IAP Medicaid Innovation Accelerator Program

Medicaid Innovation Accelerator Program Physical and Mental Health Integration

Addressing Administrative and Regulatory Barriers to Physical and Mental Health Integration

National Dissemination Webinar
March 26, 2018
1:30 pm-3:00 pm ET

Logistics for the Webinar

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Facilitator

- **Laurie Hutcheson,** Policy Fellow, National Academy for State Health Policy

Webinar Agenda

- Welcome and Introductions
- Overview of the Medicaid Innovation Accelerator Program (IAP) Physical and Mental Health (PMH) Integration Initiative
- Aligning State Functions to Support Integrated Physical and Mental Health Care
- Insights from Two States:
  - Arizona
  - New York

Presenters

- **Melissa Cuerdon,** Health Insurance Specialist, IAP PMH Lead, Center for Medicaid and CHIP Services

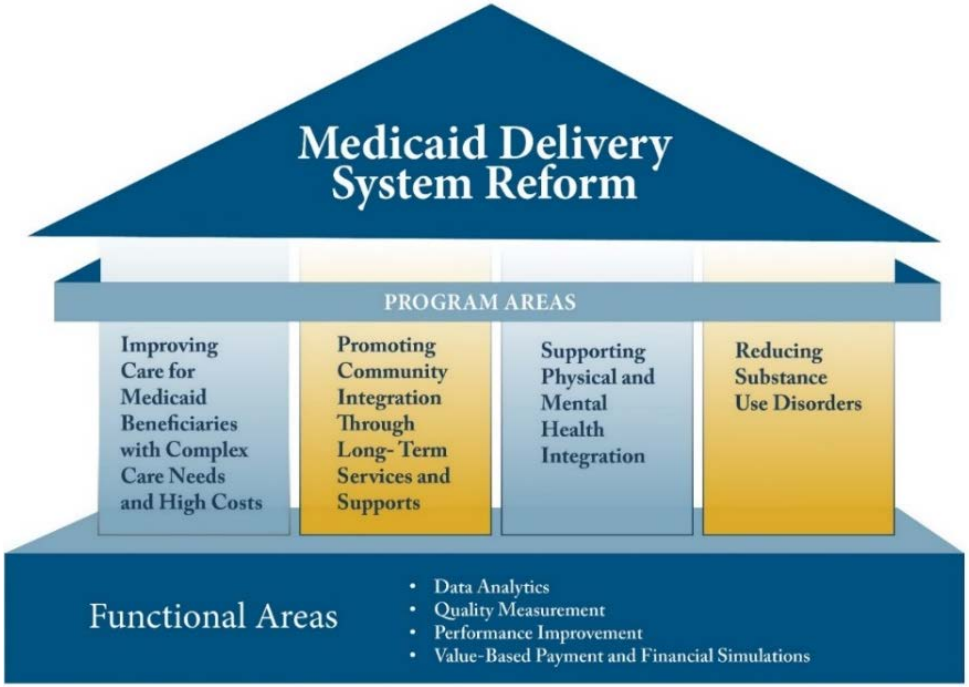
- **Kitty Purington,** Senior Program Director, National Academy for State Health Policy

Presenters (continued)

- **Tom Betlach,** Medicaid Director, Arizona Health Care Cost Containment System
- **Shaymaa Mousa,** Office of Primary Care and Health Systems Management, New York State Department of Health
- **Trisha Schell-Guy,** Deputy Counsel, New York State Office of Alcoholism & Substance Abuse Services
- **Keith McCarthy,** Director, Bureau of Inspection and Certification, New York State Office of Mental Health

Medicaid IAP: Overview

- A technical support program funded by the Center for Medicare and Medicaid Innovation that is led by and lives in the Center for Medicaid and CHIP Services
- Supports states' Medicaid delivery system reform efforts

