Physical and Behavioral Health Integration: State Policy Approaches to Support Key Infrastructure

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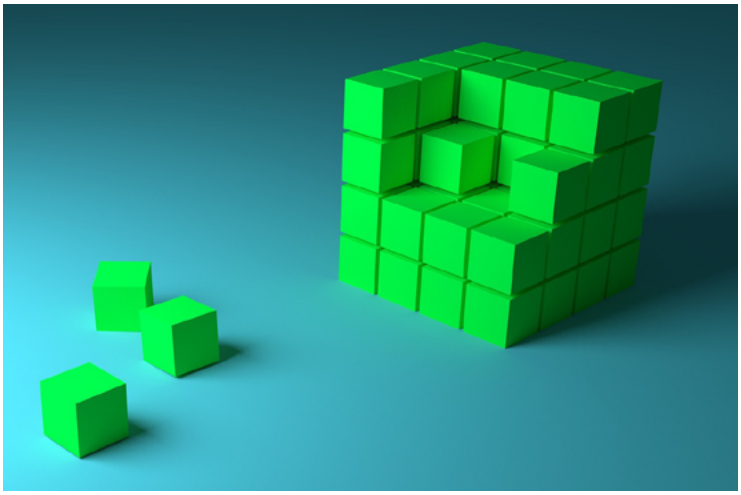

State delivery system and payment reforms that better integrate physical and behavioral health can improve outcomes for people with comorbid physical and behavioral health conditions while also reducing costs.[1] Due to the complex needs and high costs of this population within state Medicaid systems,[2] state policymakers are increasingly looking to develop and sustain integrated care approaches as a part of broader state health reform efforts. For example, all six of the states that received Round One State Innovation Model (SIM) Test Awards included integration as a key focus area,[3] and most states with a Delivery System Reform Incentive Payment (DSRIP) program are using the program to implement reforms that promote integration of physical and behavioral health.[4] Improved assessment and care management for individuals with physical and behavioral health needs have also been a focus of the Center for Medicare & Medicaid Services' Financial Alignment Initiative for dually eligible beneficiaries.[5]

While states have identified physical and behavioral health integration as an important focus for health policy innovation and reform, policymakers may still be challenged by what, exactly, "physical and behavioral health integration" should look like in the context of their states' systems. Specific models of integrated care may be site- or diagnosis-specific, but sustainable state policy approaches often need to be broad-based, creating flexibility to adapt to local and cross-population needs. State policymakers may benefit from thinking about building infrastructure, as opposed to funding specific models, to support and sustain diverse integrated care approaches across the care continuum. In this brief, NASHP reviews the emerging consensus across integrated care models and approaches, and identifies key components of integrated care infrastructure. The brief then highlights how leading states support this infrastructure using diverse policy strategies.

Key Components of Integrated Care

- Multi-disciplinary teams
- A systematic approach to care using population-based tools, clinical guidelines, and/or evidence-based practices
- Care management and care coordination, including care transitions
- Use of health information technology
- Quality measurement and improvement

Physical and Behavioral Health Integration Infrastructure: Key Components

NASHP reviewed several different approaches to integrated care delivery for which there is broad support in the field. These approaches include the 2014 National Committee for Quality Assurance Patient Centered Medical Home (NCQA PCMH) Standards,[6] required elements for Medicaid health homes,[7] and the Agency for Healthcare Research and Quality's Integration Academy Lexicon for Behavioral Health and Primary Care Integration (the Lexicon),[8] as well as the core principles defining the Collaborative Care Model.[9] While these varied approaches have been developed for different uses, together they indicate a significant amount of consistency on the core components or features of integrated care. Review of these approaches indicates that development of the following pieces of infrastructure can serve as the foundation for greater integration regardless of setting or population:

Multi-disciplinary teams: Integrated care approaches define "multi-disciplinary" in a variety of ways. The AHRQ Lexicon, for instance, defines this as "a practice team… with a suitable range of behavioral health and primary care expertise and role functions available to draw from."[10] Teams are generally physician-lead, but may vary in composition to include nurse care managers, care coordinators, licensed behavioral health providers, pharmacists, community health workers, and others. How the team functions may also vary: teams may be co-located within a single practice site with a shared electronic health record (EHR) and staff, or teams may share workflows and cross-organization protocols that allow for virtual collaboration across practices.

A systematic approach to care using population-based tools, clinical guidelines, and/or evidence-based practices: All approaches incorporate a method for systematizing patient clinical information in order to manage the health of the patient population. For instance, clinical registries may be used to support evidence-based protocols and identify patients who are not improving and may benefit from care management and coordination. Approaches also include the use of evidence-based clinical practices, which can strengthen the capacity of primary care practices to manage common behavioral health problems, or, conversely, develop key physical health capacity in community mental health settings.

Care management and care coordination, including care transitions: All approaches identify the ability to manage care, provide linkages to other services, and follow up with patients experiencing care transitions as key functions to support integrated physical and behavioral health care. This capacity includes coordination across multiple settings and the management of care transitions, such as discharge from inpatient settings.

