

Early Lessons from Pennsylvania's SMI Innovations Project for Integrating Physical and Behavioral Health in Medicaid

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About five percent of Medicaid beneficiaries account for as much as 50 percent of total Medicaid spending.¹ Although many of these beneficiaries have multiple chronic conditions, including physical and behavioral comorbidities, their care is often fragmented with little coordination across providers, leading to suboptimal care and escalating health care costs. Despite the growing consensus that improved integration of physical and behavioral health care will produce higher quality and lower costs,² evidence on how to best achieve such integration is lacking. The *Rethinking Care Program* (RCP), an initiative of the Center for Health Care Strategies (CHCS), was created to find ways to improve the quality and lower the costs of care for high-need, high-cost Medicaid beneficiaries. In 2009, the Pennsylvania Department of Public Welfare (DPW) in partnership with CHCS launched two regional pilot projects under this initiative, focusing on the integration of physical and behavioral health care services for adult Medicaid beneficiaries with serious mental illness (SMI) and co-occurring physical health conditions. The Pennsylvania pilots, collectively referred to as the SMI Innovations Project, were designed to test various approaches to addressing this elusive challenge.

This brief describes the two-year pilot programs in Southeast and Southwest Pennsylvania and presents preliminary findings based on an analysis of key informant interviews and performance measures. It provides early lessons for states and Medicaid health plans interested in implementing similar programs. Final evaluation results for the project, including outcome and utilization data, will be released in mid-2012.

Background

In the Southeast and Southwest Pennsylvania pilot regions, most Medicaid beneficiaries receive physical health benefits through managed care organizations (MCOs). Behavioral health benefits are carved-out and separately managed by county-contracted behavioral health organizations (BHMCOs). Under the SMI Innovations Project, which began in July 2009, each pilot represents a collaboration

IN BRIEF

Through the *Rethinking Care Program*, the Center for Health Care Strategies is working with four innovative state pilots to test new strategies to improve health care quality and control spending for Medicaid's highest-need, highest-cost populations. Pennsylvania's SMI Innovations Project, which includes two regional pilots, is specifically focused on the integration of physical and behavioral health care services for adult Medicaid beneficiaries with serious mental illness (SMI) and co-occurring physical health conditions. This brief describes the two-year pilot effort in Southeast and Southwest Pennsylvania and presents early lessons for states and Medicaid health plans interested in implementing similar programs.

between a physical health MCO, a BHMCO, county behavioral health offices, and participating providers. In each of the regions, the project partners designed their own programs, using a common framework of key elements of an integrated system of physical and behavioral health care that DPW developed (Exhibit 1).

DPW selected regions of the state for these pilots that would allow for the identification of promising strategies and implementation challenges from two different vantage points. In the Southeast, the pilot covered a three-county region where the physical and behavioral health MCOs are operated by separate corporate entities that had little or no prior collaboration. In contrast, the Southwest pilot operated in a single county where the MCO and BHMCO are owned by the same corporate entity.

To stimulate collaboration among the partners, DPW established a joint financial incentive program based on state-defined performance measures. DPW did not expect the incentive funds to cover program costs, but offered the money to reward joint performance and foster collaboration on activities thought to promote integrated care.

Exhibit 1: Elements of an Integrated System of Physical and Behavioral Care

The Pennsylvania Department of Public Welfare provided the below framework as a guide, but left decisions about how to implement each element to the pilot teams:

- Provider engagement and the medical home (physical or behavioral health);
- Consumer engagement;
- Data management and information exchange;
- Coordination of hospital discharge and follow-up;
- Pharmacy management;
- Appropriate emergency department use for behavioral health treatment;
- Coordination with alcohol and substance use treatment providers; and
- Co-location of services.

