Connecting the Two Worlds: States Integrating Primary and Behavioral Health Care

Thursday, August 29, 2013
12:30 pm – 2:00 pm ET

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Agenda

12:30 – 12:35 pm
Welcome and Introductions
Anne Gauthier, Senior Program Director, NASHP
Laura Tollen, Senior Health Policy Consultant, Kaiser Permanente Institute for Health Policy

12:35 – 12:50 pm
An Overview of the Issues
Jane Beyer, Assistant Secretary, Aging and Disability Services, Washington Behavioral Health and Service Integration Administration

12:50 – 1:35 pm
Making Behavioral Health Integration a Reality
Marie Zimmerman, Health Care Policy Director, Minnesota Department of Human Services
Jane Beyer, Assistant Secretary, Aging and Disability Services, Washington Behavioral Health and Service Integration Administration
Joe Roszak, Executive Director, Kitsap Mental Health Services

1:35 – 1:55 pm
Discussion
Facilitator: Anne Gauthier

1:55– 2:00 pm
Wrap-up
Project Goal and Overview

- **Goal**: Assist states ready to take immediate steps to improve delivery system integration via multi-payer payment and delivery system reforms
- Four national webinars
  - Webinar #1 laid the groundwork, Webinars #2-4 focus on specific topics of interest: choosing payment models, using data, and integrating behavioral health
- Virtual consultations with select states after each webinar
- Online “toolkit” for state policymakers
- State Refor(u)m blog posts disseminating findings

Today’s Webinar

- Integrating primary and behavioral health care
  - New care models
  - Strategies for integrating funding streams and exchanging data
  - Examples of state approaches in Minnesota and Washington
  - Provider perspective from Kitsap Mental Health Center in Washington
Managing Separate Funding Streams

In order to truly integrate behavioral and physical health care, we must reform our current payment mechanisms:

• Allow flexibility within existing funding streams
• Allow flexibility in our payment methodologies
• Include contractual requirements related to care coordination across systems
• The flexible funding that Kitsap Mental Health leveraged via a CMMI grant provides an example of what these innovations can accomplish
Data Sharing- Challenges and Opportunities

• Current treatment silos operate with distinct electronic health record (EHR) systems, if there is an EHR system

• HIPAA allows practitioners the ability to share PHI among treating providers, but mental health (MH) and chemical dependency (CD) data do require more protection under federal law

• Role state can play in sharing claims data
  • For example, Washington state’s PRISM tool demonstrates how state’s can leverage existing payment and reporting system data to improve care

Responding to the needs of people with Serious Mental Illness and others with BH needs

The systems we create must recognize that the people we serve have different needs and require more than one approach:

• Bi-directional systems, i.e. primary care in behavioral health sites and behavioral health in primary care sites

• Recovery orientation is critical

• Integration of social services, with medical, MH and CD services

• Critical role of supportive housing and access to other services to meet individual’s basic needs

• Provide standardized screening in multiple settings
Trying to bring the worlds together

Navigation between different cultures at the state agency level

Behavioral Health - combining the cultures of MH and CD:

• Recovery orientation

• While Medicaid is a big player, federal block grants also prominent in driving state policy and accountability

• Major relationship between MH and CD services and the involuntary treatment and criminal justice systems, both of which are largely at the county level

• Greater focus on populations with serious mental illness or chemical dependence

Trying to bring the worlds together

The culture of the state Medicaid agency:

• Traditionally functions under the medical model

• Hold direct contractual relationships with insurers, managed care plans and providers

• More likely to look to partnerships with state employee health benefit and private purchasers
Trying to bring the worlds together

Potential opportunities to partner across MH/CD, Medicaid medical and private purchasers:

• Shared performance measures for prevention and early intervention, and care transitions

• Shared savings models related to emergency department and hospital utilization

STATE SPOTLIGHT: MINNESOTA

Marie Zimmerman
Health Care Policy Director
Minnesota Department of Human Services
Overview of Minnesota Health Care Programs

- **Medical Assistance (MA):** Minnesota’s Medicaid program – approximately 768,000 enrollees, $5.7 billion (FY14)

- **MinnesotaCare:** premium-based coverage program — approximately 127,000, $646 million (FY14), 1115 Waiver

- **MA** is the supplement to Medicare for over 100,000 elderly and disabled Minnesotans who are eligible for Medicare but also have low incomes and need assistance with cost sharing
Minnesota Medicaid’s Current Care Delivery