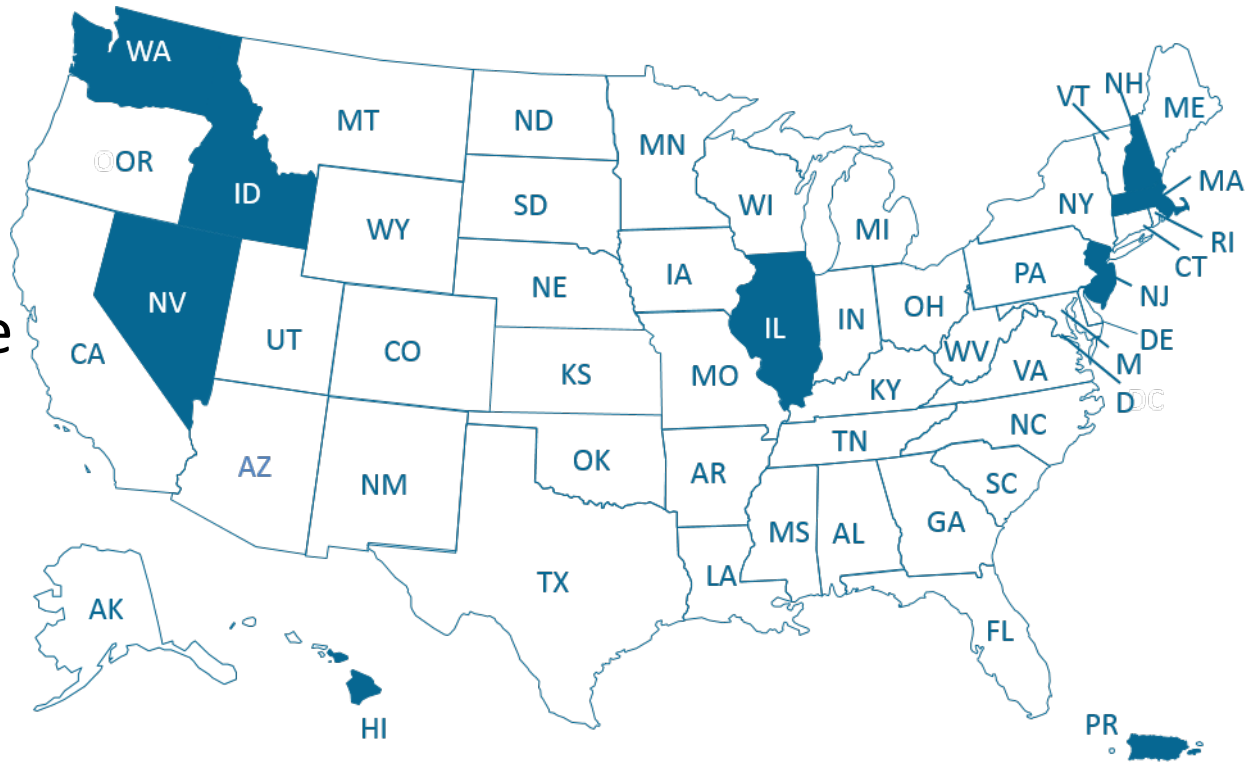


Background

- IAP worked with nine states over twelve months to enhance or expand diverse PMH integration approaches by providing technical support on issues such as:
  - Administrative alignment
  - Payment and delivery system reform
  - Quality measurement
- This webinar is the last in a series of four national dissemination webinars for the IAP PMH Integration program area

Participating Teams

- Idaho
- Illinois
- Hawai'i
- Massachusetts
- New Hampshire
- New Jersey
- Nevada
- Puerto Rico
- Washington



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Aligning State Functions to Support Integrated Physical and Mental Health Care

