

Integrating Behavioral Health and Physical Health Care Services

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Introduction

- The objective of this presentation is to provide an overview of behavioral and physical health care integration and activities to integrate services in Virginia and nationwide
- This study was approved by Joint Commission on Health Care members at the May, 2016 work plan meeting

Why Integrate Physical and Behavioral Health Care?

Unmet Behavioral Health Needs

- Often common behavioral health conditions go unrecognized by primary care providers, and medical conditions go unrecognized by behavioral health providers
- Due to stigma associated with behavioral health conditions, individuals may not feel comfortable discussing them with primary care providers; and some primary care providers may not feel comfortable diagnosing and treating behavioral health disorders*
- Sixty-seven percent of individuals with a behavioral health disorder do not get behavioral health treatment¹
- 30-50% of individuals who are referred to behavioral health from primary care don't make first appointment^{2,3}

- Two-thirds of primary care physicians report not being able to access outpatient behavioral health for their patients⁴ due to: 1) Shortages of mental health care providers; 2) Health plan barriers; 3) Lack of coverage or inadequate coverage
- Depression goes undetected in greater than fifty percent of primary care patients⁵
- Only 20-40% of patients improve substantially in six months without specialty assistance⁶
- Mental illness is more than twice as prevalent among Medicaid beneficiaries as it is in the general population
- Approximately 35% of all Medicaid enrollees have a mental health or substance use disorder
- Approximately 49% of Medicaid beneficiaries with disabilities have a psychiatric illness

¹Kessler et al., NEJM. 2005;352:515-23

²Fisher & Ransom, Arch Intern Med. 1997;6:324-333

³Hoge et al., JAMA. 2006;95:1023-103

⁴Cunningham, Health Affairs. 2009; 3:w490-w501

⁵Mitchell et al. Lancet, 2009; 374:609-619

⁶Schulberg et al. Arch Gen Psych. 1996; 53:913-919

Why Integrate Physical and Behavioral Health Care? **A Fractured System**

- Services for physical and behavioral health care and substance use have historically been financed and delivered under separate systems, and individuals often find themselves interacting with multiple public and private agencies, receiving care from myriad providers funded from different sources
- Fragmentation can impede access to care and result in poor health status, inappropriate use of services and increased costs; Integrating physical and behavioral health has been shown to reduce fragmentation and promote patient-centered care*
- Medicare, Medicaid and private insurers are providing opportunities and incentives for moving service delivery away from fragmentation to integrated care
- State and local agencies are responding to these opportunities and incentives by integrating care in a variety of ways and to various degrees

*<https://www.macpac.gov/publication/improving-service-delivery-to-medicaid-beneficiaries-with-serious-mental-illness-themes-from-roundtable-discussion/>

Why Integrate Physical and Behavioral Health Care?

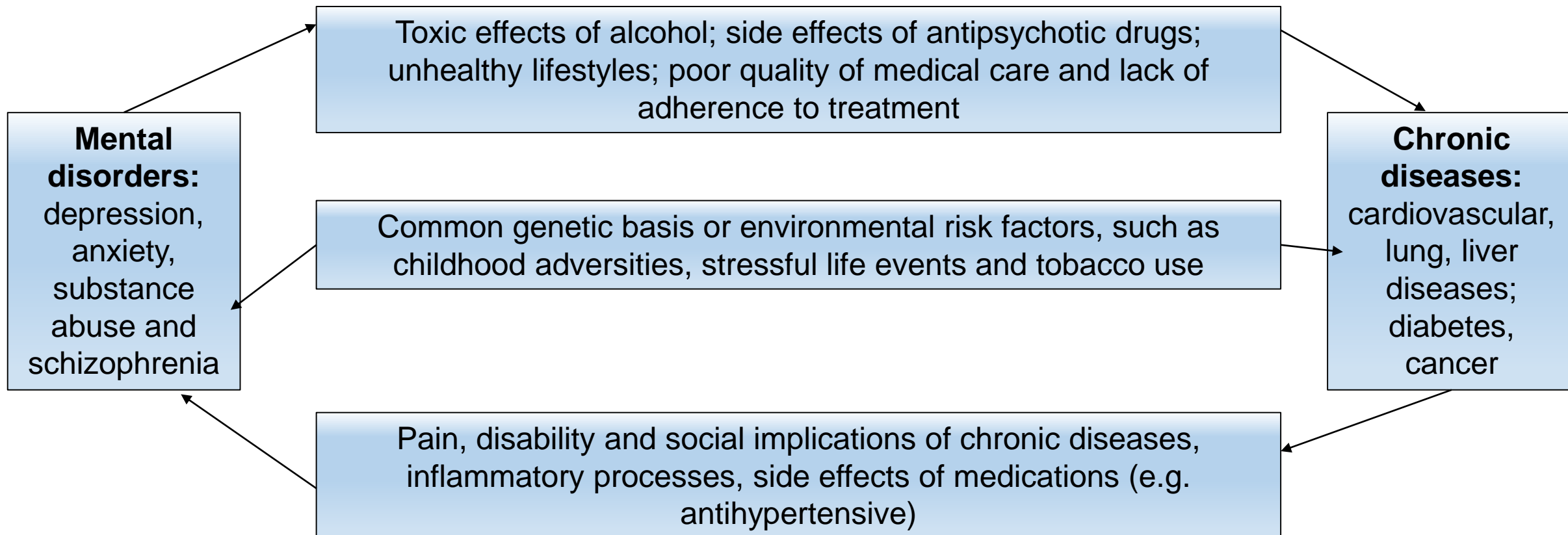
Comorbidity of Physical Chronic Diseases with Mental Health Disorders

- Compared to individuals without SMI, adults with SMI have higher rates of chronic medical conditions, including hypertension, HIV/AIDS, cardiovascular disease and diabetes; a higher frequency of multiple general medical conditions; and a higher rate of premature mortality resulting from these conditions*
 - Factors associated with this excess disease burden include socioeconomic disadvantage, substance use comorbidity, medication side effects, unhealthy behaviors, neglect of self care and inadequacies in the health care system
 - Treatments for one condition may have side effects that increase the risk of another condition, for example some behavioral health medications lead to weight gain, high blood sugar levels and high blood lipid levels that can lead to heart disease and stroke

Why Integrate Physical and Behavioral Health Care?

Comorbidity of Physical Chronic Diseases with Mental Health Disorders

The Mechanisms of Comorbidity of Mental Disorders with other Chronic Diseases



Why Integrate Physical and Behavioral Health Care?

Comorbidity of Physical Chronic Diseases with Mental Health Disorders

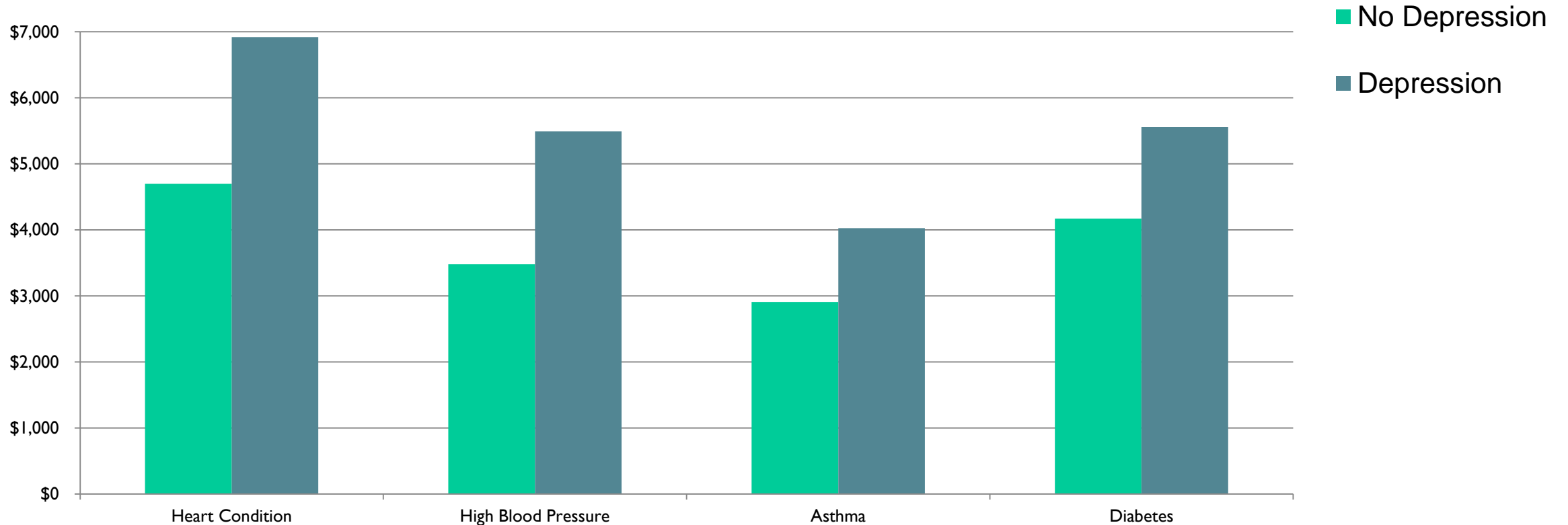
Medical Conditions among Non-Dually Eligible Adults Age 21–64
With and Without a Behavioral Health Diagnosis by Basis of Medicaid Eligibility, 2011

Medical condition	Non-dually eligible Medicaid enrollees age 21-64			
	Eligibility on basis of disability		Eligibility on basis other than disability	
	Percent w/BH	Percent wo/BH	Percent w/BH	Percent wo/BH
Cardiac disease	54%	38%	28%	13%
Hypertension	41	30	17	8
Rheumatism	33	17	25	8
Kidney disease	29	18	22	10
Diabetes	22	18	8	5
Arthritis	19	11	9	3
Cancer	14	10	9	5
Asthma	14	6	10	3
Cerebrovascular disease	10	5	3	1
Chronic liver disease/cirrhosis	5	2	2	1
Ave. no. conditions/enrollee	2.7	1.7	1.5	0.6

Why the Integrate Physical and Behavioral Health Care?