- Majority (75-80%) of Medicaid enrollees are in managed care
- Mental health reform enacted in 2007-08 creating a model mental health benefit across all public programs, incorporated previous county-administered services/grants into managed care, e.g., targeted care management
- Separate fund for chemical dependency treatment services administered by counties (FFS and non-Medicaid)

Minnesota’s Payment/Delivery Demos and Behavioral Health Integration

Minnesota Medicaid ACO models:

1. Health Care Delivery Systems (HCDS) Demo
2. Hennepin Health: A Safety-Net ACO
— Define the “what” we seek, rather than the “how”
— Work in partnership with providers to develop process
— Give providers choice to participate
— Provide multiple opportunities for innovation under a framework of several models
— Allow for local flexibility and innovation under a common framework of accountability

Framework of accountability includes
✓ Models based on, and with accountability for, total cost of care (TCOC)
✓ Models that drive rapidly away from the incentive “to do more”
✓ Models that drive rapidly towards increasing levels of integration
✓ Models that use a common quality measurement
Authorizing legislation for Minnesota’s Medicaid ACO Demonstration: Health Care Delivery Systems (HCDS)

“The Minnesota Department of Human Services shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement.”

(Minnesota Statutes, 256B.0755)

First HCDS Process and Timeline

- Started with an RFI process to gather input
- Developed and issued RFP in summer 2011, selected end of year
- Responses received were broadly representative of geographic and organizational structure
- Received federal approval August 2012
- Six providers, serving nearly 100,000 of our Medicaid enrollees, started in our HCDS model in January 2013
- Second RFP issued January 31, 2013; due June 3
HCDS Model Overview

- Total cost of care/shared savings and shared risk model over three-year demonstration period
- Patients are “attributed” – retain provider choice
- Performance on quality measures impact payment
  - Includes depression remission in core set of 8 clinical measures, groups can propose additional measures
- Requires providers to assume financial accountability for a core set of services
  - Includes outpatient MH and CD services, and most medical services
  - Optional: more intensive and residential services, e.g., ACT, IRTS

Provider Characteristics/Requirements

HCDS providers must
- Deliver the full scope of primary care services.
- Coordinate with other providers and hospitals.
- Demonstrate how they will partner with community organizations and social service agencies and integrate their services into care delivery.

Challenges
- Release of CD data to providers in monthly, patient-level reports, accountability for costs
- Building effective relationships/strategies with community providers versus building capacity in-house
Hennepin Health:
integration with social services and behavioral health

- “Safety-net ACO”
- Population focus: adults on Medicaid with incomes below 75% FPG
- Hennepin county receives capitation rate roughly equivalent to MCO cap rates
- Opportunity for savings outside the Medicaid program (i.e., corrections and social services)

Hennepin county: Minnesota’s largest county (Minneapolis)

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Hennepin Health Population

Defining characteristics of this population

- 68% Minority status
- 45% Some level of chemical dependency
- 42% Mental health needs
- 30% Chronic pain management
- 32% Unstable housing situation
- 30% More than one chronic disease (diabetes and/or heart disease are most common)
Hennepin Health “Safety-Net ACO” demonstration

• Care model includes integration of medical care with
  • Behavioral health
  • Social services
  • Other county services unique to Hennepin
• Focused on high-need populations who are frequent users of county services
• Incentives aligned under county-run safety hospital and clinics, HMO, FQHC, behavioral health and other traditional county services.

Hennepin Model Features for Behavioral Health

• **Coordinated Care Clinic**
  - Located in hospital, identified complex patients with 3 inpatient admissions in the past 12 months
  - Appointments available to for patient walk-ins, critical for persons with mental health conditions
  - Care team reflects integrated model – physician/APN, county SW, care coordinator, pharmD, psychologist, CD counselor
Hennepin Model Features for Behavioral Health

- **Contract measures focus on behavioral health**
  - Inpatient MH follow ups and Initiation of CD treatment

- **Investments from year 1 savings focus on importance of behavioral health**
  - Sober center for lower cost alternative to medical detox facility
  - In-reach care coordination for frequent ER utilizers

Minnesota Accountable Health Model under SIM

The Minnesota Model focuses on transforming our delivery system, moving toward greater integration of care among providers and in the community and on population health.

