Integrating Behavioral Health within Medicaid Accountable Organizations: Emerging Strategies

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Questions?

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Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
I. Introduction and National Overview of Behavioral Health Integration Efforts within Medicaid ACOs

II. Integration of Mental Health/Substance Abuse Services in Vermont Medicaid’s Shared Savings Program

III. Behavioral Health Integration Efforts Among Minnesota’s Integrated Health Partnerships
   ▪ Southern Prairie Community Care: The Evolution of a Rural ACO

IV. Questions and Discussion
Welcome and Introductions

Deborah Brown Kozick, Senior Program Officer
Center for Health Care Strategies

Pamela Riley, Assistant Vice President, Delivery System Reform
The Commonwealth Fund

Kara Suter, Director of Payment Reform
Department of Vermont Health Access

Mathew Spaan, Policy Specialist
Minnesota Department of Human Services

Mary Fischer, Executive Director
Southern Prairie Community Care
About the Center for Health Care Strategies

A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care.
CHCS Medicaid ACO Initiatives

- Medicaid ACO Learning Collaborative – Phase III
  - Participating states: CO, IA, MA, NC, RI, WA
- State Innovation Model (SIM)
- New Jersey Medicaid ACO Business Planning Toolkit
- ACOs & Super-Utilizers: Health Care Innovation Award spreading Camden’s model in four communities
- Totally Accountable Care Organizations (aka TACOS)
## Behavioral Health Integration within Medicaid ACOs: ACO LC Discussions

### Opportunities
- Use Medicaid ACOs to address comorbid issues for complex, high-need populations
- Leverage existing integration initiatives to support MH/SA, such as health homes
- Encourage behavioral health providers to “play” despite concern for getting “lost” within medically driven model

### Challenges
- How to encourage BH providers to integrate services?
- How to support providers in integration work at the practice level?
- How to promote shared accountability through payment mechanisms?
- How to sustain improvements and integration beyond initial grants/pilots?
Considerations for Integrating Behavioral Health Services in Medicaid ACOs

• Acknowledge differing provider capacity to assume downside financial risk

• Invest in mental health and substance abuse provider capacity building activities, including HIT and technical assistance

• Include behavioral health measures and other social outcome metrics across physical health incentive programs and in MCO contracts

• Revise licensure and other regulatory frameworks that currently serve as barriers to provider-level integration

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Integration of MH&SA in Vermont Medicaid’s Shared Savings Program

Kara Suter, MS
Director of Payment Reform
Department of Vermont Health Access
Key Integration Elements of VMSSP

Multi-Stakeholder Engagement

Program Design

- Financing
- Governance
- Care Management
- Performance

Provider Support
Multi-Stakeholder Engagement

SIM Core Team (Public/Private High-Level Decision-making Body)

SIM Steering Committee (Public/Private Advisory Group)

- Disabilities & Long-Term Services & Supports Workgroup
- Health Information Exchange Workgroup
- Quality & Performance Measures Workgroup
- Payment Models Workgroup
- Population Health Workgroup
- Care Models & Care Mgmt Workgroup
- Health Care Work Force Workgroup

Stakeholder Co-chairs of Work Groups

Stakeholder membership on Work Groups
Financing - TCOC

- Incremental approach to the inclusion of services in the Total Cost of Care spend across the three performance years.

- By following this “encourage, incent, require” approach, ACOs will have more time to develop and strengthen their relationships with providers from the home and community based services, long term services and supports, and mental health and substance abuse fields.

Year 1:
Encourage

Year 2:
Incent

Year 3:
Require

Year 1 TCOC to include only Core Services

Offer additional percentage of shared savings to ACOs if they agree to take on optional expanded TCOC

Require ACOs to incorporate additional non-core services into TCOC
ACO Governance

• Governing body (board) has responsibility for oversight and strategic direction of the ACO

• VMSSP mandated composition of ACO governing boards, including:
  • At least 75% must be providers in the ACO, and
    • At least one member must be mental health/substance abuse
    • At least one post-acute care or long term care services and supports
    • At least one beneficiary from each program the ACO participates in (Medicare, Medicaid, Commercial)
ACO SSP Measure Categories

**Payment**

Payment measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How ACO performs influences amount of shared savings.

**Reporting**

Reporting measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How ACO performs does NOT influence the amount of shared savings.

**Monitoring & Eval**

Monitoring measures are collected at the State or Health Plan levels; cost/utilization measures at the ACO level. ACO not responsible for collecting these measures. How the ACO performs does NOT influence the amount of shared savings.