Kitty Purington

Senior Program Director,

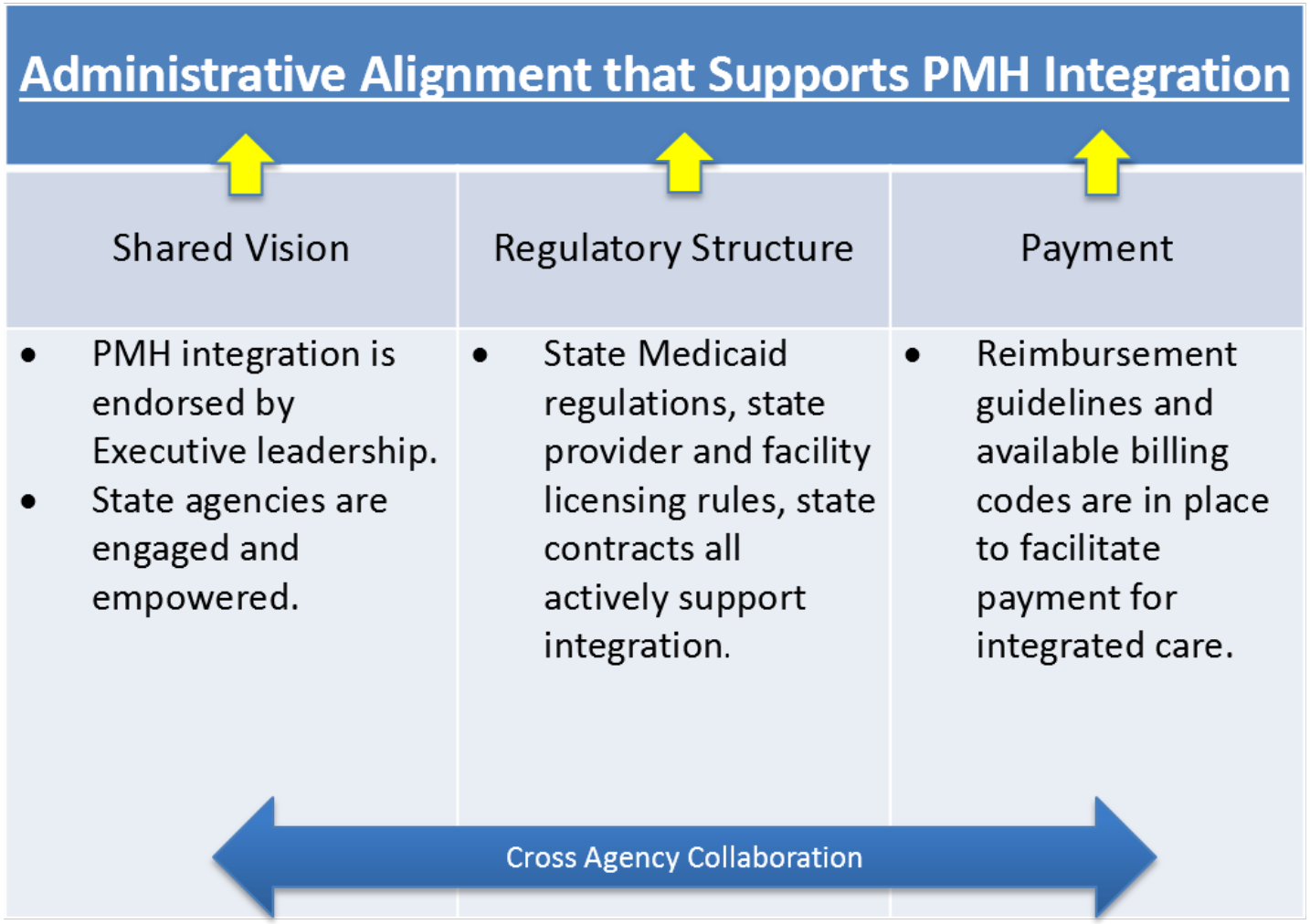
National Academy for State Health Policy

Common Components of Physical & Mental Health Integration

- Identification/screening
- Multi-disciplinary teams
- Comprehensive care planning
- Care coordination/care management
- Evidence-based practices and protocols
- Integrated and timely data

See: *Lexicon for Behavioral Health and Primary Care Integration*
https://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

Administrative Alignment can Support PMH Integration



State Agencies are not Always Integrated

- Varied administrative configurations
  - Single or multiple state administrative authorities
  - Divisions between behavioral health and physical health; between mental health and substance use disorders
  - Different constituencies and priorities
- Different delivery systems
  - Managed care, carve-ins, fee-for-service (FFS)
- Siloed, legacy systems that manage a piece of the puzzle
  - Medicaid regulations, licensing, contracts

Common Barriers to Care

- Regulations
  - Medicaid clinical/staffing requirements
- Licensing
  - Duplication, overlap, conflicting requirements
  - Facilities
- Billing
  - Available codes, billing restrictions
  - Same day issues
- Federally Qualified Health Centers (FQHCs)
- Privacy Laws