Partners would share the incentive payment by meeting four performance measures for the first year:

- 1) Stratification of at least 90 percent of eligible members into risk groups;
- 2) Development of at least 1,000 integrated care plans;
- 3) Notification of hospital admissions at least 90 percent of the time; and
- 4) Notification of prescribers of refill gaps for atypical antipsychotics at least 90 percent of the time.³

In year two of the project, DPW modified the process measures slightly, and added two outcome measures:

- 1) Incremental reductions in hospital admissions; and
- 2) Incremental reductions in emergency department (ED) visits.

DPW assessed the partners' performance on the above measures with assistance from its external quality review organization. In addition, researchers from Mathematica Policy Research conducted an independent evaluation, assessing a broad array of health care outcome measures over the two-year project to understand whether the interventions improved care and reduced costs. The outcome analysis used Medicaid claims and enrollment data to identify changes in the following outcomes among

eligible members in the study and comparison groups: ED visits, physical health, mental health, and drug and alcohol treatment-related hospitalizations, readmissions (for any type of hospitalization), and the number of days between hospitalizations. A full evaluation of outcomes measures for the two Pennsylvania pilots will be published in mid-2012.

Pilot Project Descriptions

Southeast Pennsylvania Pilot: HealthChoices HealthConnections

HealthChoices HealthConnections (HCHC) was a community-based partnership among Magellan Behavioral Health; Keystone Mercy Health Plan; and the county behavioral health offices in Bucks, Montgomery, and Delaware counties. Exhibit 2 summarizes key characteristics of HCHC. A key principle guiding HCHC was county ownership of its program. Each of the three counties developed its own approach based on existing infrastructure and resources, operating the program with different types of staff, providing different types of training for its staff, and starting the intervention at different times. This approach was preferred over a one-size-fits-all model and fostered more local buy-in, given the variation across the three counties in how behavioral health services are delivered.

The HCHC model established behavioral health provider agencies as the designated care homes for individuals with SMI. This core element of the HCHC program design was based on the experience that individuals with SMI are more likely to have established relationships with behavioral health providers than with primary care providers. HCHC sought to leverage these existing relationships, bringing greater connectivity and coordination with physical health services into the behavioral health setting.

Member engagement and enhanced care coordination through a navigator (a nurse,

behavioral health clinician, or case manager employed by a behavioral health agency) were core components of the HCHC model. Through regular contact with members, navigators played a key function within the multidisciplinary team, bridging the gap between their own agency, physical health providers, and other behavioral health providers. Navigators engaged both members and their providers to share information on recent hospitalizations and ED visits and developed individualized care plans. Interventions emphasized early recognition of symptoms that could lead to a decline in a physical or mental health condition.

The provision of integrated care within the HCHC pilot was supported by a unique member profile that incorporates detailed information about patient physical and behavioral health status, pharmacy utilization, inpatient/emergency room usage, and case management history. The profile, which was created through data sharing between Magellan Behavioral Health and Keystone Mercy Health Plan, was updated monthly and made available regularly to physical and behavioral health providers.

**Southwest Pennsylvania Pilot:
Connected Care**

The Connected Care program was a partnership between UPMC for You (a

Medicaid MCO), Community Care Behavioral Health (CCBH), and the Allegheny County Department of Human Services. Exhibit 2 summarizes key characteristics of Connected Care.

Although the same parent company owns both UPMC for You and CCBH and the organizations share offices in the same corporate complex, their staff had not always worked together systematically before this project. Accordingly, they had to build relationships and learn each other’s practices to support collaboration.

In the Connected Care program, care coordination was provided by UPMC for You and CCBH plan-based care managers for members with frequent ED or hospital use. Member contact was primarily telephonic, except for a subset of members who received services in primary care practices with plan-funded onsite nurse care managers. These practice-based care managers were in place prior to the start of Connected Care in order to enhance the practices’ care management capacity for UPMC for You members; however, once Connected Care began, UPMC for You further leveraged these on-the-ground resources to help coordinate care for Connected Care members.