**Pending**

Pending measures are considered to be of interest, but are not currently collected.
# ACO SSP Measures – Performance Year 1

## Shared Savings Program Payment Measures - MHSA

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core-4: Follow-up after Hospitalization for Mental Illness, 7 day</td>
<td>The percentage of discharges for attributed individuals 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.</td>
</tr>
</tbody>
</table>
| Core-5: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment a) Initiation, b) Engagement | The percentage of adolescent and adult attributed individuals with a new episode of alcohol or other drug (AOD) dependence who received the following:  
  - Initiation of AOD treatment  
  - Engagement of AOD treatment                                                                                                                                                                                                                                                     |

- 2 out of 8 (25%) of Vermont Medicaid ACO SSP Payment Measures for Performance Year 1 relate to mental health/substance abuse
ACO SSP Measures – Performance Year 1

Other Shared Savings Program Measures (Reporting, Pending, Monitoring & Evaluation) - MHSA

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting</td>
<td>Core-19: Depression Screening and Follow Up</td>
</tr>
<tr>
<td>Pending</td>
<td>Core-36: Tobacco Use Assessment and Tobacco Cessation Intervention</td>
</tr>
<tr>
<td>Pending</td>
<td>Core-45: Screening, Brief Intervention, and Referral to Treatment</td>
</tr>
<tr>
<td>Monitoring &amp; Evaluation</td>
<td>M&amp;E-6: Antidepressant Medication Management</td>
</tr>
</tbody>
</table>

ACO SSP Measures for Performance Year 1 that relate to mental health/substance abuse:
- Reporting: 1/20
- Monitoring & Evaluation: 1/22
- Pending: 2/22
Provider Supports

- $15.2M in SIM funds for HIE/HIT investments
  - Includes expansion of HIT and HIE interfaces to mental health and long-term services and supports providers

- Provider Sub-grant program - $4.3M to 14 awardees to develop innovative care delivery transformation and cost reduction models, including:
  - $500,000 to providers in Central Vermont to expand substance use screening intervention and treatment protocols
  - $60,145 to InvestEAP, to test the return-on-investment of behavioral health screening and follow-up in the workplace
Challenges

• Incremental change

• Mistrust among providers

• Resistance from independent providers

• Resistance for more measurement and performance targets

• Restrictions on sharing data specific to some mental health and substance abuse services
Successes

- Community collaboration formalizing with shared focus on core set of performance measures
- Trust being built
- HIT/HIE infrastructure being extended beyond traditional medical providers
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Southern Prairie Community Care
The Evolution of a Rural ACO
Minnesota County Collaborations
SPCC is a virtual “ACO” network:

- 27 provider members, including area clinics and hospitals, public health, mental health centers, and area human service agencies, focused on improving the health of people in our communities.

- The strength of our approach is the ability to quickly mobilize “the community” around those with the highest medical need. Governance of SPCC the same as area hospitals, HHS/MH orgs.
SPCC Partners

- **Minnesota Department of Human Services**
  - Integrated Health Partnership
  - 3 Year Medicaid Demonstration
  - Year Two-Inclusion of Mental Health Costs in TCOC

- **Minnesota Department of Health**

- **State Innovation Model (SIM)**
  - Health Information Exchange
  - Accountable Community for Health-Diabetes Initiative
  - Learning Community Applicant (in Process)

- **Blue Cross Blue Shield**
  - 3 Year Agreement/Sustainability Plan In Process (Beyond 2016)
Shared Savings Formula-IHP

Local, **consensus driven**, workgroup process:

- **Primary Care Network**-60%
- **Area Hospitals**-30%
- **Mental Health Centers**-5%
- **Social Service Agencies**-5%

**Considerations:**

- Medical community had to come to the table and stay engaged
- Continuous persuasion/collaboration/focus on paradigm shift
Southern Prairie Community Care

Health equity and access to care and support for all

Person and Population

Quality of Life

Improved population health in our 12-county region

Integrated, locally-driven model of care and support

Individualized care through a comprehensive health record
Integrated Community Care

- **Community** based
- **Multidisciplinary** care
- Improving care delivery through **connection**, **communication**, and **coordination**
- Identifying individuals with poor health, **high risk**, **complex conditions**, and/or high utilization due to **medical**, **mental health concerns**, emotional challenges, family circumstances and other **social determinants**
Minnesota Department of Human Services-Considerations

- Bush Foundation **System Redesign**
- **Pharmacy** - Medication Therapy Management-Expansion of Network
- Inclusion of **Mental Health Costs in TCOC**
- Integrated Community Care Team Processes-Revision of Data Sharing Agreement
- Health Information Exchange (Sandlot)-Consider **interface** of **SSIS** into SPCC **HIE**
Questions?

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