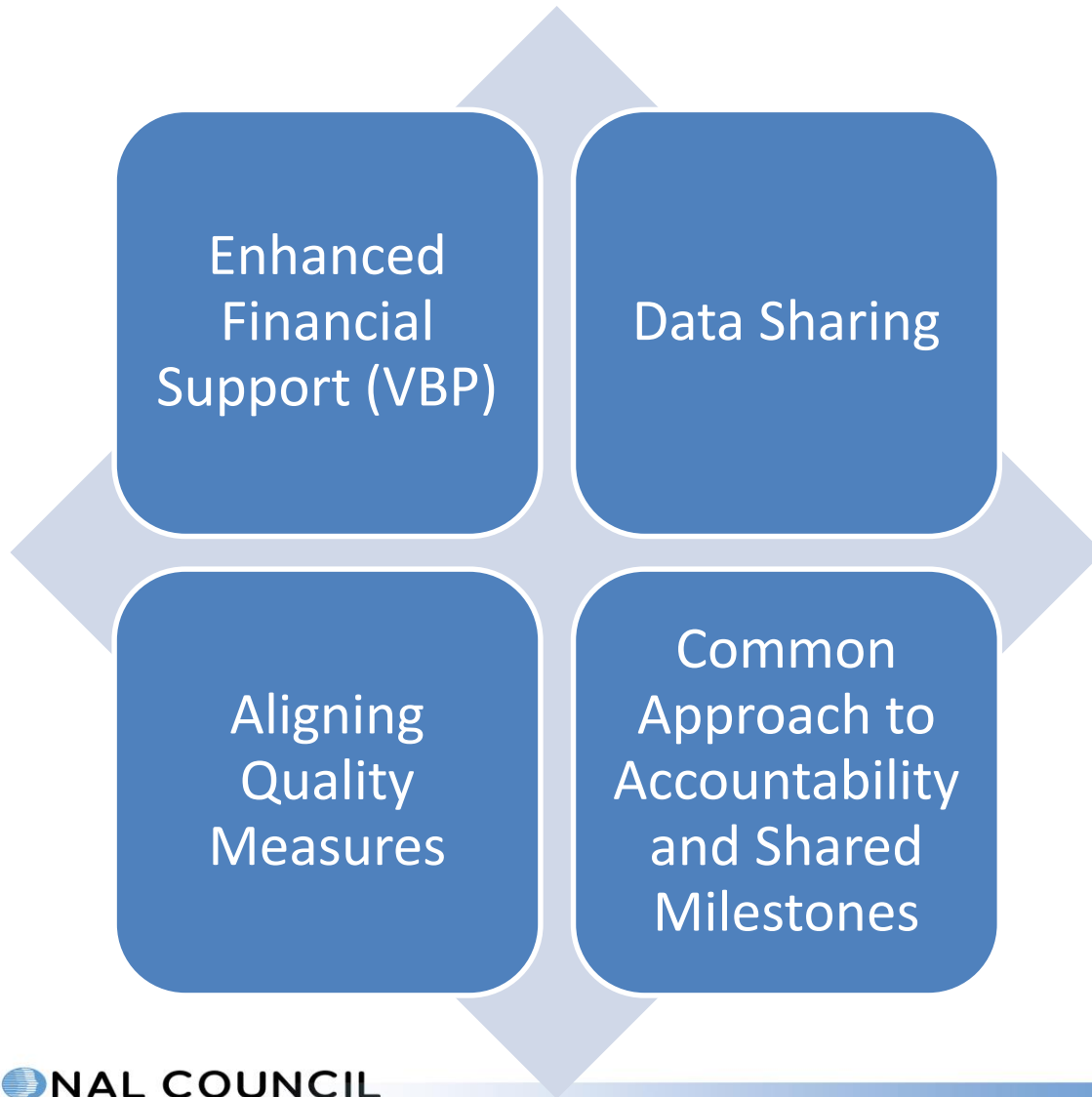


Care Delivery System Effective October 1, 2018



*Fully integrated health plans for acute and behavioral health services for members with serious mental illness (SMI) and carved out behavioral health services for foster care children and members enrolled with DES/DD.

- The State Innovation Model is an initiative of the Center for Medicare & Medicaid Innovation (CMMI) to encourage states to develop and test models for transforming health care payment and delivery systems.
- Colorado Goal: Improve the health of Coloradans by providing access to integrated physical & behavioral health care services in coordinated systems, with value-based payment structures, for 80% of Colorado residents by 2019.
- Participation of up to 400 primary care practices and 4 community mental health centers who are integrating care and working through practice transformation milestones.



Participating Payers:

- Colorado Medicaid
- Anthem Blue Cross Blue Shield
- Cigna
- Colorado Choice Health Plans
- Kaiser Permanente
- Rocky Mountain Health Plans
- UnitedHealthcare

Other State Financing Strategies to Support Integration

- ✓ Medicaid ACO-like structures with VBP and/or care coordination payments (OR, MN, VT, CO, Maine)
- ✓ FQHC APMs (OR, OH, MN, WA, MA, CO, HI, DC, MI, NV, OK)
- ✓ Enhanced SUD Treatment Benefits -e.g. Addiction and Recovery Treatment (ARTS, VA)
- ✓ “Opening up” new codes
 - ✓ Collaborative care (WA)
 - ✓ Health and Behavior Codes (numerous states)
 - ✓ SBIRT (numerous states- Utah notable example for oral health)



Consulting – Integrated Health

- National Council's Center for Integrated Health Solutions
 - National training and technical assistance center on the bidirectional integration of primary and behavioral health care
- Individualized technical assistance to behavioral health and primary care settings
 - Organizational readiness and leadership development
 - Workforce development
 - Integrated care models
 - Financing and sustainability
- Training and implementation support for best practices
 - Screening, Brief Intervention and Referral to Treatment (SBIRT)
 - Motivational Interviewing
 - Whole Health Action Management (WHAM)
 - Case Management to Care Management
 - Trauma Informed Care



Discussion



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