Through Connected Care, UPMC for You and CCBH care managers enhanced outreach to high-risk members and

Exhibit 2: Southeast and Southwest Pennsylvania Pilot Overviews		
	HealthChoices HealthConnections	Connected Care
County	<ul style="list-style-type: none"> Bucks, Montgomery, and Delaware counties 	<ul style="list-style-type: none"> Allegheny County
Behavioral Health Plan	<ul style="list-style-type: none"> Magellan Behavioral Health 	<ul style="list-style-type: none"> Community Care Behavioral Health
Physical Health Plan	<ul style="list-style-type: none"> Keystone Mercy Health Plan 	<ul style="list-style-type: none"> UPMC for You
Program Model	<ul style="list-style-type: none"> Decentralized, community-based model 	<ul style="list-style-type: none"> Centralized, plan-based model
Key Program Elements	<ul style="list-style-type: none"> Member contact centered around a navigator employed by a behavioral health agency. Member health profile integrated key behavioral and physical health, pharmacy, and provider contact information. Case rounds with staff from both plans and the behavioral health navigator. 	<ul style="list-style-type: none"> Member contact (primarily by telephone) centered around plan care managers. Integrated care plan facilitates information exchange between health plans. Multidisciplinary case conferences inform care planning for complex cases.

information sharing between plans and with providers through multidisciplinary case review meetings, notifications of hospitalizations, ED visits, and potential care gaps, and an integrated care plan that included health conditions, service utilization, wellness and support service needs, and gaps in care. Care managers in each organization focused on conducting comprehensive assessments that identified members' behavioral health, medical, and psychosocial needs and linking members to services. They also provided education about appropriate ED and service use and follow-up after hospitalizations.

Early Findings

During the two years of the SMI Innovations Project, HCHC actively engaged approximately 900 members, and Connected Care engaged approximately 2,500 members. Preliminary results suggest that in each year, each pilot achieved five out of six performance measures associated with the project's joint incentive pool (Exhibit 3).

Following are preliminary lessons from the initiative that provide valuable information

for Medicaid stakeholders who seek to integrate care for high-cost Medicaid beneficiaries with SMI and physical health comorbidities.

1. **Pilot partners benefited from a balance of state-level and local leadership.** The SMI Innovations Project benefited from having Pennsylvania's Secretary of Public Welfare as an early champion who believed in the benefits of integration, encouraged DPW behavioral health and medical divisions to work together, and ensured that funds for the joint performance incentive would be available even in a difficult budget climate. Although strong state commitment was necessary to launch a new program, the state also had to allow the partners to take ownership of their programs at a local level.
2. **Privacy issues related to information exchange were critical for the state and partners to address early.** To realize the goals of integrated care, the SMI Innovations Project required project partners to share health information across

Exhibit 3: Summary of Performance Measures*

	HealthChoices HealthConnections		Connected Care	
	MET GOAL			
PERFORMANCE MEASURES	Year 1	Year 2	Year 1	Year 2
Joint risk stratification and annual restratification	✓		✓	✓
Integrated care plan/ member health profiles	✓	✓	✓	✓
Real-time hospital notification		✓	✓	✓
Prescriber notification of refill gaps for atypical antipsychotics leading to a medication possession ratio of less than 0.8	✓	✓		
Reduced rate of ED visits	N/A	✓	N/A	✓
Reduced rate of hospital admissions (for physical and mental health diagnoses combined)	N/A	✓	N/A	✓

* Based on results determined by DPW and its external quality review organization.

systems and providers, subject to the constraints of federal and state privacy laws. Given the complexities associated with these laws, the state invested considerable time in developing specific guidance on consent requirements for sharing drug, alcohol, mental health and/or HIV information between different entities and providers. This guidance established the bounds within which partners could begin planning their information exchange strategies. However, due to the sensitivities associated with these privacy issues, the partners proceeded more conservatively than the state otherwise required.