State Strategies: Aligning State Systems, Removing Barriers

- Prioritize integrated care
- Convene and engage across agencies
  - Discuss alignment for key state functions: Medicaid, mental health, licensing, contracting
  - Include providers and other stakeholders
- Review for and enhance regulatory alignment
  - Create new models or adapt existing ones
- Identify and clear remaining hurdles to payment
  - Identify codes and methodologies that work
  - Clarify misconceptions/provide guidance

Arizona Policy Integration

Tom Betlach,

Medicaid Director

Arizona Health Care Cost Containment System

Presentation Outline

- Reasons for Changing to Shared Vision Across State Agencies
  - History
  - Complexity of Populations
  - General Fund Growth
- State Agency Configuration Created Barriers
  - 3 Levels of Integration
  - Sister Agency Dynamics Challenging
- Solution: Merge Agencies to Align the Vision
  - Administrative Merger Components, Process & Timeframes
  - Early Wins
- Future
- Lessons Learned

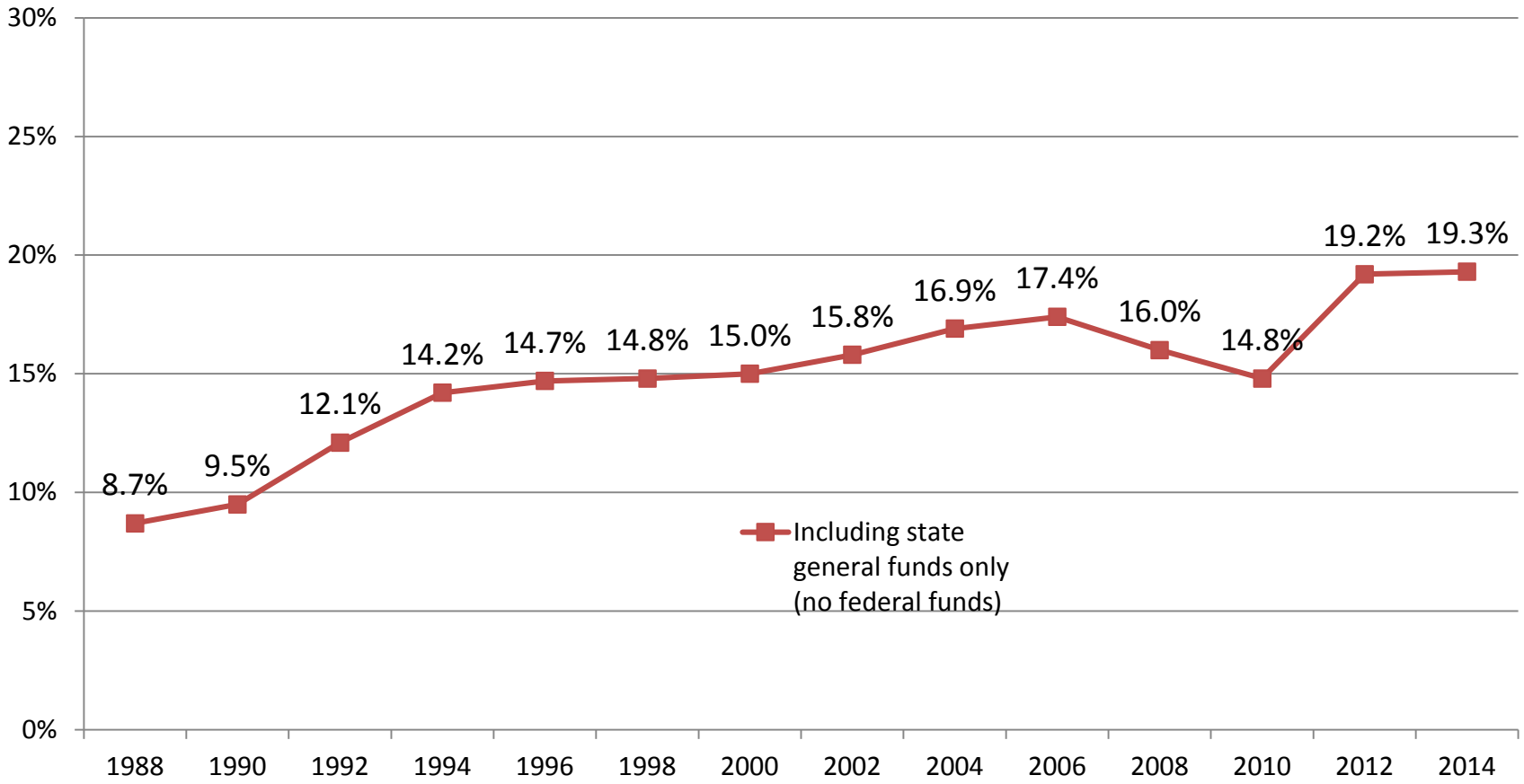
Reasons for Change

30 Years

Reasons for Change: Complex Populations

Condition	Asthma	Diabetes	HIV/AIDS	Mental Health (MH)	Substance Use Disorder (SUD)	Delivery	Long Term Care (LTC)	None
Asthma		24.5	3.9	65.1	29.1	6.5	7.3	17
Diabetes	18.5		2.6	52.4	23.9	3.1	12.7	29.7
HIV/AIDS	17.9	15.6		48.1	39.4	2.1	7.2	29
MH	17.6	18.7	2.8		26.7	4.0	11.9	42.9
SUD	20.8	22.6	6.0	70.8		4.5	10.2	15.6
Delivery	9.3	5.9	0.7	21.3	9.0		0.5	66
LTC	12.5	28.6	2.8	74.7	24.4	0.6		14.1

Reasons for Change: State General Fund Growth



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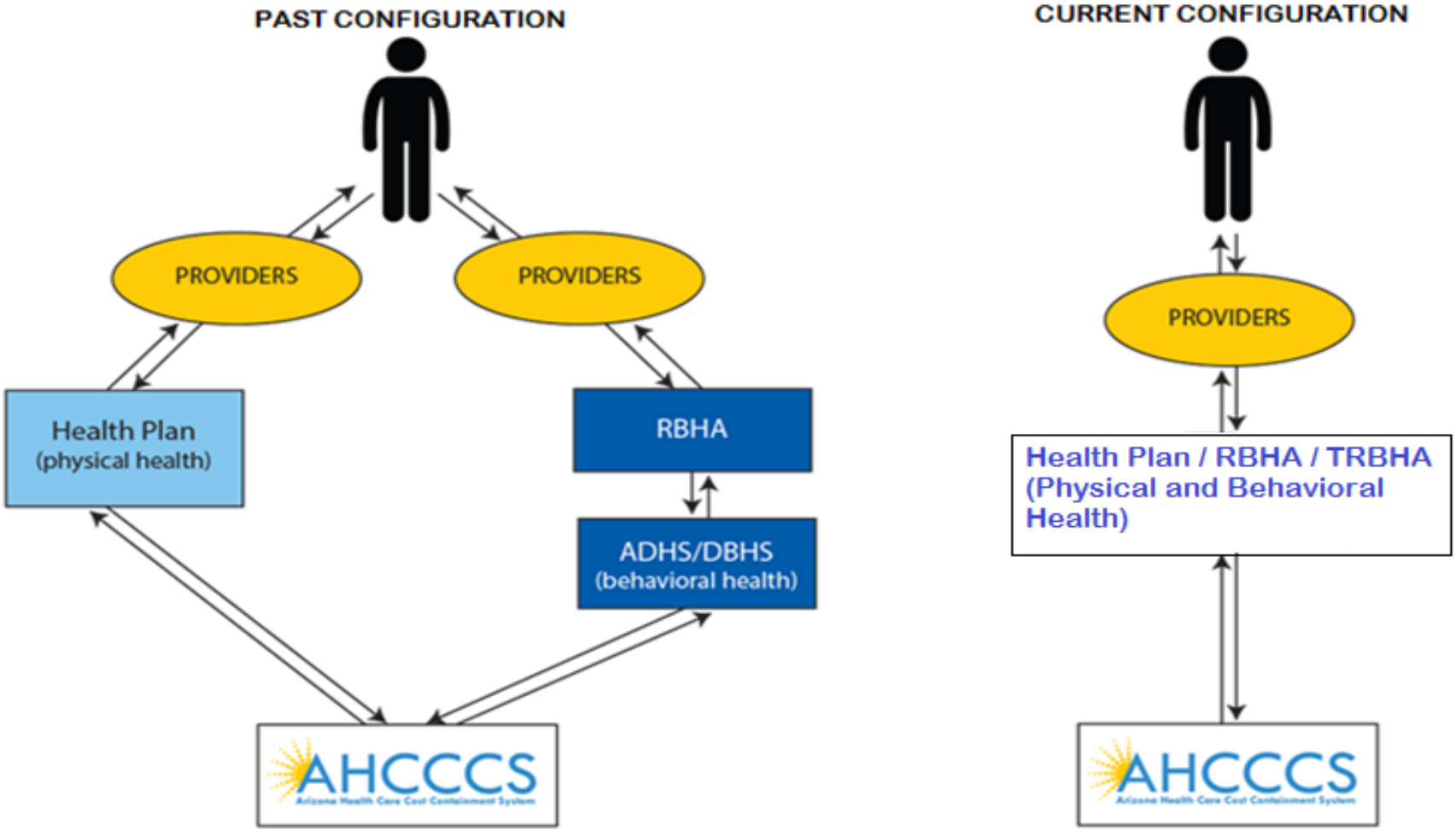
State Agency Configuration: 3 Levels of Integration