The High Cost of Unmet Behavioral Health Needs

Annual healthcare costs are much greater for patients with a chronic disease and depression

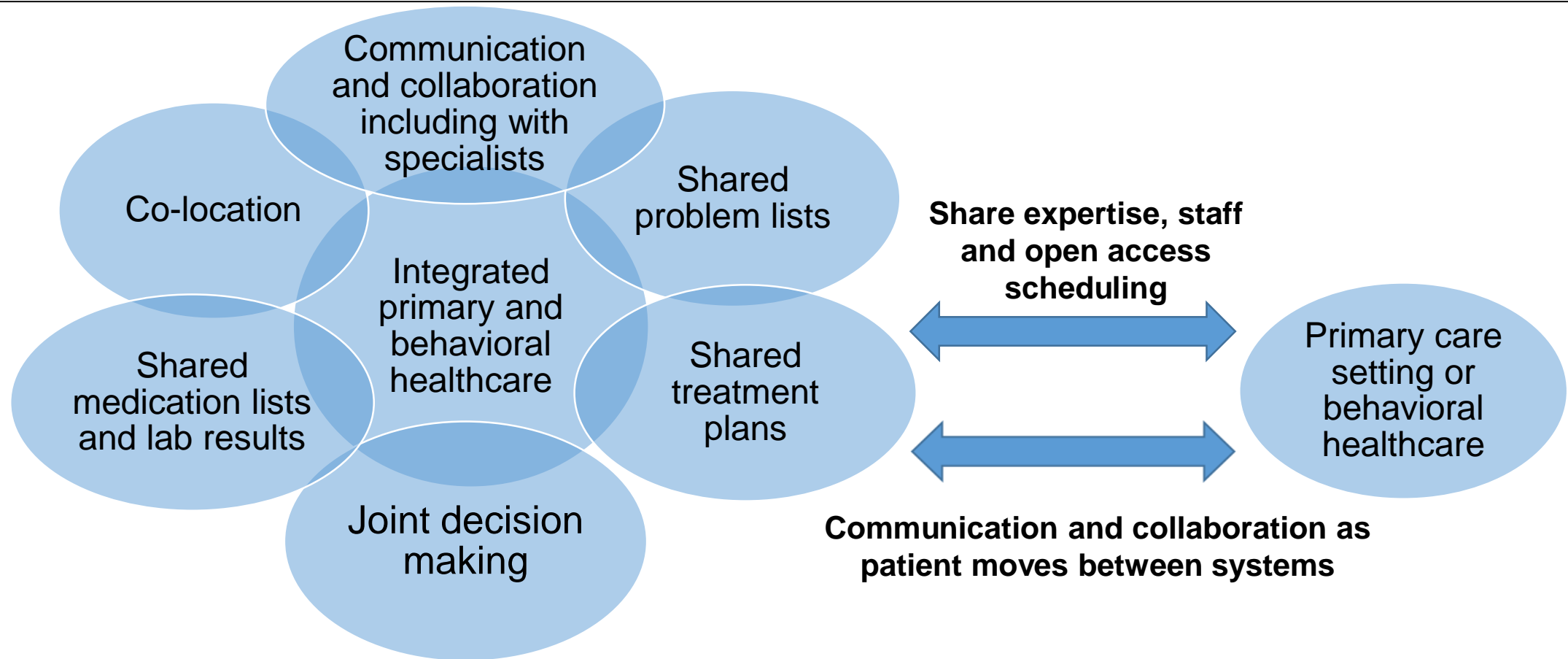


Individuals with chronic medical & behavioral health conditions combined cost 46% more than those with only a chronic medical condition

The “Gold Standard”

- Integrated Physical and Behavioral Health Services
- Financial Accountability
 - Performance guarantees/risk
 - Shared incentives
- Accountable Care Home
 - Team of physical and behavioral health providers
 - Information exchange
 - System navigation and access to social supports

Core Components of Successful Integrated Models*



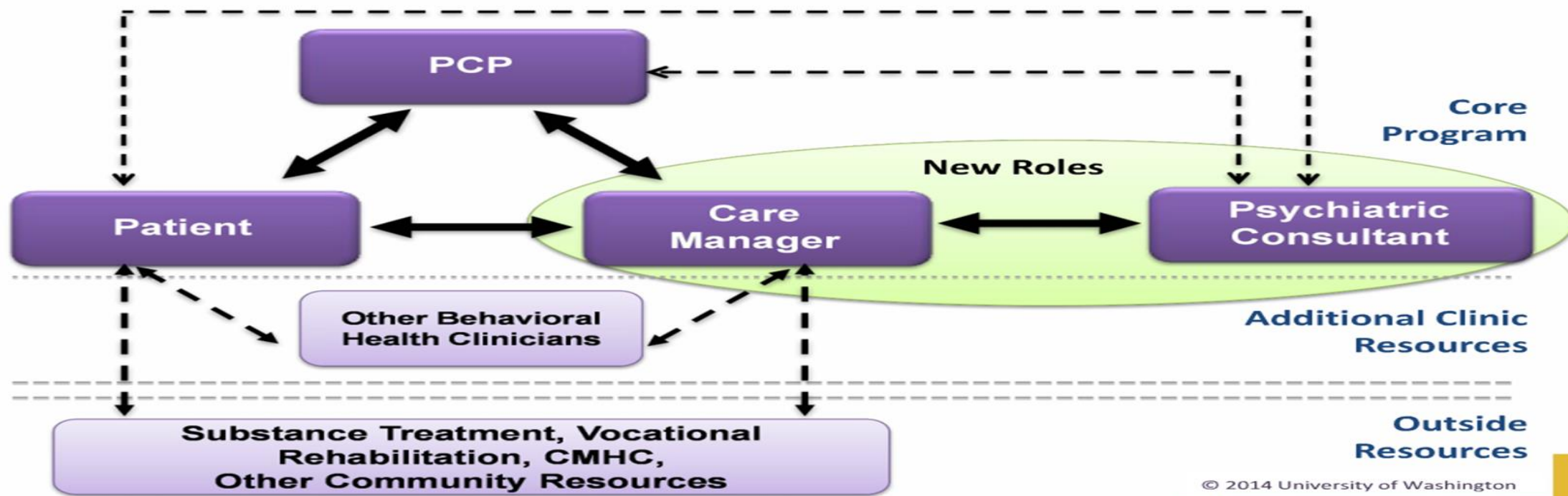
Integration needs to happen across the entire spectrum of interventions, from prevention to management of disorders and across all levels of care, from primary to tertiary care

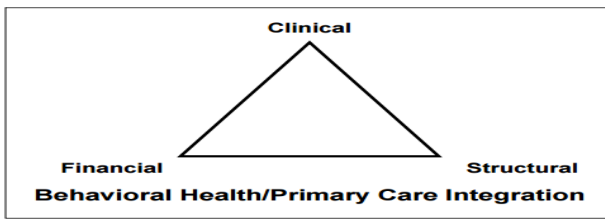
Ideal Elements of Integrated Care

- Comprehensive physical and behavioral health screening
- Electronic data system
- Clear designation of physical and behavioral health home
- Engagement of consumers at multiple levels (e.g., program design, self-management, care plan development, maintaining existing provider relationships)
- Shared development of care plans addressing physical and behavioral health
- Care coordination support for beneficiaries and providers (care homes)
- Sensitive and competent physical primary health providers with training and support to appropriately deliver medical care and change health behaviors
- Standardized protocols and evidence-based guidelines that can be tailored to individual needs
- Joint and standardized clinical and performance measures, treatment follow-up, and feedback mechanisms that are shared among providers
- Mechanisms (e.g., pay-for-performance) for rewarding quality care
- Mechanisms for sharing savings from reductions in avoidable emergency and inpatient utilization across physical and behavioral care delivery systems

Implementing effective collaborative care programs requires substantial practice change

Collaborative Team Approach





Integrated care is an omnibus concept defined in many ways and can include a mix and match of clinical and business relationships and employ a variety of payment methods

Clinical Integration – the extent to which patient services are coordinated across people, functions, activities and sites over time

- Occurs through the way service delivery and working relationships between providers are organized
- Can include a spectrum of integration from enhanced referral relationships, to co-location, to staff models and fully integrated multidisciplinary care teams
- Clinical integration can be difficult to achieve without financing mechanisms and structures or infrastructure that support the collaborative effort

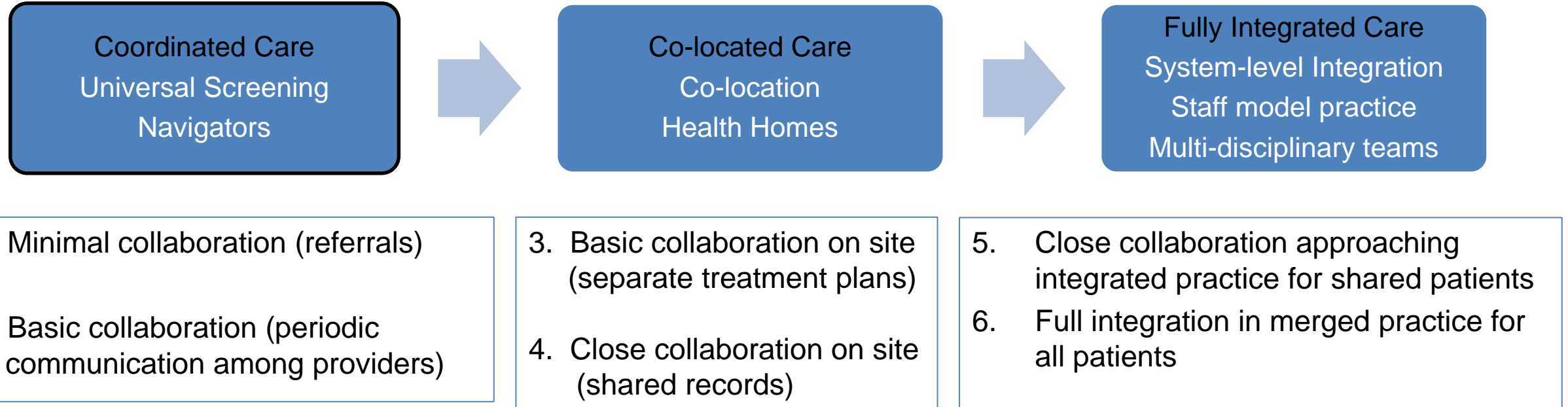
Structural Integration – the availability and functionality of linking structures that enable and sustain clinical integration

- Structural integration can occur to varying degrees from minimal collaboration between providers to fully merged practices under one administrative umbrella, including shared medical information, billing and scheduling functions

Financial Integration – the degree to which financial incentives for care systems are aligned in the service of integrated care

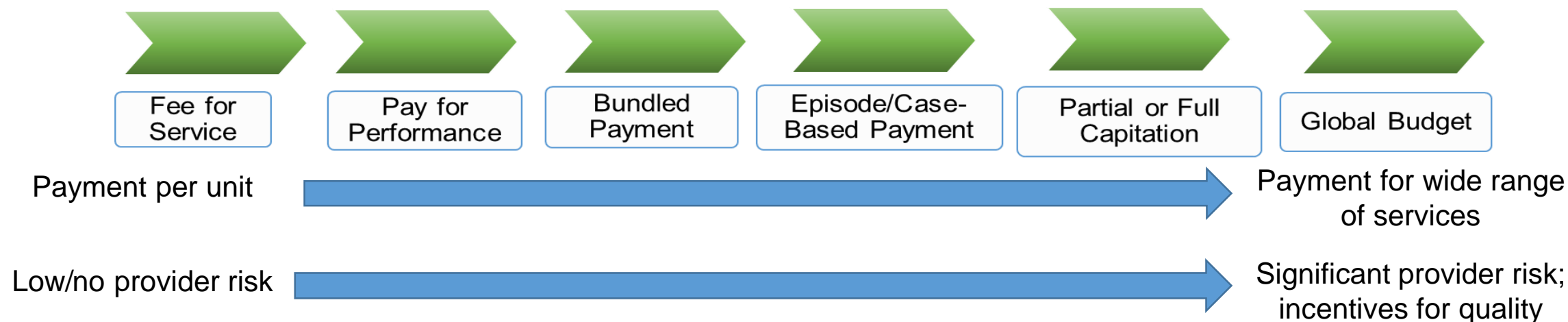
- Can include a variety of funding and payment methods with differing levels of financial risk and incentives to providers, such as different benefit packages, “carve-ins” and “carve-outs”, shared risk pools, shared savings, global payments, partial- and full-risk capitation payments, and episode-of care or bundled payments

A Conceptual Framework for Integration: Three Practice Structures - Six Levels of Integration*



