Integrating Behavioral Health into Primary Care through Medicaid Managed Care

November 18, 2021, 2:30-3:30 pm ET

Part of CHCS’ Strengthening Primary Care through Medicaid Managed Care learning series.

Made possible through support from The Commonwealth Fund.
Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.
Agenda

• Welcome & Introductions
• A National Perspective on Behavioral Health Integration
• A Deep Dive into Arizona’s Approach to Integrating Behavioral Health Care
• Provider Perspectives on Behavioral Health Care Integration
• Q&A
Welcome & Introductions
Today’s Presenters

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Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field’s best thinking and practices to meet critical needs

- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.

- **Equitable outcomes for people** that improve the overall wellbeing of populations facing the greatest needs and health disparities.
Core Features of Advanced Primary Care and Levers to Drive Uptake and Spread

- **Enhance Team-Based Care**
- **Use Technology to Improve Access**
- **Integrate Behavioral Health Care**
- **Identify and Address Social Needs**
- **Engage Communities and Achieve Health Equity**
- **Promote Accountability for MCOs**
- **Move to Value-Based Payment in Primary Care**
- **Monitor Primary Care Spending and Investment**

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Center for Health Care Strategies
For implementation considerations, state examples, and sample managed care contract language, access the toolkit at: www.chcs.org/primary-care-innovation.
A National Perspective on Behavioral Health Integration

Logan Kelly, MPH, Senior Program Officer, CHCS
Why Pursue Physical-Behavioral Health Integration

• Adults reporting depression symptoms have tripled during the pandemic.

• 57% of adults with mental illness and nearly 90% of people with a substance use disorder never receive treatment for their behavioral health condition.

• Medicaid spending is 4x higher for individuals with behavioral health conditions, largely due to increased physical health spending.

• Many people with co-occurring conditions experience gaps in care due to poor coordination and information sharing between providers.

• Evidence suggests that clinical integration can improve health outcomes and quality of life, and reduce costs.

## State Approaches to Advancing Integration

<table>
<thead>
<tr>
<th>Service Type</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Managed Care</td>
<td>32 states</td>
</tr>
<tr>
<td>Accountable Care Organizations</td>
<td>12 states</td>
</tr>
<tr>
<td>Medicaid Health Homes</td>
<td>22 states</td>
</tr>
<tr>
<td>Certified Community Behavioral Health Clinics</td>
<td>Over 430 in 42 states</td>
</tr>
</tbody>
</table>
Behavioral Health Financing Models by State*

Integrated financing in managed care organizations (28 states)

Behavioral health benefits carved out to behavioral health organizations or FFS (12 states including DC)

Physical and behavioral health benefits financed in FFS (11 states)

*Note: Some states use different models for different populations.
Outcomes Associated with Integrated Financing

• Limited overall evidence base

• Some early evidence from states or regions that have shifted to integrated managed care:
  → Arizona: Integrated plans for serious mental illness associated with improved patient experience, preventive care, and chronic disease management; mixed results for inpatient utilization
  → Oregon: “Carving-in” of behavioral health led to improved integration of services for those with mild-to-moderate behavioral health conditions, those benefits not seen for individuals with serious mental illness
  → Washington State: Region with fully-integrated managed care showed improvements in access to MH and SUD treatment, quality, coordination of care, and social measures

Medicaid ACO Approaches to Advance Physical-Behavioral Health Integration

**COLORADO**
- Regional Accountable Entities coordinate care across physical and behavioral health.

**OREGON**
- Coordinated Care Organizations have integrated global budget, flexibility to cover “health-related services.”
Behavioral Health Homes

• Medicaid health homes integrate physical and behavioral health care for people with complex needs, including serious mental illness, to promote access to and coordination of care.

• Evidence suggests that behavioral health homes can lead to improved access to care and quality of care:
  → Medicaid enrollees with behavioral health conditions were more likely to have received mental health or SUD treatment in states with health homes
  → Enrollees reported better general overall health
  → In Missouri, behavioral health home yielded reduced acute care utilization, lower per member per month costs, improved health outcomes
Certified Community Behavioral Health Clinics

- Designed to provide whole-person care (integrated, person-centered, trauma-informed, recovery-oriented), and must directly provide/contract for nine core service types, such as:
  - 24/7 crisis mental health services
  - Outpatient mental health and substance use services
  - Outpatient clinic primary care screening and monitoring
  - Targeted case management
- Prospective payment system rate reimburses expected cost of services (for states participating in Medicaid demonstration)
- Reported impacts include:
  - Increased access to behavioral health care
  - Reduced acute care utilization
  - Increased use of evidence-based practices
  - Hiring and retention of behavioral health workforce
State, Plan, and Provider Levers for Integration: Data-Sharing and Quality Measures

**States**
Invest in statewide data-sharing infrastructure and develop a quality measure set that assesses outcome across full continuum of services

**Plans**
Share enrollment and encounter data with providers, where permissible, and support providers in using newly available data, including through incentives

**Providers**
Use integrated data to identify gaps, coordinate treatment plans, and assess the impact of services delivered on consumer outcomes
State, Plan, and Provider Levers for Integration: Clinical Practice and Service Design

1. **States**
   - Provide guidance and comprehensive monitoring and assess the need for regulatory reforms to ensure that all consumers can access high-quality integrated care.

2. **Plans**
   - Develop provider networks that incorporate the full array of needed services and provide care management across the full continuum of needs.

3. **Providers**
   - Redesign services and staffing to enable integrated team-based and patient-centered care – including through integrated screening and care plans and by addressing SDOH.
State, Plan, and Provider Levers for Integration: Payment and Business Practices

- **States**: Minimize financing silos, develop financial incentives for integrated practices, move plans to implement APMs, and support provider readiness for integration.

- **Plans**: Partner with providers to develop value-based payment arrangements inclusive of BH and PH, and account for varying provider capacity to assume risk.

- **Providers**: Pursue partnerships and relationships that increase services and advance integrated practices, as enabled by new payment models.
State Value-Based Payment Approaches for Behavioral Health

• **Value-based payment (VBP) approaches:**
  → Targets in Medicaid managed care organization contracts
  → VBP models that are behavioral health-specific or cover comprehensive services
  → CCBHC demonstrations

• **Opportunities reported by behavioral health providers:**
  → Incentivize evidence-based, coordinated care
  → Emphasis on data collection and sharing can support quality improvement
  → Address funding gaps in the behavioral health system

• **Challenges for VBP adoption:**
  → Difficulty of initiating VBP arrangements
  → Risk-based arrangements can be challenging for small providers

Integration requires action at multiple system levels

There is more than one path to integration

Partnerships are key

Data sharing is essential

Measures and incentives matter

It’s all about supporting person-centered relationships
A Deep Dive into Arizona’s Approach to Integrating Behavioral Health Care

Jami Snyder, Director, Arizona Health Care Cost Containment System
Integrating Behavioral Health Care into Primary Care through Medicaid Managed Care

Center for Health Care Strategies
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Three Levels of Integration
Payor Integration

1989
ALTCS/EPD
29,200

2013
CRS
17,000

2014
SMI
Maricopa
18,000

2015
SMI
Greater AZ
17,000

2016
AIHP/TRBHA
80,000
GMH/SU
Duala
80,000

2018
ACC- Children and GMH/SU
Adults
1.5 million

2019
ALTCS/DDD
35,000

2021
Foster Children
13,500
Provider Integration: Targeted Investments Program

• Five year (2017-2021), $300 million program
• Offers incentive payments to participating providers (primary care practices, behavioral health organizations, acute and psychiatric hospitals, justice clinics) based on meeting milestones that support integration and whole person care
• 440 provider locations participating

Reduce fragmentation between acute and behavioral health care.

Increase efficiencies in service delivery for members with BH needs by improving integration at the provider level.

Improve health outcomes for members with physical and behavioral health needs.
Provider Milestones

• Implementation of integrated care plan
• Participation in health information exchange (bidirectional data exchange)
• Use of trauma-informed care protocols
• Availability of peer & family support for justice involved individuals
• Screening for social determinants of health
• Screening for behavioral health in primary care setting
• Implementation of provider to provider communication protocols
• Performance on select HEDIS metrics, etc. (years 4 -6; CMS Core Set, CMS ScoreCard, NCQA HEDIS)
  – Well child visits
  – Follow-up after hospitalization for mental illness (7 day, 30 day; adult & pediatric)
  – Metabolic monitoring for children and adolescents on antipsychotic medications
  – Diabetes screen for people with schizophrenia or bipolar disorder who are using antipsychotic medications
  – Engagement of alcohol and other drug abuse or dependence treatment
• Ongoing assessment using Integrated Practice Assessment Tool
In FFY 2020, 4,755 formerly incarcerated members received services through the integrated justice clinics.
Quality Improvement Collaborative (QIC)

• Partnership with ASU College of Health Solutions and Center for Health Information Research (CHiR)
• QIC participation is a provider milestone
• QIC offers
  o Dashboards for providers on quality measures performance
  o Assistance with quality improvement actions
  o Technical assistance
  o Peer learning
• All Targeted Investments participants currently engaged with the QIC
Measuring Practice Transformation: Integrated Practice Assessment Tool

Sixty percent of unique provider sites reported an increase in integration by at least one IPAT level, and 38 percent of provider sites reported an increase by at least two IPAT levels.

Most notably, nearly 25 percent of PCP participants attested to increasing their IPAT scores by four or more levels—transitioning from levels one or two (minimal coordination) to levels five or six (fully integrated care), within one year.*

*change between demonstration years 2 and 3
Transformation Outcomes and Opportunities

- Behavioral health co-location in primary care
- Payment for behavioral health services in primary care
- Engagement of justice involved members
- Behavioral health support in chronic disease management
- Focus on high risk members
- Bridging physical and behavioral health cultures
Extending Our Understanding of Integrated Care
Targeted Investments 2.0

- Seeking waiver authority to extend the TI Program from 2022 through 2027
- Concept paper provides further details on the structure and requirements of the TI Program 2.0
  - Concept Paper - TI 2.0
TI 2.0 Program Goals

Sustain the integration efforts of current TI participants

Expand integration opportunities to new providers

Enhance program incentives to focus on whole person care

Align and support the AHCCCS Strategic Plan
Provider Perspective on Behavioral Health Care Integration

Justin Bayless, CEO, Bayless Integrated Healthcare
April Rhodes, President and CEO, Spectrum Health Group
Questions?

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