ADHS/DBHS: Arizona Department of Health Services, Division of Behavioral Health Services
T/RBHA: Tribal/Regional Behavioral Health Authority
AHCCCS: Arizona Health Care Cost Containment System

Sister Agency Dynamics

Five years ago when integration efforts began:

1. Lack of trust
2. Medicaid viewed as inflexible regulator
3. Behavioral Health (BH) viewed as limited capacity
4. Medicaid knew very little about BH
5. BH knew nothing of overseeing physical health
6. Significant duplication of infrastructure & effort
7. Successful integration at other levels depended on policy integration

Administrative Merger to Align the Vision

- January 2015 - Included in executive budget
- 2015 Session - Supported by stakeholders
- 2015 Session - Unanimously approved by legislature
- Emphasized value of BH resources in Medicaid
- Emphasized value of single voice
- Emphasized value to stakeholders of working with just one agency
- July 1, 2016 - Merger complete

Merger Process

- One year to merge 140 staff with 1,000
- Dedicated project manager from each agency
- Created project team to manage other issues i.e. systems, legal, space
- Wanted to integrate staff – not just create a new division
- Held public forums to provide updates
- Created steering committee with providers and managed care organizations (MCO) to reduce administrative requirements

Early Wins

- Created Division of Healthcare Advocacy and Advancement
  - Office of Individual and Family Affairs
  - Office of Human Rights (Advocates)
- Medicaid never had this ability to interface with members directly and continuously
- How best to leverage in new organization
- Opportunity and Trends
  - Provider Issues
  - MCO issues
  - Population Issues

Early Wins

- Leverage BH expertise on all MCO Contracts and populations
  - Focus on requirements
  - Ability to score more complex questions
  - Stronger ability to assess readiness
- Leverage new resources – staffing and funds
  - Housing, employment, grants (opioid), crisis, peer services
- Reduced provider reporting requirements for assessments
  - Training for all members

Early Wins

- Support providers working towards integration
  - Integrated clinics designation – increased funding
  - Targeted investments funding
- Supported efforts to have providers join Health Information Exchange (HIE)
- Work to resolve billing issues like same day and more robust telehealth
- Working through non-emergency medical transportation (NEMT) policies
- AZ has pretty robust BH benefits

Future

- Staffing integration continues – more cross training and sharing of expertise
- Integrated policy infrastructure is key in supporting $50 billion request for proposal on street
- Will continue to push integration at all three levels
- Work around broader resources of housing, employment, crisis, justice, and grants