Comprehensive, patient-centered care planning: Patient-centered care is defined in the medical home model as care that is "relationship-based with an orientation toward the whole person."[11] In a medical home, this may mean an individualized care plan that supports individuals' preferences and involves shared decision-making.[12] In community behavioral health settings, recovery-based principles may guide care planning. Regardless of setting, comprehensive planning denotes individualized care plans that identify and address both physical and behavioral health needs, as well as social determinants that can also affect health outcomes.

Use of health information technology: The importance of health information technology (HIT) is noted across integrated care approaches: many of the NCQA PCMH standards are aligned with Stage 2 Meaningful Use requirements, which promote the use of certified EHRs to identify the needs of patients, as well as to collect and report clinical data. The Lexicon recommends a shared EHR to support integrated care, while health homes criteria include the use of HIT to link services, "as feasible and appropriate."[13]

Quality Measurement and Improvement: All of the approaches reviewed include quality measurement and improvement as a key piece of infrastructure for physical and behavioral health integration. While the different approaches all see the need for providers to gather and use data to improve patient care, the Collaborative Care Model has a more specific vision: its "Treatment to Target" methodology supports providers in regularly measuring patient outcomes (using evidence-based tools) and modifying care plans until specific clinical goals are met.[14]

These core components provide a flexible foundation for a number of integrated care approaches, and can be leveraged in different settings and for a variety of populations. State policymakers have several options when it comes to funding and sustaining this infrastructure, including a range of Medicaid funding authorities, the use of provider requirements to promote change, and specific initiatives and investments that target provider transformation.

State Policy Approaches to Building the Infrastructure for Integrated Care

NASHP reviewed state delivery system and payment reform initiatives to identify how states are supporting and promoting the development of integrated care infrastructure. NASHP identified states that are actively engaged in significant health reform initiatives, including the SIM initiative, the implementation of a health home state plan option, and DSRIP. The following themes emerged from this review:

States are leveraging a range of Medicaid funding strategies to build infrastructure for integrated care. In addition to grant funds to help providers cover costs associated with practice transformation, states use various Medicaid authorities to sustain enhanced payments to practices that adopt core components of integrated care. These payments, which are commonly made on either a per member per month (PMPM) or cost basis, are especially important for funding multi-disciplinary teams, population-based health strategies, and care coordination capacity, which might otherwise be non-reimbursable under fee-for-service arrangements. **Table 1** provides a high-level summary of selected Medicaid authorities that states have used to support integrated care in diverse care settings.

Table 1: Selected Medicaid Authorities Supporting Integrated Physical and Behavioral Care

Vehicle *(Authority)*	**Flexibility**	**Common Payment Methodologies Supporting Integrated Care Infrastructure**	**State Examples**
Health Homes *(§1945 State Plan Option)*	State must identify populations that meet federal health home eligibility requirements, either: two chronic health conditions, one chronic health condition with the risk of a second, or a severe and persistent mental illness.	Population-based PMPM Rates Cost-based Monthly Case Rates Fee-for-Service	**Connecticut**: Behavioral Health Homes for Individuals with Serious Mental Illness **Missouri:** Primary Care Health Homes
Primary Care Case Management *(§1932(a) State Plan Amendment; §1915(b) Waiver)*	PCCM may be used for a broad Medicaid population or to target specific diagnoses/ disorders.	Population-based PMPM Rates Performance-based Payments	**Idaho**: Healthy Connections
Mandatory Managed Care *(§1915(b) Waiver)*	State may implement broad-based managed care or have specialty plans that target specific populations.	Capitation to plans, which may in turn develop alternative payment arrangements for providers (including population-based PMPM or performance-based payments).	**Idaho**: Idaho Behavioral Health Plan
Medicaid Demonstration Projects *(§1115 Demonstration Waiver)*	Demonstration waivers may be used to test multiple models for broad or targeted populations, including managed care arrangements.	Broad authority to test alternative payment methodologies.	**Arizona**: Health Care Cost Containment System Regional Behavioral Health Agencies
§1905(a) State Plan Services*	May be subject to statewide, freedom of choice, and comparability of service requirements.	Varies by service, but may include direct reimbursement for relevant providers and services (e.g., peer recovery supports; Health Behavior and Assessment Intervention services).	**Georgia**: Whole Health Peer Program (Rehabilitative Services Option)

* For example: Physicians' Services; Other Licensed Practitioners' Services; Federally Qualified Health Centers; Targeted Case Management; Rehabilitative Services Option.

Adapted from: CMS, "At-a-Glance Guide to Federal Medicaid Authorities Useful in Restructure Medicaid Health Care Delivery or Payment," April 2012. https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/At-a-glance-medicaid-Authorities.pdf.