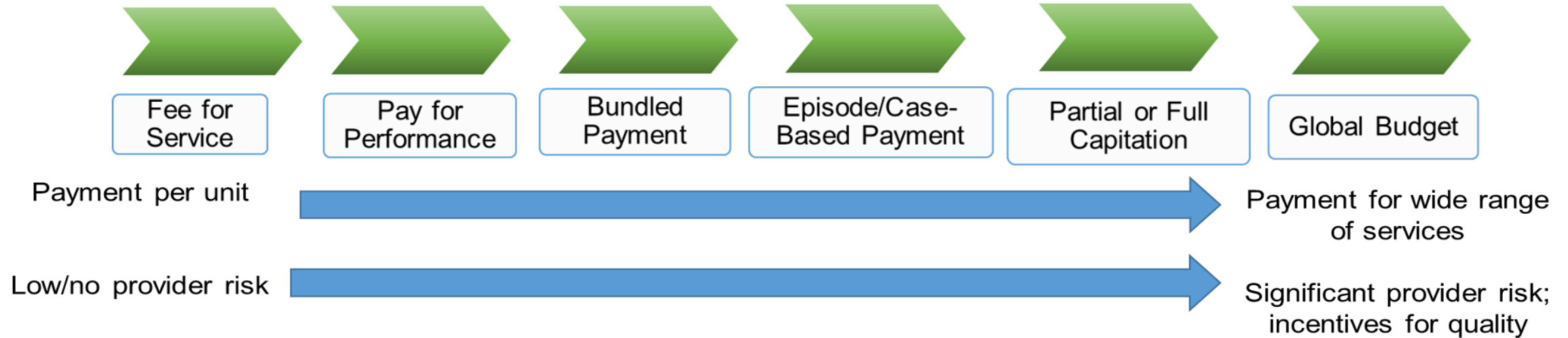
The terms *integrated care* and *collaborative care* are used somewhat interchangeably throughout the literature

Levels of Integration and Methods of Financing



- **Fee for service may include shared savings and pay for performance**
 - Used in situations with minimal provider collaboration
 - Medicare shared savings program allows both upside risk only contracts (providers receive bonus if they meet quality measures) or upside/downside risk contracts (where providers also may get penalized for poor outcomes); the great majority of providers opted for upside risk only contracts
- **Bundled and episode/case based payments**
 - Basic collaboration
 - One payment across a single episode of care, such as hip or knee replacement
 - Prospective bundling - fee set before services provided, and no claims would be submitted by providers
 - Providers may receive shared savings based on actual to target price savings
 - Can encourage providers to work together and better coordinate care

Levels of Integration and Methods of Financing, Continued



- **Partial Capitation may include basic or partially integrated practice**
 - Partial risk model - Blend of capitation and fee-for-service payment with some services 'carved out' of the integrated care provider contract
- **Full capitation may include basic or partially integrated practice**
 - Full-risk model – integrated care provider paid a monthly fee for all services required
 - Whole networks of hospitals and physicians band together to receive a single, fixed monthly payment for enrolled members
 - Provider group determines a method of dividing the total payment among group members
- **Coordinated Care Organizations (CCO) fully integrated practice**
 - Hybrid of insurance companies and accountable care organizations
 - Includes all services, including social services, housing, transportation and more
 - Operate under a risk-adjusted global budget

Side-by-Side Comparison of Service Delivery and Payment Models*

Attributes	Fee-for-service with shared Savings	Primary Care Health Homes	Bundled Payments	Partial Capitation	Full Capitation Global Budgets
Strengths & Weakness	Providers are accountable for total costs through bonuses and penalties	Provide referrals and care coordination but not accountability for total costs	No accountability for total costs – providers only accountable for services included in the bundle	“Upfront” payments can be used to improve infrastructure and process	‘Upfront’ payments can be used to improve infrastructure and process; requires ‘lock-in’; risk to providers
Strengthens Primary Care?	Yes – incentive to focus on disease management	Yes – better care coordination and disease management	Only for bundled payments that increase support for primary care	Yes – if primary care services included in capitation	Yes - ‘Upfront’ payments can be used to improve infrastructure and process
Fosters coordination among all providers?	Yes – significant incentive to coordinate care	No – specialists, hospitals, other providers not incented to coordinate care	Yes – depending on how payment is structured	Yes – strong incentive to coordinate and reduce overall costs	Yes - strong incentive to coordinate and reduce overall costs

* Source: Miller, J.E., August 2012 National Association of State Mental Health Program Directors. Taking Integration to the Next Level: The Role of New Service Delivery Models in Behavioral Health.

Side-by-Side Comparison of Service Delivery and Payment Models, Continued*

Attributes	Shared Savings	Primary Care Health Homes	Bundled Payments	Partial Capitation	Full Capitation Global Budgets
Removes incentive to increase volume?	Yes bonuses/penalties based on value, not volume	No	Not for payments outside of the bundle; strong incentives to shift costs to outside the bundle	Yes— strong efficiency incentive	Yes— very strong efficiency incentive
Fosters accountability for total per capita costs?	Yes— in the form of shared savings and penalties on total per capita costs	No— incentives not aligned across providers; no global accountability	No - for payments outside of the bundle; no global accountability; no accountability for total per capita costs	Yes - strong efficiency incentive	Yes— very strong accountability for total per capita costs
Requires providers to bear risks for excessive costs?	Limited risk— the model does not require	No— no risks for providers who continue to increase volume and intensity	Yes - within an episode; providers paid fixed payment per episode and bear risks within the episode	Yes— to degree that payment is weighted in overall payment	Yes— providers are responsible for costs that are greater than the payment
Requires‘ lock-in of patients to specific providers?	No— patients are assigned on previous care patterns; no incentives to provide services within ACO	Yes— to give per member per month payment, patients must be assigned	No— bundled payments are for a specific duration or procedure and do not require‘ lock-in	Likely— depending on the model; patients might need to be assigned to a primary care physician	Yes— to calculate appropriate payments, patients must be assigned

Barriers to Behavioral and Physical Health Care Integration

Policies and practices that offer no incentives for or discourage integrated care

- Managed care contracts that carve out behavioral health services

Billing policies and restrictions

- Prohibition against billing for both a behavioral and physical health visit on the same day or more than one encounter per day

Regulations on Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2)

- Limits information sharing of alcohol or drug abuse treatment information
- Requires detailed patient consent forms listing providers
- SAMHSA proposed changes, but significant consent barriers remain
- H.R. 2646 includes language directing the Secretary of Health and Human Services to promulgate legislation to clarify when PHI can be disclosed in the treatment of persons with SMI with providers, family members and caregivers

Federal changes may partially address billing and confidentiality barriers

- The Centers for Medicare and Medicaid Services (CMS) proposed payment changes related to new billing codes that separately pay for chronic care management for individuals with cognitive impairment and behavioral health conditions for the calendar year 2017 Medicare Fee Schedule
- Pending federal legislation: H.R. 2624 Helping Families in Mental Health Crisis Act of 2016 includes language clarifying that billing for mental health and physical health service on the same day is not prohibited under Medicaid

Barriers to Behavioral and Physical Health Integration

Prohibition on Medicaid Funding for Institutions for Intermediate Mental Disease (IMD)

- Since the Medicaid program was first enacted, there has been a preclusion of funding for inpatient treatment of adults between the ages of 21 and 64 in any institution for IMD with 17 or more beds - or any other needed care for such inpatients (Social Security Act §1905(a)(B))
- This statutory funding limitation was based in part on the historic role of states in funding long-term inpatient psychiatric care and, in part, on concerns about the warehousing of psychiatric patients in large institutions
 - Creates disincentive for physical health care providers to provide care in IMDs or accept referrals
 - Creates disincentive for long-term care facilities to accept Medicaid patients with behavioral health diagnoses as they run the risk of being classified as an IMD and losing federal Medicaid payments
 - **H.R. 2646 would allow states to receive full federal match on capitation payments for enrollees in managed care organizations aged 21-65 for up to 15 days/month in an IMD, although 15 days may not be sufficient to meet all patient needs**

Barriers to Behavioral and Physical Health Integration

Lack of adoption of health information technology

- Some behavioral health facilities and providers are ineligible to receive federal incentive payments for implementing electronic health records

Temporary funding, such as planning, implementation and demonstration grants that are time-limited; sustainability may be an issue once funding ends

- The Medicaid Emergency Psychiatric Demonstration was recently determined to not be cost efficient and will end one year early
- The Innovation Accelerator Program

Licensing requirements

- If a behavioral health organization provides physical health services, it may need to meet standards regarding exam rooms, bathrooms, drug storage, etc.
- If a physical health organization provides behavioral health services, it may need to meet requirements such as presence of a psychiatrist

Workforce shortages, especially mental health professionals

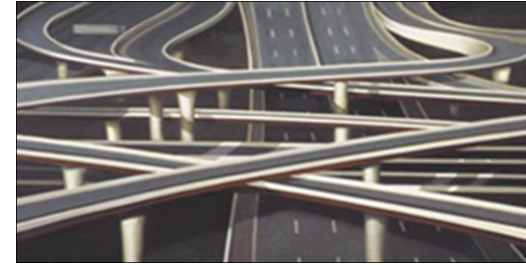
Avenues of Integration



Avenues of Integration: Include behavioral health services in existing Medicaid managed care organization (MCOs) contracts

The number of behavioral health services carved into Medicaid MCO contracts across the country as of October 2015*:

- Thirty-one states carve in outpatient mental health services
- Twenty-eight states carve in inpatient mental health services
- Thirty states carve in substance abuse services



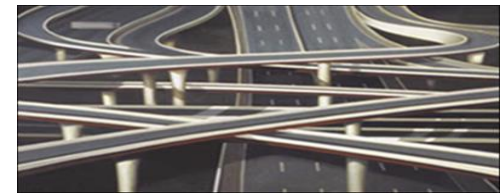
Advantages of carving behavioral health services into MCO contracts include:

- Federal Medicaid MCO requirements include strong purchasing standards and state contract oversight on:
 - Provider network adequacy standards (physical and behavioral)
 - Provider screening and credentialing (physical and behavioral specialties)
 - Utilization and financial tracking and reporting
 - Annual Health Effectiveness Data and Information System (HEDIS) and other quality of care measures
 - Annual Consumer Assessment of Health Plan Survey on access and satisfaction with care
 - Focused studies on special topics, such as use of asthma medications

MCOs have the flexibility to cover additional social services not covered by Medicaid in order to reduce cost and improve quality of care via:

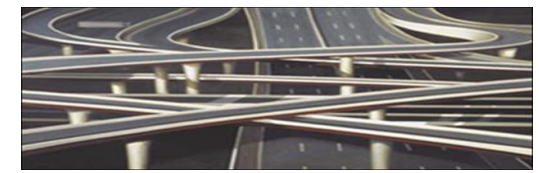
- **“In-lieu-of services”** are services or settings not covered in the state plan or MCO contract but are medically appropriate, and cost effective alternatives to covered services
- **“Value-added services”** are services not covered under the state plan or MCO contract which may be included in the administrative portion of capitation payments, or medical portion, if they improve health care quality under (45 CFR Section 158.150) *<http://files.kff.org/attachment/tables-managed-care-Medicaid>

Avenues of Integration: Medicare Accountable Care Organizations (ACO)



- ACOs are groups of doctors, hospitals and other health care providers who come together voluntarily to deliver coordinated, high quality care to Medicare patients – Medicare offers several ACO programs:
 - Medicare Shared Savings Programs - helps Medicare fee-for-service providers become an ACO
 - Advance Payment ACO model - provides upfront monthly payments which can be used to make important investments in their care coordination infrastructure
 - Pioneer ACO model - for early adopters of the ACO model who were ready to move from a shared savings payment model to a population-based model
- ACOs must have the ability to:
 - Provide and manage patients across the continuum of care and multiple settings
 - Prospectively plan budgets and resource needs
 - Have the sufficient size to support comprehensive, valid and reliable performance measurement
- Shared savings programs can help reduce the incentives to provide higher volume and intensity (measure of the number, technical complexity, or attendant risk) of services, but the value of the shared savings may not be large enough to offset the decrease in volume