Early Lessons Learned

- Collaboration with conflicting agencies requires engaged commitment from leaders over sustained period
- Commitment must be communicated through various platforms to various groups – internal – external
- Look to identify and build off strengths of each organization – Medicaid data – BH Stakeholders
- Define what success for collaboration looks like
- Generate definable short-term wins to change cultures
- Take the time to set up formal training opportunities to share information/experiences

Lessons Learned

- Integration/merger of policy expertise critical to overall three tier integration strategy
- Required strong stakeholder support
- Leadership from executive branch was key
- Had time (one year) to make informed decisions and plan for systems etc… Still working on policies etc.
- Many unanticipated benefits from merger– member voice
- Some staff did not want to deal with change
- Continue to engage stakeholders and explain progress

Q&A

New York State: Facilitating the Integration of Primary and Behavioral Health Care

New York State Team

- **Keith McCarthy**, Director, Bureau of Inspection and Certification, Office of Mental Health
- **Trisha Schell-Guy**, Deputy Counsel, NYS Office of Alcoholism & Substance Abuse Services
- **Shaymaa Mousa**, MD, MPH, Office of Primary Care and Health Systems Management, NYS Department of Health

Presentation Outline

- Impetus for Integration in NY
- Background on NY's Strategies
- Efforts Initiated by Medicaid Redesign Team Behavioral Health Care Reform Workgroup
- What Next?
- Advice to States/Lessons Learned

The Imperative to Facilitate the Integration of Care

- Co-occurring physical and behavioral health (BH) needs, yet services are delivered and billed separately
- Fragmented structure for providing health and BH services
- Need to integrate substance use disorder, mental health services, and physical health care services and to improve coordination and accessibility of care
- Goal: Improve the overall quality of care for by treating the whole person in a more comprehensive manner

The Need for Service Integration

- Medicaid members diagnosed with BH account for **20.9%** of the overall Medicaid population in New York State
- The average length of stay (LOS) per admission for Behavioral Health Medicaid users is **30%** longer than the overall Medicaid population's LOS
- Per Member Per Month (PMPM) costs for Medicaid Members with BH diagnosis is **2.6** times higher than the overall Medicaid population

The Need for Service Integration

Medicaid members diagnosed with BH account for:

- **32%** of Medicaid primary care provider (PCP) visits
- **45.1%** of all Medicaid emergency department visits
- **60%** of the total Medicaid cost of care in New York State
- **53.5%** of Medicaid admissions

Background on NY's Strategies: Integration Models and Approaches

- Multiple Licenses
- Licensure Thresholds
- Integrated Outpatient Services (IOS) Regulations
- Delivery System Reform Incentive Payment (DSRIP) Project 3.a.i Licensure Threshold

Multiple Licenses

- Three separate state agencies license or certify providers of health and BH care services:
  - New York State Department of Health (DOH);
  - Office of Mental Health (OMH);
  - Office of Alcoholism and Substance Abuse Services (OASAS).
- A provider may integrate primary care and BH services by applying for a license or certificate from the agency that licenses or certifies the additional services

Licensure Thresholds

- Allow a single provider to offer services otherwise licensed or certified by another agency, without needing to submit an application:
  - A clinic site licensed by DOH must be licensed by OMH if more than 10,000 or 30% of its annual visits are for MH services
  - A clinic site licensed by OMH or certified by OASAS must be licensed by DOH if more than 5% of its visits are for medical services or any visits are for dental services
  - Licensure thresholds are not applicable for OASAS services – clinic sites need to be licensed by OASAS to perform any volume of SUD services

Medicaid Redesign Team (MRT)

- Established in 2011 to engage stakeholders and make recommendations to improve quality and outcomes, and incorporate efficiencies
- Recommendations incorporated into State budget, laws, regulations and administrative practices
- DSRIP Program
  - Allows NY to reinvest $8 billion of Medicaid savings generated as a result of MRT initiatives

MRT Behavioral Health Care Reform Workgroup

- Realized the need for integration of substance use disorder (SUD)/MH services in addition to physical health/BH services
- Explored co-location of services, peer and managed addiction treatment services, potential integration with BH organizations (BHOs)
- Provided guidance about health homes and other ideas to improve coordination of care
- Workgroup facilitated integration through various payment and delivery models

Integrated Licensure Project

- 2012-13 State budget enacted legislation authorizing OMH, OASAS, and DOH to facilitate the delivery of integrated and coordinated primary care and BH services
  - Reduce administrative burden on providers by streamlining the approval and oversight process
  - Improve the quality of care by improving overall coordination and accessibility
- Identified seven pilot providers with licenses from at least two of the three participating state agencies
- Resulted in approval of 15 clinic sites

Integrated Licensure Project (cont.)