States are using provider requirements to build infrastructure for integrated care. Policymakers increasingly articulate the state's vision for integrated care by linking enhanced payments to specific provider requirements. Health home programs, which currently operate in 20 states and the District of Columbia, are a common vehicle for states to use when specifying integrated care expectations. In Connecticut, for example, the state's behavioral health home state plan amendment requires providers to deliver care through a multidisciplinary team that includes both behavioral health and primary care professionals.[15] Other states, such as Maine and Missouri, require primary care-based health homes to obtain NCQA PCMH recognition or meet similar national standards. Beyond health homes, New York's Advanced Primary Care (APC) model—a key feature of the state's SIM grant—requires provider capacity in HIT, population health, care management, and quality improvement, among other features.[16]

Arizona: Leveraging Managed Care Contract Requirements to Build Integrated Care Capacity

In addition to provider requirements, some states use managed care contracts as another tool for developing integrated care capacity. For example, Arizona has built integrated care infrastructure through managed care contract language that requires comprehensive care planning, integrated care teams, coordination and follow up, and other features tied to the state's vision of physical and mental health integration. For example, Arizona requires its acute and behavioral health managed care plans to share data with one another, in order to "eliminate blind spots… and allow the plans to see [utilization data] across the entire continuum of care."

Furthermore, Arizona's contract with Mercy Maricopa Integrated Care specifies: "Providers of integrated care must operate as a team that functions as the single-point of whole-health treatment and care for all of a member's health care needs. Co-location or making referrals without coordinating care through a team approach does not equate to integrated care." Furthermore, "[t]he team must involve the member as an equal partner by using appropriate levels of care management, comprehensive transitional care, care coordination, health promotion and use of technology as well as provide linkages to community services and supports and individual and family support to help a member achieve his or her whole health goals."

Sources: State of Arizona, *SIM Initiative Project Narrative,* p.3, https://www.azahcccs.gov/AHCCCS/Downloads/StateInovation/ArizonaSIMProjectNarative.pdf;
Arizona Health Care Cost Containment System, AHCCCS Contract Number: YH17-0001 (Amendment 2), p. 29, effective October 1, 2016, https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/TitleXIX2016MaricopaCountyAmendment2.pdf.

States are supporting provider transformation through training, workforce development, and administrative alignment. States are investing significant resources (SIM funding, DSRIP funding, Medicaid payments, and other state resources) to support the transition to integrated care. Oregon's SIM initiative features the Transformation Center, a hub for that state's clinical transformation efforts, which provided resources and technical assistance to providers, systems, and other stakeholders. Other states are developing new workforce capacity: Vermont funds community care teams through its multi-payer Blueprint for Health initiative, expanding the ability of primary care providers to coordinate care and link to community services. States such as Arizona and New York are also working to better align administration of services: Arizona, for instance, has undertaken a comprehensive cross-agency review of regulation with the goal of removing regulatory barriers to facilitate delivery of integrated care regardless of setting.[17]

States are supporting development of data infrastructure for behavioral health providers. Behavioral health providers did not generally benefit from technology investments made under the Health Information Technology for Economic and Clinical Health (HITECH) Act, and as a result have had a slower uptake of health information technology (HIT) than their physical health counterparts. States working on physical and mental health integration have started to fill this void, leveraging SIM and other funding opportunities to build this key piece of infrastructure. Massachusetts, for instance, made funding available for interoperable EHRs to behavioral health providers as part of its eQuality Incentive Program (eQIP) and continued to support these providers on workflow and other issues under the state's SIM grant.[18] Similarly, Maine provided funds to behavioral health providers to support interoperability and access to that state's health information exchange (HIE).[19] Minnesota has created a road map for behavioral health providers, including recommendations, use cases, and resources for behavioral health, public health, long-term care, and social service providers looking to adopt HIT and HIE.[20]

Maine: Leveraging Public-Private Partnerships to Build Integrated Care Capacity

States may wish to consider partnering with quasi-public or non-governmental agencies to support data sharing in order to lessen the burden on state staff and resources. For example, Maine contracted with the Maine Health Management Coalition (MHMC, a purchaser-led non-profit organization) to conduct data analytics as part of the state's SIM initiative. In addition to maintaining the state's all-payer claims database, MHMC developed a provider portal and practice feedback reports.

Source: Maine Health Management Coalition, SIM Data Analytics and Reporting Deliverables, accessed March 20, 2017, http://www.mehmc.org/sim/sim-work-areas/sim-data-analytics/.

Conclusion

State policymakers are increasingly looking to build infrastructure for integrated care delivery, recognizing that integrated care approaches hold potential to improve outcomes and reduce cost for high-need, high-cost Medicaid beneficiaries with complex needs. Emerging consensus in the field can offer guidance on the core components of this infrastructure, while leading states illustrate the variety of strategies that can be used to build and sustain these core features. Through the use of flexible Medicaid funding authorities, managed care contracting, provider payment strategies, and other key investments, state policymakers are finding ways to remove barriers and support this important transformation of care.

Endnotes

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Acknowledgments:
The authors wish to thank the all of the state officials from Round One State Innovation Model Initiative Model Test Award states and the NASHP staff that helped shape a previous version of this issue brief. The authors also thank Pamela Riley and The Commonwealth Fund for making this work possible.