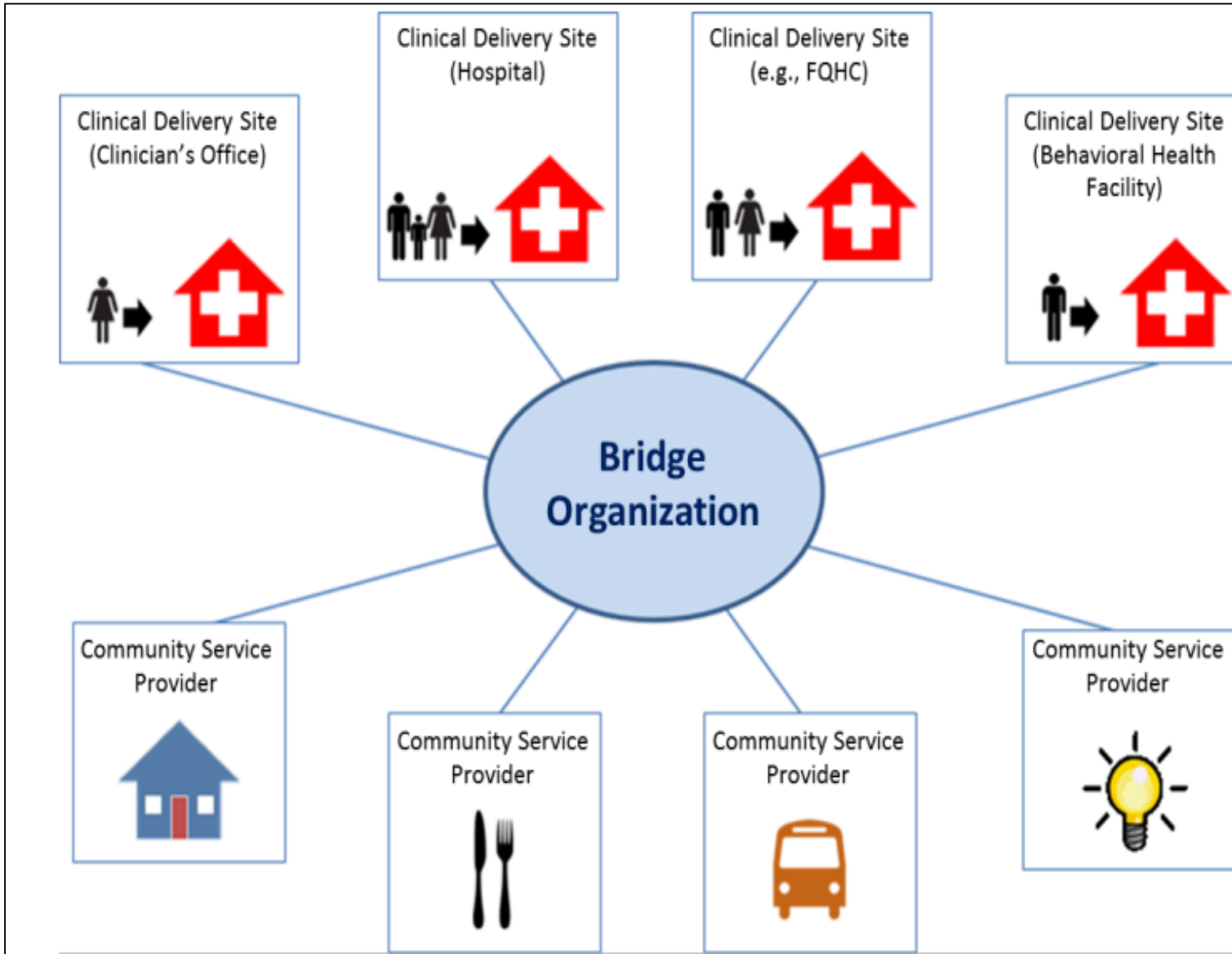
Avenues of Integration: Accountable Health Communities (AHCs)



- A 5-year grant made available by the Centers for Medicare and Medicaid Services (CMS) that tests whether systematically identifying and addressing the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries impacts total health care costs and utilization; awards will be announced in 2017
- Grantees must use their awards to fund interventions intended to connect community-dwelling beneficiaries with those offering such community services
- CMS will award a total of 44 cooperative agreements ranging from \$1.17 million to \$4.5 million to successful applicants to implement the AHC model
- Applicants will partner with state Medicaid agencies, clinical delivery sites, and community service providers and are responsible for coordinating community efforts to improve linkage between clinical care and community services
- CMS funds for this model cannot pay directly or indirectly for any community services (e.g., housing, food, violence intervention programs, and transportation)

Avenues of Integration: Accountable Health Communities (AHCs), continued

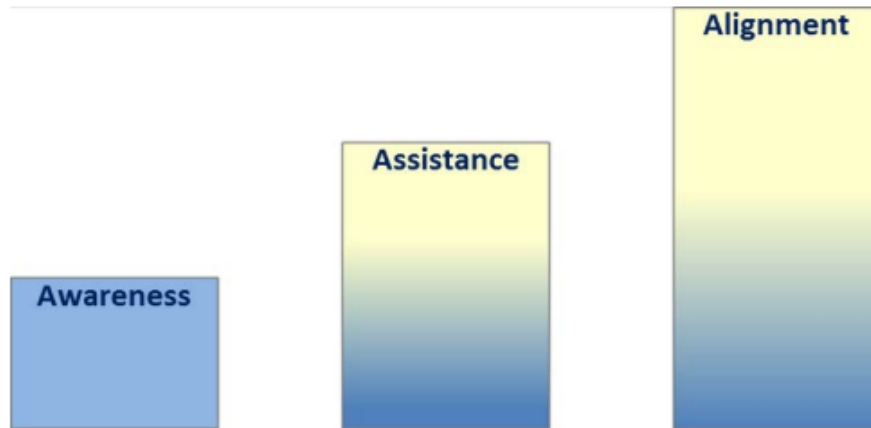
The AHC grant will fund award recipients, called *bridge organizations*, to serve as *hubs*



Bridge organizations will be responsible for coordinating efforts to:

- Identify and partner with clinical delivery sites
- Conduct systematic health-related social needs screenings and make referrals
- Coordinate and connect community-dwelling beneficiaries who screen positive for certain unmet health-related social needs to community service providers that might be able to address those needs
- Align model partners to optimize community capacity to address health-related social need

Avenues of Integration: Accountable Health Communities, Continued Intervention Approaches - Summary of the Three Tracks



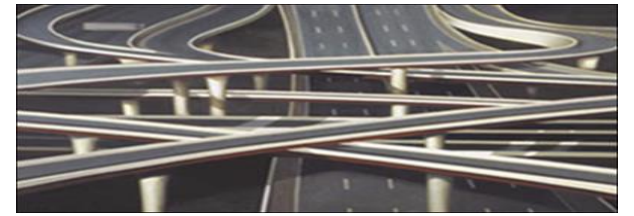
- **Track 1: Awareness** – Increase beneficiary *awareness* of available community services through information dissemination and referral
- **Track 2: Assistance** – Provide community service navigation services to *assist* high-risk beneficiaries with accessing services
- **Track 3: Alignment** – Encourage partner *alignment* to ensure that community services are available and responsive to the needs of beneficiaries

- The initial application period for Tracks 1 closed in May 2016
- Applications for Tracks 2 & 3 are currently under review
- Successful applicants will be selected to participate in a single track only
- Virginia Center for Health Innovation is facilitating applications – *there are three Virginia applications* under CMS review (two in SW and one in Central Virginia) and include individuals with behavioral health issues

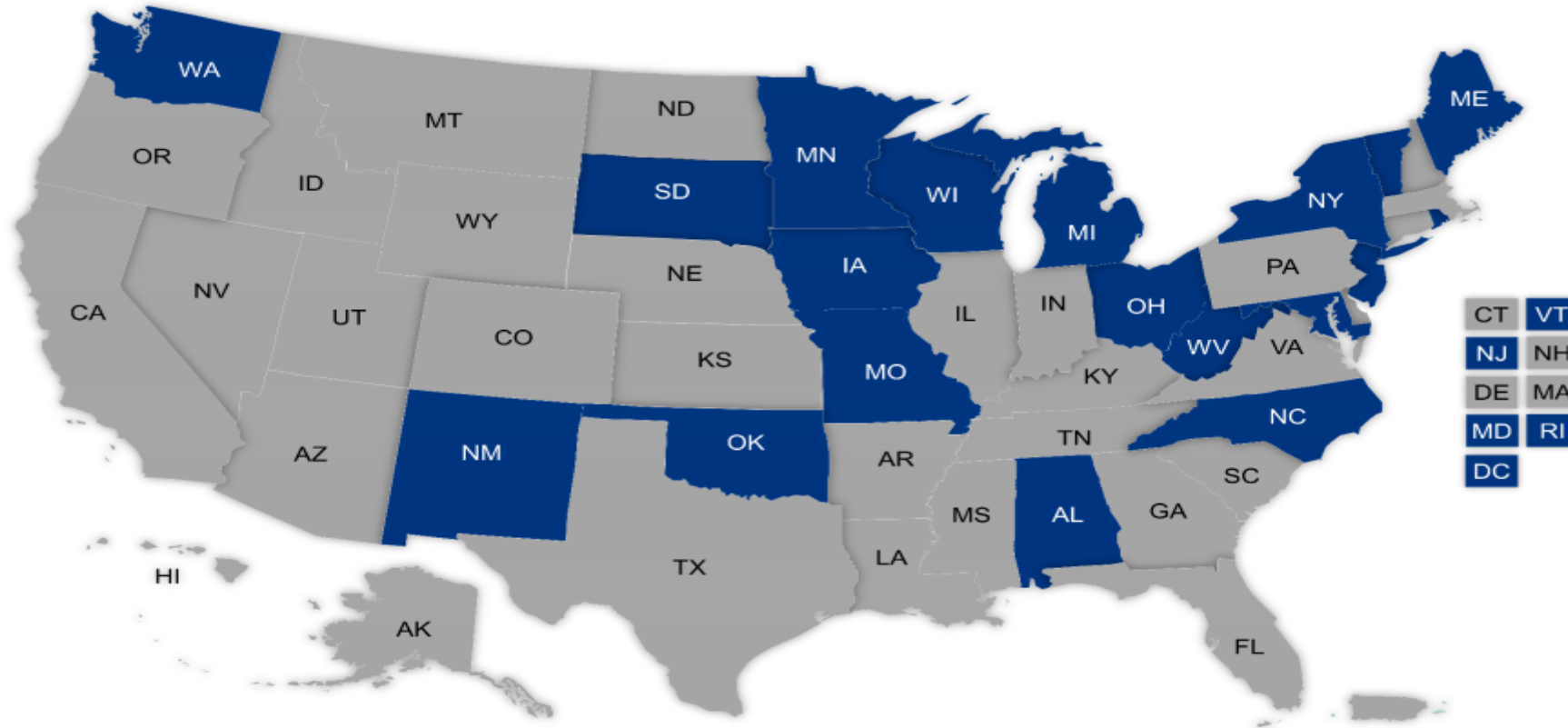
Eligible applicants include: community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, for-profit and not-for-profit local and national entities – must partner with state Medicaid agency

Avenues of Integration

Section 2703 Health Homes Medicaid State Plan Amendment



- The state plan amendment integrates behavioral, primary and acute care health services and long-term services and supports into a single practice and team-based approach to care for patients through a spectrum of disease states and across various stages of life
- Includes individuals with multiple, state-specified chronic health conditions and serious mental illness and/or substance use disorders
- Must be available statewide to any enrollee who meets inclusion criteria, including dual eligible individuals (most of the savings for dual eligible individuals would be for Medicare covered services, e.g., ED and inpatient costs)
- States receive a ninety percent enhanced federal match rate for two years after state plan approval for *care coordination services only* (care management, care coordination and transitional care), other services are matched at state's regular federal match rate
- States are encouraged to use a full or partial capitation reimbursement method



As of July 2016, 19 states and the District of Columbia have a total of 28 approved Medicaid health home models.

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

Avenues of Integration - New Opportunities: State Innovation Model Grant Opportunity

- The Centers for Medicare and Medicaid Services (CMS) has announced that it will award no more than 15 states grants of up to \$3M each to design a new health system innovation plan over a one-year period for the purposes of:
 - Partnering with states to implement delivery and payment models across multiple payers in a state
 - Facilitating alignment of state and federal payment and service delivery reform efforts, and streamlining interactions between the Federal government and states
 - Moving states towards future implementation (2021 target) of all-payer (Medicare, Medicaid and private insurance) concepts to align care delivery and payment and for states to assume financial accountability for health outcomes of the entire state population
- States could receive supplemental awards to implement standardized care interventions of high priority, including physical and behavioral health integration, substance use treatment, and coordinating care for high-risk, high-need beneficiaries across the entire Medicaid program



Avenues of Integration - New Opportunities: Congressional Mental Health Legislation has Bipartisan Support

- [H.R. 2646, the Helping Families in Mental Health Crisis Act of 2015](#), and [S. 2680, the Mental Health Reform Act of 2016](#), passed the House with near unanimous support in July, and S. 2680 is ready for consideration by the full Senate, having been unanimously passed out of the Health, Education, Labor, and Pensions Committee earlier this year
 - Implements key structural reforms, notably clinician leadership, across federal departments and agencies that ensure science-driven and evidence-based approaches to care of individuals with mental illness and/or substance use disorders
 - Establishes new and support existing efforts centered on how to address the critical shortages of psychiatrists and other mental health practitioners, and grow the next generation of mental health practitioners
 - Substantially improves enforcement of the Mental Health Parity and Addiction Equity Act by requiring annual reports to Congress on parity compliance investigations from federal departments, and requiring the Government Accountability Office to investigate compliance of the parity law
 - Supports funding for innovative models of care that have the power to reduce long-term disability for individuals with severe mental illness including the Recovery After an Initial Schizophrenia Episode (RAISE) program, which helps individuals with schizophrenia to lead productive, independent lives while aiming to reduce financial impacts on public systems
 - [Support models that improve the coordination between mental health and physical health providers](#)



Virginia Initiatives





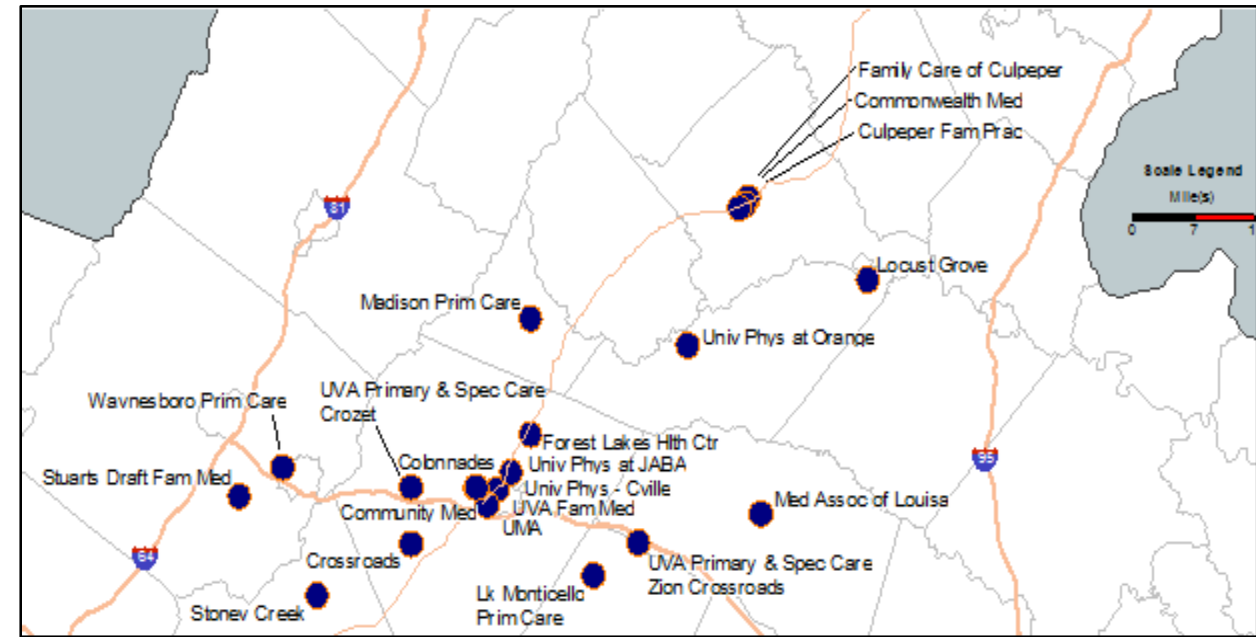
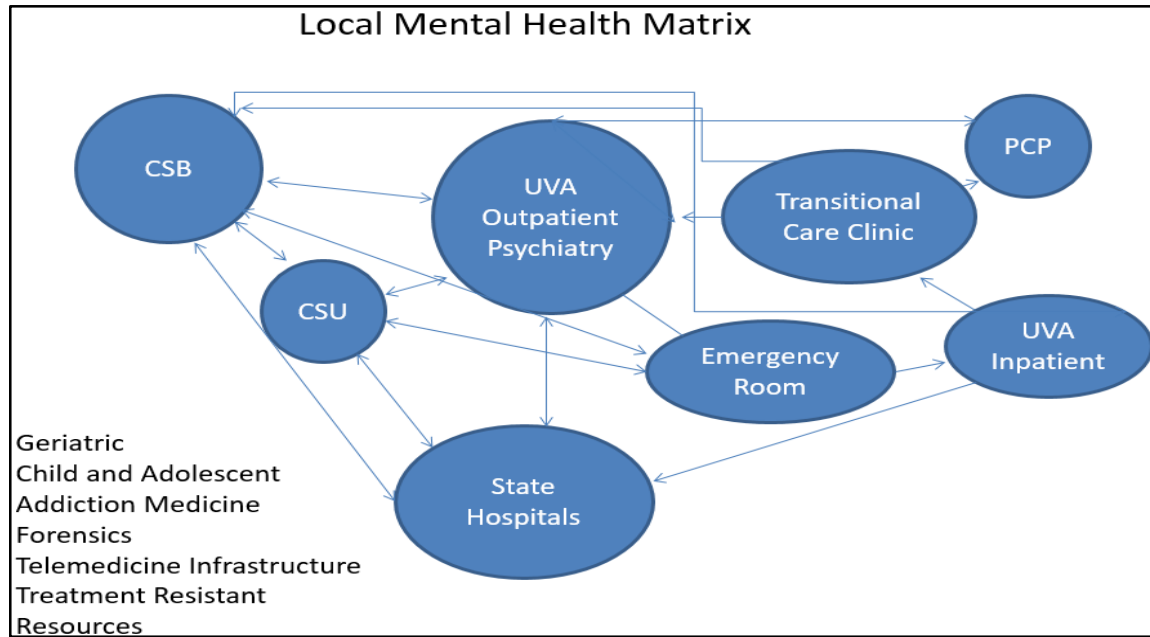
Virginia Medicare ACOs

ACO Name	Location
Doctors Connected	Roanoke
Augusta Care Partners	Fishersville
Well Virginia	Charlottesville
MD Valuecare, LLC	Glen Allen
Mary Washington Health Alliance, LLC	Fredericksburg
Tidewater Accountable Care Organization, LLC	Newport News



There are six Medicare ACOs operating in Virginia

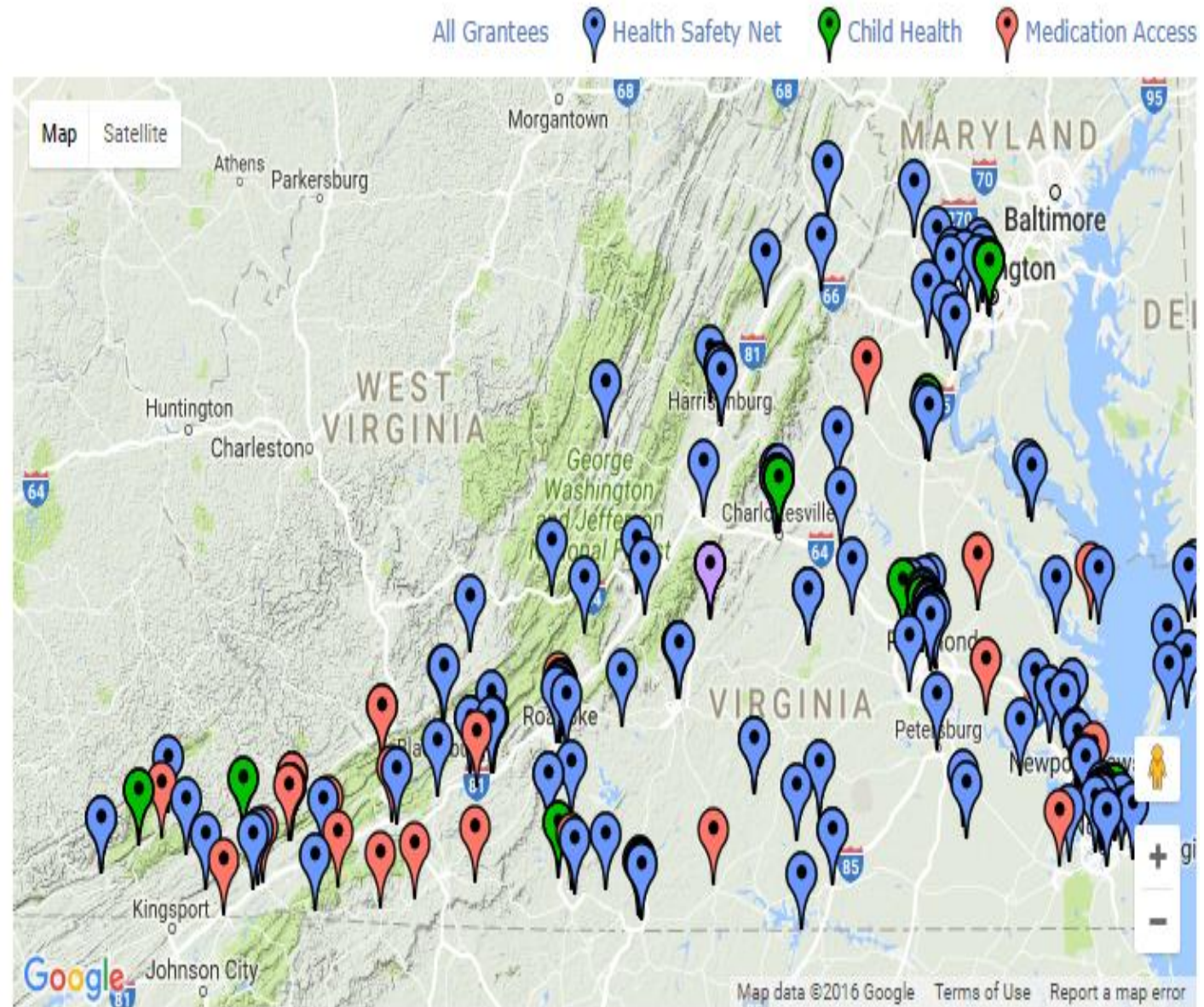
Well Virginia Accountable Care Organization – University of Virginia