3. **Nurses were critical to multidisciplinary care teams because they possessed the clinical expertise necessary for managing a population with comorbid physical and behavioral health conditions.** The SMI Innovations Project partners recognized the tremendous value that nurses would bring to multidisciplinary teams in integrating care for individuals with SMI. Experienced registered nurses were crucial, particularly in behavioral health-led integration efforts, because of the learning curve related to understanding various medical conditions and their impact on members' behavioral health. Registered nurses were well-positioned to facilitate clinical discussions on members' care with PCPs and pharmacists, advocate on a member's behalf, and serve as a clinical bridge between physical and behavioral health providers.
4. **Engagement strategies needed to be flexible.** The partners realized they needed to be flexible to allow time to find engagement strategies that resonated with members and providers. Connected Care's initial consumer engagement strategy relied on

telephone contact by health plan care managers. Members were mailed an introductory letter along with an incentive (\$25 gift card) if they received an annual physical examination at their primary care doctor. Care managers phoned consumers to explain the program, consent process, and coordinate enrollment. This approach did not solicit as much interest as anticipated. In response, Connected Care bolstered efforts to engage providers at behavioral health agencies who already had relationships with members and changed the incentive so members had to agree to consent to participate to receive the gift card, which yielded much greater participation.

5. **Provider relationships were critical for supporting integrated care, and took time and resources to build.** Particularly in HCHC, where the designated care home was rooted in the behavioral health setting, successful integration required effective outreach and engagement of primary care providers, who were less directly connected to the project. In many cases, these outreach efforts required high-touch and time-intensive approaches. For example, in-person outreach from nurse navigators or care managers was more effective in engaging PCPs than sending faxes or letters to PCPs without any personal contact. In the HCHC model, nurse navigators developed relationships with PCP office staff over several months, sharing information about medications or hospitalizations. Over time, a number of PCPs saw the navigators as a resource and, in some cases, initiated contact with them. A second strategy used by one behavioral health agency was engaging PCPs through educational luncheons, which were attended by the agency's medical director. PCP offices have

subsequently called the agency for assistance with members.

6. **Integrated health profiles provided invaluable information to support integrated care management and care coordination.** The member health profile developed and used for the HCHC pilots served as a single source of integrated physical and behavioral health information shared across providers. It is seen as a significant achievement of the program because it facilitated data exchange across two separate systems and provided critical information, such as gaps in care and medications, to help navigators address key member needs. It also provided a valuable tool for facilitating conversation across providers and directly with consumers.

lessons for advancing integration of physical and behavioral health care. HCHC and Connected Care were able to build on existing relationships to meaningfully engage members and providers in their programs. Taken together, the pilots suggest that designated care homes, multi-disciplinary care teams, information exchange, and aligned incentives hold significant promise for providing integrated models of care for individuals with both physical and behavioral health needs. The pilot programs also confirmed the importance of program leadership and adequate planning for issues such as privacy, information sharing, and evaluation. Results of the full evaluation, slated for mid-2012, promise to further inform efforts across the states to build integrated models of care – particularly for individuals with serious mental illness.

Conclusion

Preliminary results from the two-year pilot program in Southeast and Southwest Pennsylvania provide a compelling set of

Endnotes

¹ Kaiser Commission on Medicaid and the Uninsured estimates based on MSIS 2007/2008.

² Institute of Medicine. *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. Washington, DC: National Academy Press, 2006; World Health Organization. *Organization of Services for Mental Health*. Geneva: WHO, 2003.

Additional Resources

This brief is a product of CHCS' *Rethinking Care Program*, which is developing and testing new strategies to improve health care quality and control spending for Medicaid's highest-need, highest-cost populations. It is made possible by Kaiser Permanente. For more information about the *Rethinking Care Program*, as well as tools for improving care management for Medicaid beneficiaries with complex needs, visit www.chcs.org.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. In collaboration with state and federal agencies, health plans, providers, and consumer groups, CHCS pursues innovative and cost-effective strategies to better serve Medicaid beneficiaries. Its program priorities are: enhancing access to coverage and services; improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity.