IAP | Medicaid Innovation Accelerator Program

Aligning State Policies to Support Physical and Mental Health Integration

Drawing from lessons learned in working with the nine states, IAP has developed resources that share insights and information in order to assist other states that are engaged in similar efforts. This resource provides strategies for aligning state policies to support physical and mental health (PMH) integration.

States have a breadth of strategies they can use to effectively support the adoption of integrated physical and mental health care within state Medicaid delivery systems. As states increasingly undertake delivery system reforms to support more integrated physical and mental health care, state policy makers are also examining how their own administrative functions and processes can be aligned to better support these efforts. Figure 1 describes some of the indicators of alignment within and across state agencies that administer and oversee the delivery of health care.

This factsheet describes a few of the strategies used by states to better align administrative oversight and functions such as licensing, contracting, and payment, to better support the delivery of integrated care.

FIGURE 1. Indicators of Alignment

ADMINISTRATIVE ALIGNMENT THAT SUPPORTS PHYSICAL AND MENTAL HEALTH INTEGRATION

Shared Vision	Regulatory Structure	Payment
• Physical and mental health integration is endorsed by executive leadership • Integration has been communicated as a priority across relevant state agencies • All relevant state agencies are engaged and empowered to make necessary changes in how services are administered	• State Medicaid regulations actively support delivery of integrated PMH services • State provider and facility licensing rules actively support integrated care • State contracts, including managed care contracts, actively support integrated care	• Reimbursement guidelines and available billing codes are in place for payment of integrated care models

Cross-agency collaboration: Medicaid, behavioral health, licensing, etc.

Supporting Physical and Mental Health Integration

In July 2014, the Centers for Medicare & Medicaid Services (CMS) launched a collaborative between the Center for Medicaid and CHIP Services and the Center for Medicare & Medicaid Innovation called the Medicaid Innovation Accelerator Program (IAP). The goals of IAP are to improve health and health care for Medicaid beneficiaries and to reduce associated costs by supporting states in their ongoing payment and delivery system reforms through targeted technical support. IAP represents CMS' unique commitment to support state Medicaid agency efforts toward system-wide payment reform and delivery system innovation. From April 2016-April 2017, the IAP provided nine state Medicaid agencies with technical support and resources to assist them in expanding or enhancing physical and mental health (PMH) integration efforts in their states. IAP is also working with states on other health care delivery system reform efforts in three additional program areas: improving care for Medicaid beneficiaries with complex care needs and high costs, promoting community integration via long-term services and supports, and reducing substance use disorders.

PRIORITIZE INTEGRATION OF CARE AT THE LEADERSHIP LEVEL, AND ACROSS AGENCIES

Physical and mental health integration requires breaking down silos that separate state functions, scrutinizing long-standing administrative practices, and engaging state subject matter experts across multiple agencies. States whose leaders are communicating PMH integration as a clear priority are well-positioned to identify and remove barriers: Washington's Governor Jay Inslee has convened a Behavioral Health Integration Work Group, noting that participating state agencies "have been tasked to understand the functional, structural and financial changes needed to achieve financial and functional integration at the state level that best supports clinical integration." The workgroup includes staff and managers from the Behavioral Health Administration, Washington State Health Care Authority, the Office of Financial Management and the Governor's office. In Arizona, Governor Doug Ducey called for the merger of that state's Department of Behavioral Health Services into the state's Medicaid agency, the Arizona Health Cost Containment System (AHCCCS). The merger brought management of both behavioral health and physical health services under one state agency, reflecting service delivery and managed care contracting that had been moving toward innovative integrated care models for some time. The state's Regional Behavioral Health Authorities, for instance, had been partnering with managed care plans to deliver fully integrated mental health and physical health benefits to populations with serious mental illness; these contracts had previously been administered by two separate agencies within state government.

SYSTEMATICALLY REVIEW AND REMOVE REGULATORY BARRIERS

State Medicaid regulations, licensing, and contracting can create unintended barriers for PMH integration. Primary care providers, federally qualified health centers (FQHCs), community mental health centers (CMHCs) and other providers may face duplicative or conflicting regulations and licensing criteria that can prevent the delivery of integrated care, and/or make it prohibitively expensive or complicated to implement. Supporting the delivery of integrated care can require both stakeholder engagement and a deep dive into state regulations to uncover language that can restrict (and add cost to) PMH integration. In New York, the state's Office of Mental Health, Office of Addiction and Substance Abuse Services, and its Department of Health committed to an extensive cross-agency effort to update state Medicaid licensing rules to support PMH integration. The work culminated in the development of licensing standards for Integrated Outpatient Services that bring clinical and facility requirements, and other licensing components, into alignment using a unified application.

WORK ACROSS AGENCIES AND WITH STAKEHOLDERS TO FULLY UNDERSTAND AND ADDRESS PAYMENT ISSUES

Arizona, following the merger of its Medicaid and behavioral health agencies, reaped benefits from closer collaboration across agencies and with its provider community. Early wins for the state included elimination of same day billing barriers that had hindered integrated care, and enhancing support for providers to bill for telepsychiatry services, including diagnostic consultation and evaluation, medication monitoring, counseling, and case management.

Key Regulatory and Licensing Areas to Consider

State policymakers may wish to initiate a process to identify common administrative policies and practices that may hinder the ability of community-based providers (e.g., primary care practices, behavioral health providers) to deliver co-located or integrated care. States may wish to focus on barriers to the delivery of behavioral health services in primary care settings, barriers to the delivery of primary care in behavioral health settings, or both. Relevant sources of documentation to review include applicable licensing and regulations, managed care contracts, billing notices, and other state guidance as applicable. Table 1 identifies regulatory and licensing areas that can perpetuate barriers to delivering integrated care. This list is not exhaustive, but may help to provide a starting point on which to build a review that is tailored to the state's specific context and priorities. States may also find it helpful to seek input from providers and other stakeholders who have navigated this process in their own states to help identify additional state-specific issues.

TABLE 1. Regulatory and Licensing Areas that can Perpetuate Barriers to Delivering Integrated Care

Regulatory and Licensing Area	Potential Barriers
Facility Licensing	• Conflicting or duplicative requirements across primary care and mental health clinics, multiple layers of licensing to add or deliver behavioral or physical health care in varied settings/facilities.
Provider Licensing	• Multiple licensure types, processes, definitions, and guidance for providers to deliver behavioral health and primary care services. • Licensing or credentialing barriers that limit the types of staff that can be paid for certain functions (e.g. medical director, charge nurse, etc.) or services (e.g. for behavioral health providers to deliver primary care).
Same Day Services	• Prohibitions on billing for two codes or encounters (e.g., one for physical health code, one behavioral health code) on the same day. • Multiple co-pays for same-day physical and behavioral health services. • Incorrect/outdated assumptions, practices, or misconceptions among providers.
Place of Service	• Medicaid and/or licensing language that limits behavioral health services or the use of certain behavioral health codes to specific facilities, such as CMHCs. • Different requirements across settings, such as use of mandatory screening tools, service documentation, and domains required in plan of care.
Clinical, Staffing Requirements	• Staffing configurations or requirements (e.g., for team-based care, specific behavioral health services, or 24-hour access) that are challenging to implement across diverse settings. • Clinical requirements, such as use of specific assessments or detailed care plans that are burdensome in diverse settings.
Facility/Physical Plant Standards	• Physical plant requirements for physical and behavioral health settings that are duplicative, conflicting, or unnecessarily burdensome, e.g., additional inspections, separate waiting rooms.
State Privacy Laws	• State laws, regulations, or licensing standards regarding privacy and information sharing that conflict, duplicate, or create burdens. • State interpretation of federal law.
Available Billing Codes	• Ability for diverse providers to use: — Health and Behavioral Assessment codes; — Screening, Brief Intervention, and Referral to Treatment codes; — Chronic Care Management codes; — Distinct codes for depression and other mental health/substance use screening; — Codes for group therapy; and — Telehealth.
FQHCs	• Behavioral health and integrated care services included as part of scope of services/ additional services menu. • Policies regarding payment for behavioral health, either as part of the prospective payment system (PPS), or outside the PPS. • Complexity in payment for same-day services, group therapy in conjunction with encounter-based billing.

States across the country have initiated payment and delivery system reforms to support care that can effectively and seamlessly address both physical and behavioral health needs. To ensure the success of these models, states policy makers also need to look internally: how services are regulated, licensed, and paid for can be determining factors in whether providers and systems can actually participate and sustain new models of care. As outlined in this factsheet there are states that have found that strong leadership, cross-agency collaboration, and systematic review of regulatory barriers can help support these important integration efforts.

Appendix: Additional Reading and Resources

- Letter from the Health Resources and Services Administration (HRSA) Administrator to the Director of the Center for Medicaid & State Operations, clarifying the statutory authority for Medicaid payment for services provided in federally qualified health centers (FQHCs) and rural health clinics (RHCs) by clinical psychologists, clinical social workers, and nurse practitioners.
- A report from the Substance Abuse and Mental Health Services Administration (SAMHSA) displaying findings on payment for mental health services in primary care settings, particularly screening and assessment, same-day encounters, telehealth, care management, and provider training.
- State Billing and Financial Worksheets designed by SAMHSA to assist providers and others in identifying available billing codes by state to support PMH integration.
- Nationwide map of states that have turned on Medicaid's Health and Behavioral Assessment/Intervention (HBAI) codes, including specific state restrictions on code use.
- A report from the Commonwealth Fund on state strategies for integrated care in Medicaid, containing information on administrative structure, purchasing strategies, and regulatory requirements.
- A report from the Commonwealth Fund highlighting how the state of Arizona has accelerated PMH integration through its administrative alignment strategies.
- An issue brief from the Kaiser Commission on Medicaid and the Uninsured, focused on promising Medicaid models for integrate care. Its discussion of co-located care explores how Medicaid's system of prospective, cost-based payment for health centers supports this model.
- An issue brief from the National Association of Community Health Centers, describing FQHC encounter language across multiple states that governs Medicaid payment for multiple same-day encounters and highlighting the experience of Florida.
- A fact sheet from the American Psychological Association compiling Medicaid state barriers to payment for psychological services.
- A report prepared by Bailit Health Purchasing illuminating the licensing, privacy, and payment barriers to behavioral health integration in Massachusetts.

CONTACT: Additional information on the IAP PMH Integration program, including materials from national webinars, is available on the Medicaid IAP PMH Integration webpage.