- Well Virginia has been operating since January 2014
- It serves over 20,000 patients from Shenandoah to Louisa County
- It includes Internal and Family Medicine clinics with co-location of psychiatrists, psychologists and behavioral health care managers (BHCM) and operates a family stress clinic
- Added co-located behavioral health services at an internal medicine clinic in Orange County in November 2015
- Biggest barriers include:
 - The inability to find qualified behavioral health care managers – the education pipeline is narrow (VCU and Radford University have behavioral health care manager training programs, but they are not yet meeting need)
 - Reimbursement restrictions (e.g., Medicare does not pay for behavioral health care managers or telemedicine in non-rural areas)
 - The ability to reimburse providers at the “top of their qualifications”
 - The need for more residential substance use disorder treatment beds

A New Lease on Life (ANLOL)

- *A New Lease On Life* was a \$2 million special initiative from 2009-2013 to provide uninsured Virginians with treatment for basic mental health services
- *A New Lease on Life* linked local health safety net organizations (free clinics, community health centers) and local community services boards to address serious unmet needs
- *A New Lease on Life* was a collaboration with the Office of the Attorney General of Virginia, the Virginia Health Care Foundation, the Virginia Community Healthcare Association, the Virginia Association of Free and Charitable Clinics, and the Virginia Association of Community Services Boards
- *A New Lease on Life* is not currently accepting new applications for funding
- *A New Lease on Life* provided services through 26 organizations to over 12,000 patients and provided a return on investment of \$11 to \$1
- Considerations learned included the need to blend professional cultures, nurture collaboration, regularly evaluate operations and outcomes, the need to overcome patient fears and stigma and the need for resources for program sustainability

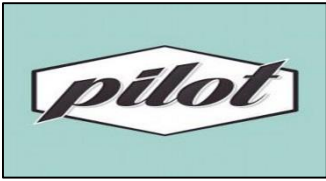


Virginia Medicaid Managed Care Behavioral Health Home Pilot

The Medicaid health plans implemented five behavioral health home pilot programs that went live July 1, 2015

- Each MCO targets adults enrolled in its health plan who have been diagnosed with serious mental illness in a specific locality or region:
 - Model A: Cooperate with Magellan (the DMAS contracted behavioral health administrative services organization) to integrate behavioral health services/supports (4 MCOs)
 - Model B: “All-in” Management where all services are managed by the MCO (1 MCO)
- Criteria for Medicaid enrollee participation includes the following pathways:
 - Medicaid behavioral health medical claims history
 - High mental health pharmaceutical use
 - History of inpatient admission to hospital for SMI
 - History of emergency department use for SMI
- The pilot care team must include a behavioral health home pilot lead, a psychiatrist, a case manager, a pharmacist, and a primary care physician
- Quality measurements include:
 - The percent of members participating with at least one successful contact with the member’s primary care physician, treating psychologist/psychiatrist, behavioral health consultant, psychologist, psychiatrist, or licensed clinical behavioral health case manager over the past month
 - Thirty-day follow-up after discharge from a behavioral health hospital





Virginia Medicaid Managed Care Behavioral Health Home Pilot

Key Points

- The Pilot structure assures adults with SMI benefit from coordinated behavioral health and medical care
- Each plan offers a unique care model in different regions of the state with a variety of partners
- Team-based care coordination is driven by providers who consult one another and are dedicated to improving the lives of clients
- Consistent with the Commonwealth Coordinated Care program that provides coordinated behavioral health and medical care for members with Medicare and Medicaid
- Goals: improve member outcomes; empower providers to work together to provide the right care at the right time; evaluate programs and processes

Regional Pilot Areas and MCOs

- Central – Coventry and Anthem
- Northern – INTotal
- Tidewater – Optima
- Roanoke/Alleghany – VA Premier

BHH Pilot Performance Measure Results 2016

Behavioral Health Home Program	April	May	June	Q2
Measure	Score	Score	Score	Score
Number of Members	220	208	205	211
Percent of Members w/ BHH Care Team Contact	35%	47%	54%	45.3%
Percent w/Current Month MCO CM Contact	22%	42%	54%	38.7%
# Members w/ 7 day Follow Up Post BH Hospital Stay	100%	86%	43%	67%
# Members w/7 day Follow Up Post MD Hospital Stay	20%	27%	40%	29%
* Scores are weighted				

Outcome scores may be higher as the program matures

Medicare-Medicaid Financial Alignment Demonstration 2014 – 2017



- Managed care organizations responsible for both Medicare and Medicaid services
- Medicare-Medicaid Plans partner with nineteen Community Services Boards to provide behavioral health homes that include case management and access to integrated primary and behavioral health care to those enrolled in the demonstration
- Enhanced Coordinated Care (ECC) - Designed for individuals with serious mental illness and one or more other chronic conditions, CSB care coordinators arrange transportation, accompany patients to primary care appointments and assist with adherence to recommended treatments

Department of Behavioral Health and Developmental Services (DBHDS) Office of Integrated Health

- A new office established to form collaborative relationships with expertise from behavioral health, substance use and developmental disability services and other departments within DBHDS
- Supports initiatives associated with Virginia/Community Behavioral Health Clinics, the Delivery System Reform Incentive Payment grant and other health related policies and programs
- Goals are to build cohesive associations with the Virginia Department of Health, community clinicians and other state agencies with a focus on population health



The Governor's Access Plan (GAP) for medical and behavioral health services for the seriously mentally ill

- Provides primary care and behavioral health services for Virginians who are uninsured, aged 19 – 64, live in the community, have income below 80% of the federal poverty level and have serious mental illness
- GAP was implemented January 2015 through a Medicaid §1115 waiver, and as of July 2016, enrollment included approximately 8,000 individuals
- DMAS is working with the Department of Corrections to permit access to the Magellan website to submit eligibility screenings for individuals involved with the justice system

There are three main areas of services rendered by the existing medical provider network and the behavioral health network through Magellan of Virginia (behavioral health services administrative organization)

1) Outpatient medical services; 2) Outpatient behavioral health services, and 3) Additional services covered by Magellan

Medical Services	Behavioral Health Services	Magellan Only Services
<ul style="list-style-type: none"> • Primary and Specialty Care • Laboratory • Pharmacy • Diagnostic Services <ul style="list-style-type: none"> ○ Physician's Office ○ Outpatient hospital coverage is limited to diagnostic ultrasound, diagnostic radiology (excluding PET scans), and EKG including stress. • Diabetic Supplies 	<ul style="list-style-type: none"> • GAP Case Management • Psychiatric Evaluation, Management & Treatment • Crisis Stabilization • Crisis Intervention • Psychosocial Rehabilitation • Outpatient Psych & Substance Abuse Treatment Services • Substance Abuse Intensive Outpatient (IOP) • Methadone & Opioid Treatment 	<ul style="list-style-type: none"> • Care Coordination including Community Wellness and Community Connection • Crisis Line available 24/7 and staffed by licensed mental health professionals • Recovery Navigation Services including a state wide warm telephone line staffed by trained peers and limited, local, voluntary, in-person supports.

Governor's Access Plan Waiver Amendment

Virginia's Addiction and Recovery Treatment Services Delivery System Transformation

*Virginia GAP Program for the
Seriously Mentally Ill
1115 Demonstration*
Application for Amendment
August 2016

Department of Medical Assistance Services

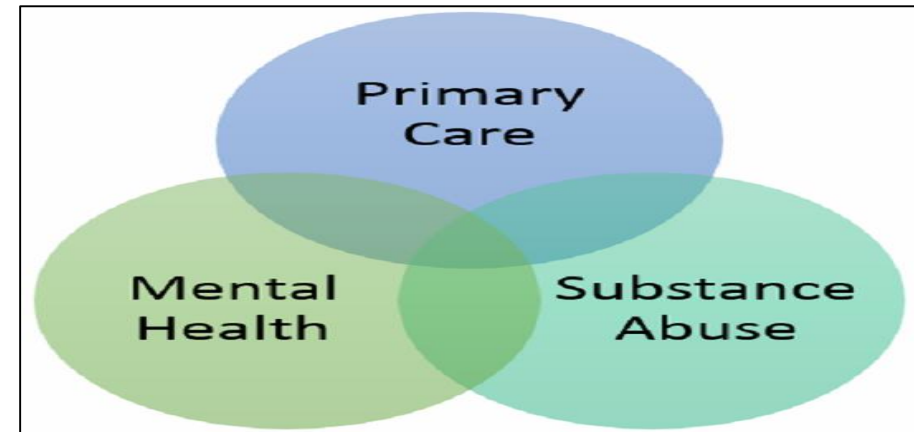
Medicaid 1115 Demonstration Waiver

- Medicaid 1115 Demonstration waiver submitted on **August 5** to Centers for Medicare and Medicaid Services to:
 - Allow federal matching Medicaid dollars for services provided in an IMD, which is currently prohibited for mental health or SUD treatment delivered in facilities with > 16 beds
 - Allow Virginia Medicaid to pay for services provided in residential treatment facilities > 16 beds, significantly increasing SUD treatment capacity
- Waiver would NOT change who is eligible for treatment services
- Waiver would require Medicaid health plans and providers to use American Society of Addiction Medicine (ASAM) criteria in all substance use assessment and treatment services

RICH Recovery

An integrated health care program for Richmond Behavioral Health Authority (RBHA) consumers

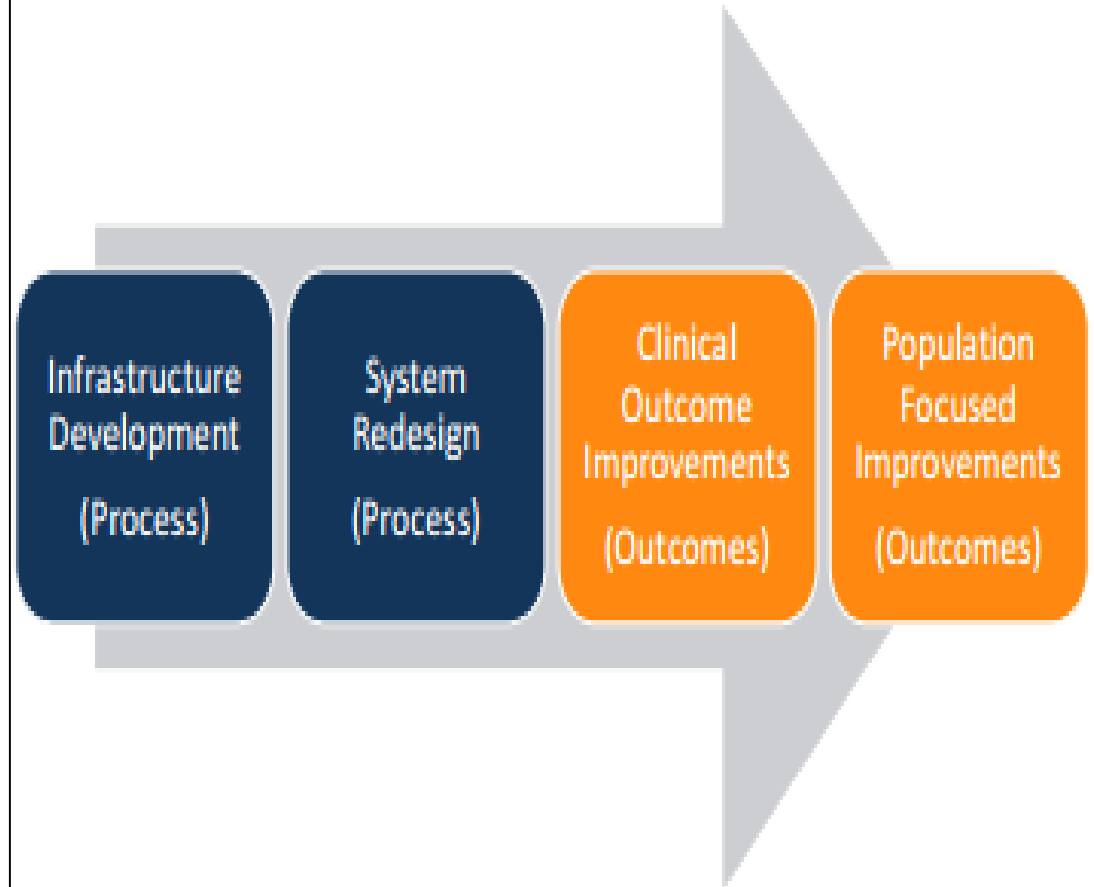
- RBHA received support from A New Lease and Life award and a four-year, \$1.6M grant from the Substance Abuse and Mental Health Services Administration in July 2013 to integrate primary and behavioral health care services and used the funds to establish and operate an on-site clinic
- The clinic includes two exam rooms (to be expanded to 4) a full-time nurse practitioner, a collaborating physician, and care coordinator/navigator
- Services include:
 - Medical services
 - Health Screenings
 - Health education, fitness and wellness groups
 - Referrals to specialists
 - Peer navigation
 - A 12-bed, 24 hour crisis treatment center
- RBHA board is committed to the program and RBHA is working on funding sources to sustain the clinic after the grant expires
- RBHA is in the process of purchasing Rubicon residential substance use disorder treatment center in Richmond and will operate it under RBHA administration