- Developed single set of administrative standards, single application and survey process under which providers operate and are monitored
- Allowed providers to develop their own records (subject to applicable law and regulation), but still have an "integrated" record
- Pilot sites provided with 5% Medicaid rate increase for integrated services
- Pilot providers overseen by a single state agency (the "host" agency) and were subject to survey by an interagency team rather than multiple agencies

Integrated Outpatient Services (IOS) Regulations

- A provider licensed or certified by more than one agency may add services at one of its sites (the "host" site) without additional license or certification, if it is licensed or certified to provide such services at another site:
  - Primary Care Host Model (DOH-licensed providers adding mental health and/or substance use disorder services);
  - Mental Health Behavioral Care Host Model (OMH licensed-providers adding primary care and/or substance use disorder services);
  - Substance Use Disorder Behavioral Care Host Model (OASAS certified providers adding primary care and/or mental health services).

IOS Regulations (cont.)

- A clinic site licensed by DOH seeking to add BH services must submit an application through the DOH Certificate of Need electronic application process
- A clinic site licensed by OMH or certified by OASAS seeking to add PC or BH services must submit the application available on the OMH and OASAS websites
- IOS providers must meet operating and physical plant standards set forth in the IOS regulations

DSRIP Program

- Builds upon success of the MRT
- Promotes community-level collaborations and focuses on system reform
  - Goal: 25% reduction in avoidable hospital use over five years
- 25 Performing Provider Systems (PPSs) collaborate on projects focusing on:
  - System transformation;
  - Clinical improvement;
  - Population health improvement.

Where do we go next?

- Regulatory Modernization Initiative
- Integrated Billing Workgroup
- Assess need for new licensure category

Regulatory Modernization Initiative (RMI)

- Convened providers, payers, and consumers for workshop series to examine existing laws, regulations, and policies
- Participants identified barriers and recommended solutions
- Recommendations will modernize health care regulatory structure to better align with and foster transformation

RMI: Integration of Primary Care and BH Workgroup

- Barriers still exist:
  - Rules regarding which patients can be served;
  - Volume thresholds for different services;
  - Various billing rules and codes;
  - Multiple licensing requirements;
  - Varying surveillance processes and rules.
- Workgroup recommended:
  - New licensure category allowing existing clinics to add services without obtaining an additional license
  - Incentivize integrated services by making it easier to receive reimbursements

Integrated Billing Workgroup

- Providers, payers, and state convene to discuss barriers in billing and payment for integrated services
- Issues raised include:
  - Problems obtaining contracts from health plans for other services;
  - Provision of primary care versus physical health services and definition in the Medicaid managed care contract;
  - Credentialing at a facility level for BH providers versus at an individual level for physical health providers;

Integrated Billing Workgroup (cont.)

- Negotiating rates for services;
- Plans contracting with BHOs to manage that benefit result in payment issues for BH providers integrating care;
- Which practitioner should go on a claim if more than one service is provided.

New License Type(s)

- Assess the need for alternative licensure types after the implementation of the new licensure category

Lessons Learned

- Buy-in from State Agency Leadership is critical – the right people from the start
- Understand your legal & regulatory authority
- There is no success if providers can't get paid
- Begin with pilot providers, get their input, learn from their experience
- Flexibility is key

Q&A

Key Take Aways

- Leadership can set the tone to get work done across agencies
- Stakeholders can be experts in pinpointing what is preventing integrated care: “there is no success if providers can’t get paid”
- Share lessons learned and provide training
- There can be early wins, but not too many quick fixes: detailed, systematic process is needed

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   - [rate from Strongly Agree to Strongly Disagree]
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