Delivery System Reform Innovation Program (DSRIP) Waiver

- A five-year §1115 Medicaid waiver that provides federal funds for system transformation by investing in infrastructure development, system redesign, outcome improvement, population-focused care, and value-based reimbursement
- Goals include integrating behavioral and medical care services and integrating the social determinants of health into medical care
- It does not pay for health care services – it can pay for the development of data systems, educational resources and other structural elements to facilitate reform
- Virginia's proposed structure:
 - Create *Virginia Integration Partners (VIP)* - broad provider organizations paid on an 'at-risk' basis that also partner with managed care organizations for administrative support
 - *Affiliated providers* that are not ready to move to a risk-based payment model – DSRIP funds will be used to help prepare them for that model

DSRIP waivers generally focus on 4 main areas with an increasing focus on clinical and population improvements over time.



CA Includes HIV Transition Projects as a 5th category of DSRIP projects.



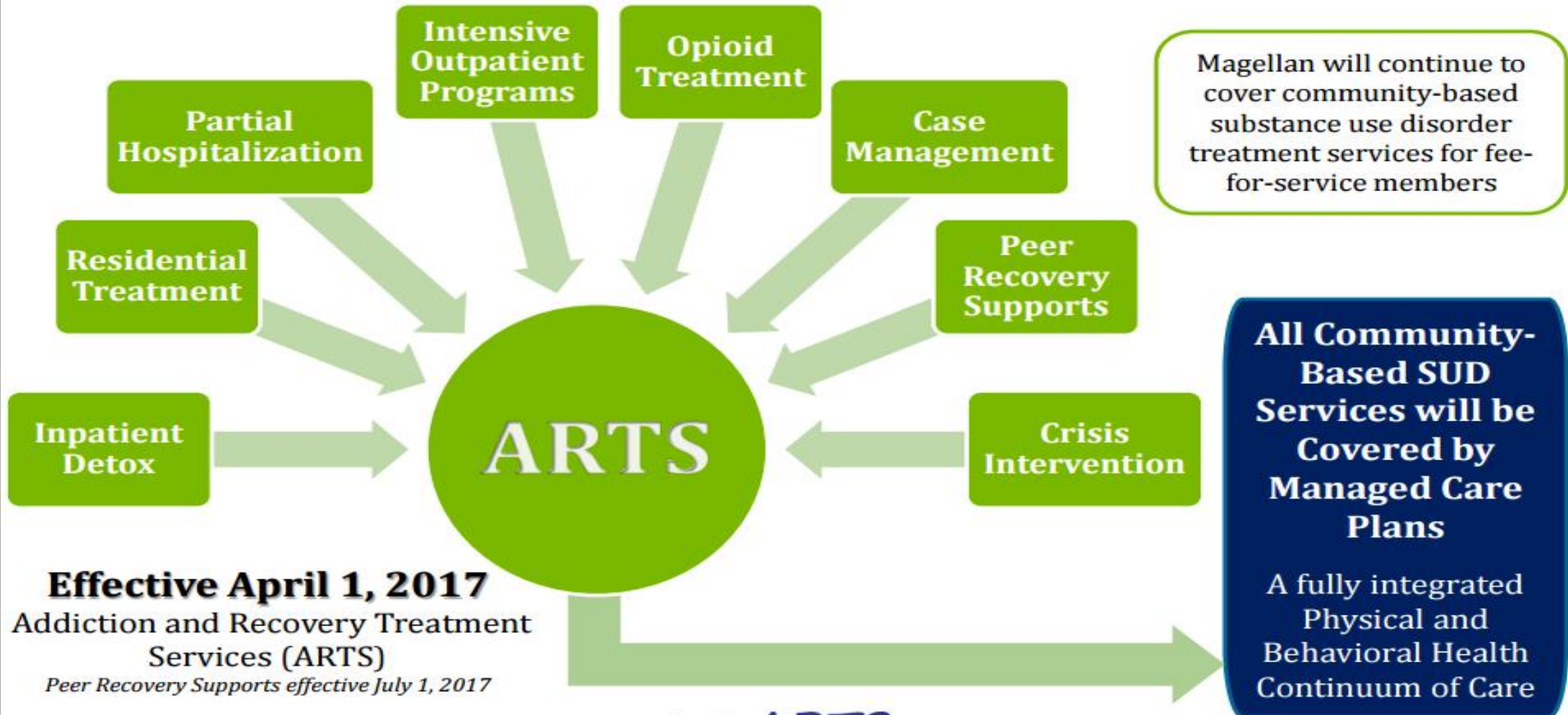


Medicaid Addiction and Recovery Treatment Services

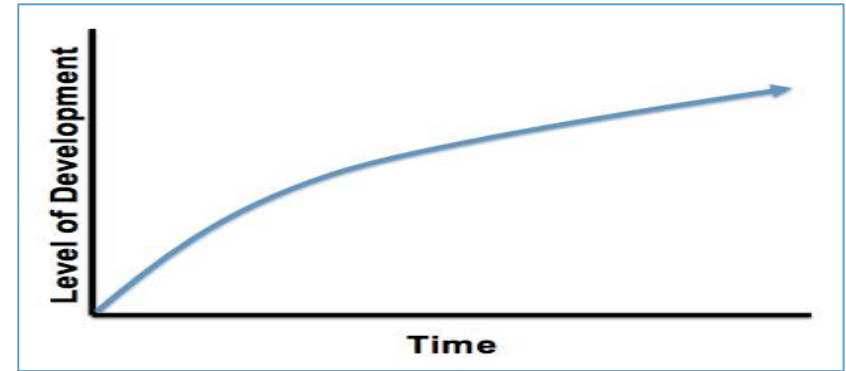
- Starting in 2017, all Medicaid community-based substance use disorder (SUD) services will be covered by managed care organizations (MCO) for MCO enrollees
- Expands short-term SUD inpatient detox to all Medicaid/FAMIS members
- Expands short-term SUD residential treatment to all Medicaid members
- Increases payment rates for existing Medicaid/FAMIS SUD treatment services
- Adds peer support services for individuals with SUD and mental health conditions
- Requires SUD care coordinators at the Medicaid managed care organizations
- Provides provider education, training and recruitment activities

Medicaid Addiction and Recovery Treatment Services (ARTS)

Reforming the Current Delivery System for Community-Based Services



Conclusions



- The Integration of behavioral and physical health services is an emergent model developing along a continuum
- In order for integration to occur, new treatment paradigms must be adopted by providers and resources for restructuring provider systems is needed
- There is a need for additional behavioral health professionals in Virginia
- The right incentives need to be in place and systems scaled for sustainability
- Integration is a process and it will take several years for systems to mature and results to be achieved

Visit the Joint Commission on Health Care website

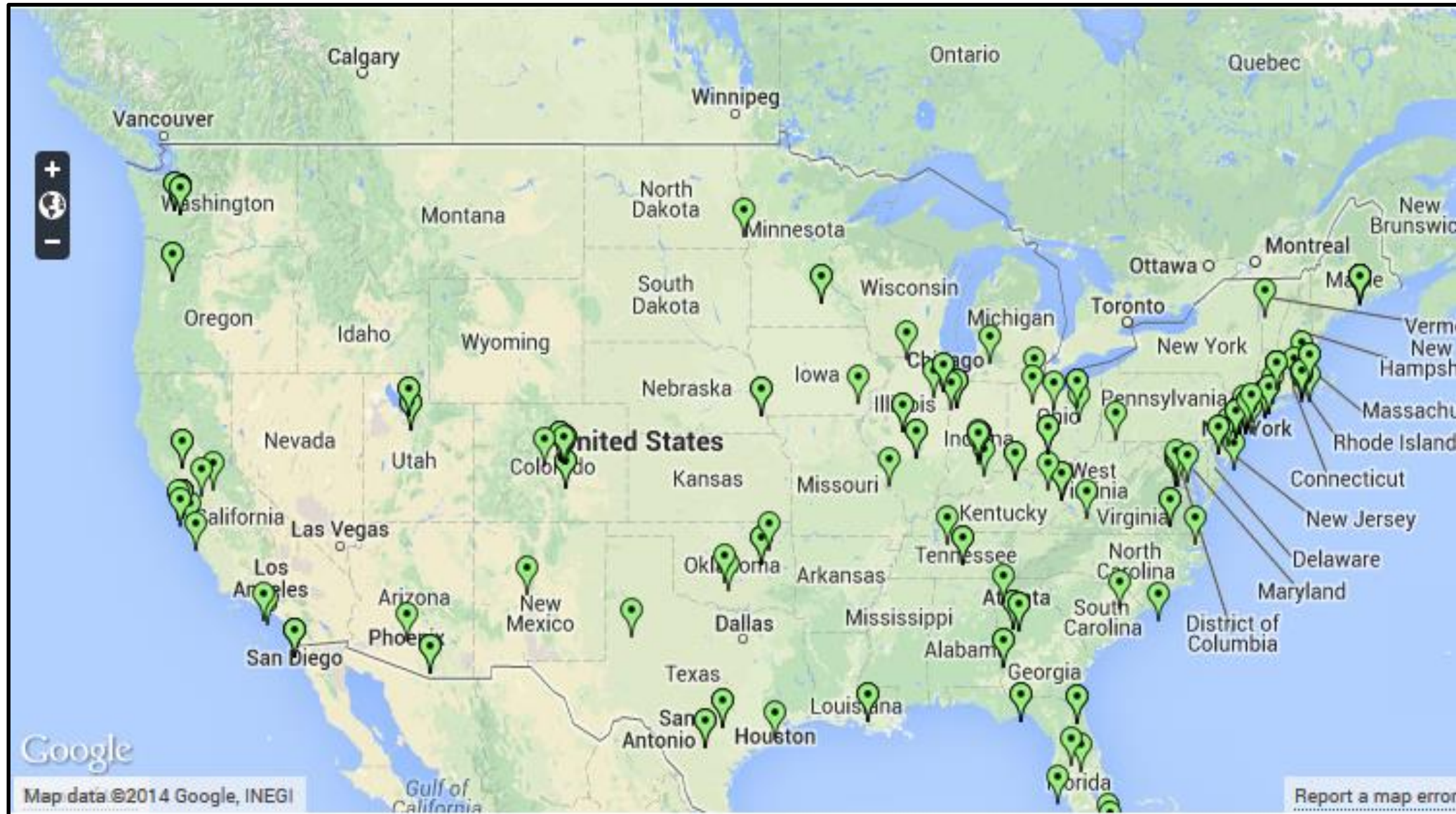
<http://jchc.virginia.gov>

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APPENDIX

Where Integration is Happening



Source: AHRQ, The Academy Integration Map. Accessed September 2014. http://integrationacademy.ahrq.gov/ahrq_map

Models Worth Watching

- Tennessee: Carving behavioral health services back into its mandatory managed care program (includes SSI adults with SPMI)
- Pennsylvania: Implementing shared savings pool based on measures for which physical MCO and behavioral MCO are held jointly accountable
- Washington: Contracting (full-risk) with a MCO for physical, mental health, chemical dependency treatment, and long term care services
- Massachusetts: Contracting with a BHO for physical and behavioral services for small group of state-funded chronically unemployed adults
- New York: Piloting Chronic Illness Demonstration Projects (CIDP) designed for persons with chronic medical and behavioral illness who are exempt or excluded from managed care
- Indiana: Contracting with a Care Management Organization (Schaller Anderson/Aetna) that is working with a non-risk organization to broker arrangements with community mental health centers.

Behavioral Health and Medical Services Integration in Other States

State	Program name	Start year	Area	Pilot?	Medicaid target population	Includes dually eligible beneficiaries?	Other groups included in target population?
Managed care							
AZ	Mercy Maricopa Integrated Care	2014	Select region	No	Adults with SMI only ¹	Yes	Medicaid only ²
FL	Magellan Complete Care Serious Mental Illness Specialty Plan	2014	Selected regions	No	Children with SED only ³ Adults with SMI only	Yes	Medicaid only
MA	Massachusetts Behavioral Health Partnership	2012	Statewide	No	All children ⁴ All adults ⁴	Yes	Medicaid only
MN	Preferred Integrated Network Program	2009	Selected regions	No	Children with SED only Adults with SMI only	Yes	Medicaid only
Primary care case management/patient-centered medical home							
NC	Community Care of North Carolina	2010 ⁵	Statewide	No	All adults	Yes	Medicaid only
VT	Blueprint for Health	2006	Statewide	No	All children All adults	Yes	Private coverage ⁶ Medicare
Health home program							
IA	Integrated Health Homes	2013	Statewide	No	Children with SED only Adults with SMI only	Yes	Medicaid only
KS	KanCare Health Homes	2014	Statewide	No	Children with SED only Adults with SMI only	Yes	Medicaid only
ME	MaineCare Behavioral Health Homes Program	2014	Statewide	No	Children with SED only Adults with SMI only	Yes	Medicaid only
MD	Maryland Health Home Program	2013	Statewide	No	Children with SED only Adults with SMI ⁷	Yes	Medicaid only
MO	Missouri Community Mental Health Center Healthcare Homes	2012	Statewide	No	Children with SED ⁸ Adults with SMI ⁸	Yes	Medicaid only
NJ	New Jersey Behavioral Health Homes	2014	Select region	No	Children with SED only Adults with SMI only	Yes	Medicaid only
OH	Ohio Health Homes	2014	Selected regions	No	Children with SED only Adults with SMI only	Yes	Medicaid only

Behavioral Health and Medical Services Integration in Other States, Continued

State	Program name	Start year	Area	Pilot?	Medicaid target population	Includes dually eligible beneficiaries?	Other groups included in target population?
OK	Oklahoma Health Homes	2015	Statewide	No	Children with SED only Adults with SMI only	Yes	Medicaid only
RI	Community Mental Health Organization Health Homes ⁹	2011	Statewide	No	Adults with SMI only	Yes	Medicaid only
WV	West Virginia Health Homes	2014	Selected regions	No	Other children ¹⁰ Other adults ¹⁰	Yes	Medicaid only
Accountable care organization							
CO	Accountable Care Collaborative	2011	Statewide	No	All children All adults	Yes	Medicaid only
MN	Hennepin Health	2012	Select region	No	Other adults ¹¹	Yes	Medicaid only
MN	Integrated Health Partnerships Demonstration: Southern Prairie Community Care	2014	Selected regions	No	All children All adults	No	Medicaid only

Notes: SMI is serious mental illness (adults only). SED is serious emotional disturbance (children only).

¹ Medicaid-enrolled adults with SMI (including dually eligible beneficiaries) are the only individuals who receive integrated physical health and behavioral health benefits. Other Medicaid-covered adults and children with general behavioral health needs receive behavioral health services only.

² Mercy Maricopa provides limited behavioral health services for persons diagnosed with a serious mental illness who do not qualify for Arizona's Medicaid program.

³ Florida's Magellan Complete Care Serious Mental Illness Specialty Plan covers children age six and older.

⁴ Massachusetts's Behavioral Health Partnership covers only individuals who are enrolled in the MassHealth Primary Care Clinician Plan.

⁵ Community Care of North Carolina officially launched statewide in 2001, but behavioral health integration efforts began in 2010. However, the state has moved to end this program and plans to transition Medicaid beneficiaries into Medicaid managed care.

⁶ Private coverage includes self-insured employer plans.

⁷ Maryland's Health Home program also includes adults with an opioid substance use disorder and those who are at risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use.

⁸ Beneficiaries who are eligible for Missouri's Community Mental Health Center Healthcare Homes must have SMI or SED, or another behavioral health problem combined with another chronic condition. Missouri has another health home program, Primary Care Health Home Initiative, which targets individuals with chronic conditions.

⁹ Rhode Island has three approved health home programs. This table includes only the Community Mental Health Organization Health Home, which focuses on individuals with SMI. The other health home programs include: (1) the CEDARR Family Centers Health Home program, which focuses on children with SED who also have two chronic conditions, and (2) the Opioid Treatment Programs Health Home program, which focuses on opioid-dependent Medicaid beneficiaries.

Behavioral Health and Medical Services Integration in Other States, Continued

State	Program name	Key organizations	Payment model	Direction of integration			Colocation?	Independent evaluation?
				PH into BH	BH into PH	Two-way integration		
Comprehensive managed care								
AZ	Mercy Maricopa Integrated Care	MCO	Shared risk	Yes	No	No	Yes	No
FL	Magellan Complete Care Serious Mental Illness Specialty Plan	BHO	Shared risk	No	No	Yes	Yes	Yes
MA	Massachusetts Behavioral Health Partnership	BHO	Shared risk	No	No	Yes	No	No
MN	Preferred Integrated Network Program	MCO County	Shared risk	Yes	No	No	Yes	Yes
Primary care case management/patient-centered medical homes								
NC	Community Care of North Carolina	Other lead entity PCPs	Enhanced payments	No	Yes	No	Yes	Yes
VT	Blueprint for Health	Other lead entity PCPs	Enhanced payments	No	Yes	No	No	No
Health home programs								
IA	Integrated Health Homes	BHO CMHCs FQHCs	Enhanced payments Incentives	Yes	No	No	No ¹	Yes ²
KS	KanCare Health Homes	MCOs CMHCs Counties FQHCs Other	Enhanced payments Incentives	No	No	Yes	No	Yes ²
ME	MaineCare Behavioral Health Homes Program	CMHCs PCPs	Enhanced payments	Yes	No	No	No	Yes ²
MD	Maryland Health Home Program	CBHCs	Enhanced payments	Yes	No	No	No	Yes ^{2,3}
MO	Missouri Community Mental Health Center Healthcare Homes	CMHCs	Enhanced payments	Yes	No	No	No	Yes ²
NJ	New Jersey Behavioral Health Homes	CMHCs	Enhanced payments	Yes	No	No	Yes ⁴	Yes ²
OH	Ohio Health Homes	CBHCs	Enhanced payments Incentives	Yes	No	No	No	Yes ²
OK	Oklahoma Health Homes	CMHCs Other lead entity	Enhanced payments	Yes	No	No	No	Yes ²

Behavioral Health and Medical Services Integration in Other States, Continued

State	Program name	Key organizations	Payment model	Direction of integration			Colocation?	Independent evaluation?
				PH into BH	BH into PH	Two-way integration		
RI	Community Mental Health Organization Health Homes	CMHCs	Enhanced payments	Yes	No	No	Yes ⁵	Yes ²
WV	West Virginia Health Homes	CMHCs FQHCs Other lead entity	Enhanced payments	No	Yes	No	No	Yes ²
Accountable care organizations								
CO	Accountable Care Collaborative	Other lead entity PCPs BHOs	Enhanced payments	No	Yes	No	Yes ⁶	No
MN	Hennepin Health	Hospital/provider system County FQHC	Shared risk	No	Yes	No	Yes	Yes
MN	Integrated Health Partnerships Demonstration: Southern Prairie Community Care	Other lead entity Hospital/provider system FQHCs PCPs CMHCs Counties	Shared savings	No	No	Yes	No	No

Notes: PH is physical health. BH is behavioral health. MCO is managed care organization. BHO is behavioral health organization. PCP is primary care practice. CMHC is community mental health center. FQHC is federally qualified health center. CBHC is community behavioral health center.

¹ Based on publicly available resources, it is unclear whether Iowa Integrated Health Homes have physical health provider satellite offices within behavioral health homes.

² The Urban Institute is under contract with the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, to conduct a five-year, independent evaluation of all Medicaid health home initiatives.

³ The State of Maryland is also conducting an evaluation of its health home program.

⁴ All New Jersey Behavioral Health Homes must be fully or partially colocated within three years of certification.

⁵ Colocation of physical and behavioral health providers varies by health home in Rhode Island. However, some health homes have noted colocated providers.

⁶ Colocation of physical and behavioral health providers participating in Colorado's Accountable Care Collaborative may exist in some cases, but colocation can be dependent on the five regional care collaborative organizations.

Source: SHADAC 2015.

Appendix A: Framework for Levels of Integrated Healthcare

Level of Integration	Characteristics Achievable in Different Settings
Minimal Collaboration	<ul style="list-style-type: none"> • Separate facilities and services with rare communication • Private practices and agencies • Can handle routine medical/behavioral problems with little interplay between mental health, social and medical interactions and few care management difficulties
Basic Collaboration at a Distance	<ul style="list-style-type: none"> • Separate facilities with period sharing on common patients • Facilities with active referral linkages • Providers view each other as resources but do not share common language or understanding • Can handle moderate interplay between mental health, social and medical interactions where management of both medical and behavioral problems are proceeding well
Basic On-Site Collaboration	<ul style="list-style-type: none"> • Shared facility but some separate systems • Regular communication on common patients, sometimes face-to-face • Managed care settings, rehabilitation centers, clinics with behavioral health specialists who primarily perform referral-oriented services • Providers appreciate each other's roles, but do not share common language or understanding • Can handle moderate interplay between mental health, social and medical interactions and coordinate complex treatment plans

[http://www.integration.samhsa.gov/about-us/Mauers Behav Health Models Competerencies Infra.pdf](http://www.integration.samhsa.gov/about-us/Mauers_Behav_Health_Models_Competerencies_Infra.pdf)

Appendix A: Framework for Levels of Integrated Healthcare, Continued

Level of Integration	Characteristics Achievable in Different Settings
Partly Integrated	<ul style="list-style-type: none"> • Shared facility and limited shared systems (e.g., scheduling, charting) • Regular face-to-face interactions, mutual consultation, coordinated treatment plans • Managed care settings, rehabilitation centers, hospice centers, family practice training programs • Providers have a shared allegiance to a physical/social/medical paradigm, but pragmatics are sometime difficult • Can handle significant interplay between mental health, social and medical interactions and management complications
Fully Integrated	<ul style="list-style-type: none"> • Shared facility, systems, vision and seamless services • Regular team meetings to address both patient and team collaboration issues • Some hospice centers, special training and clinical programs • Providers are committed to biopsychosocial/systems paradigm, have a deep understanding of roles and cultures and make conscious effort to balance power and influence • Can handle most difficult and complex interplay between mental health, social and medical interactions with challenging management issues