- HCDS and TCOC payment models to improve financial incentives
- Focus on care models that integrate behavioral health, long-term and social services
- Infrastructure investment in IT, data analytics, quality improvement/measurement
- Move toward greater community involvement/integration
Next Steps

- Development and implementation of a Behavioral Health Home for adults and children with severe mental illness (over 100,000 enrollees)
- Minnesota’s SIM application (testing) builds on HCDS
- Expansion to additional populations (duals, complex)
- Strong emphasis on integration of primary/acute care and behavioral health integration as well as other care settings and long-term services and supports (more global community responsibility)
- Lessons from the HCDS and Hennepin Health demonstrations

Contact

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STATE SPOTLIGHT: WASHINGTON

Jane Beyer
Assistant Secretary for Aging and Disability Services
Washington Behavioral Health and Service Integration Administration

Connecting the Two Worlds: States Integrating Primary and Behavioral Health Care

National Academy for State Health Policy

Jane Beyer
Behavioral Health and Service Integration Administration
August 29, 2013
Medicaid-Only - High Risk/High Cost

**TOTAL 44,608**

GRAND TOTAL: 44,608

Shaded Area Between Doomed Outline and Circles = 4,228

9%

TOTAL LTC = 35,411

79%

TOTAL SMI = 12,390

28%

TOTAL AOD = 3,191

7%

TOTAL DD = 2,608

6%

AOD ONLY = 641

12%

AOD + LTC = 1,463

10%

AOD + SMI = 1,962

12%

AOD + SMI + LTC = 2,208

9%

SMI ONLY = 1,356

3%

SMI + DD = 1,208

6%

SMI + LTC = 1,164

5%

LTC + AOD = 7,985

18%

LTC + DD = 329

7%

LTC + SMI = 7,296

18%

LTC ONLY = 25,296

57%

DD ONLY = 877

2%

DD + SMI = 437

1%

DD + LTC = 47

<1%

DD + AOD = 24

<1%

SMI + AOD = 844

5%

AOD + SMI + DD = 2,962

12%

AOD + SMI = 2,542

11%

AOD + DD = 1,988

8%

AOD + LTC = 2,733

11%

SMI + LTC = 1,550

6%

SMI + AOD = 941

4%

SMI ONLY = 2,208

9%

LTC ONLY = 2,793

11%

LTC + SMI = 1,164

5%

LTC + AOD = 1,463

4%

LTC + SMI + DD = 2,208

9%

TOTAL = 24,006

30%

GRAND TOTAL = 24,006

Shaded Area Between Doomed Outline and Circles = 7,052

29%

TOTAL AOD ONLY = 2,516

10%

TOTAL SMI ONLY = 2,542

11%

TOTAL DD ONLY = 1,988

8%

TOTAL LTC ONLY = 2,733

11%

TOTAL AOD + SMI = 816

3%

TOTAL SMI + AOD = 844

5%

TOTAL AOD + SMI + LTC = 816

3%

TOTAL SMI + LTI + DD = 789

3%

TOTAL DD + SMI + LTC = 24

<1%

TOTAL = 24,006

30%

AOD + SMI + DD = 2,962

12%

AOD + SMI + LTC = 769

3%

AOD + LTI + SMI = 2,793

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11%

Shaded Area Between Doomed Outline and Circles = 7,052

29%

**Washington State Department of Social & Health Services**

For 68,000 high cost/high risk clients:

All have complicated medical conditions

11,200 are engaged in the health system alone

41,000 have long term need, either alone or with substance abuse, serious mental illness, developmental disabilities

11,000 have a serious mental illness/or substance abuse w/o engagement in LTC or DD systems

5,000 have a developmental disability, either alone or with a substance abuse or serious mental illness (56% of those are Medicaid only)

See Appendix F for detailed definitions.
Current Services and Purchasing

- 1.2 million individuals receive full medical coverage from Medicaid: 81% enrolled in managed care contracts with private insurers. This includes 700,000 children; 220,500 adults
- Mental health services are provided through managed care contracting with regional county-based entities
- Chemical dependency treatment is paid for through fee for service

PRISM (Predictive Risk Intelligence System)

A Decision Support tool designed to support care management interventions for high-risk clients

- Identifies clients based on risk scores developed through predictive modeling
- Integrates information from medical, social service, behavioral health, and long term care payment and assessment data systems
- Intuitive and accessible display of client health and demographic from administrative data sources
Health Homes

- Section 2703 of the Affordable Care Act
- State Plan Amendment
- Phased Implemented (except King and Snohomish)
  - First Phase July 2013
  - Second Phase October 2013
- Available to High risk/cost individuals
  - Medicaid or both Medicare and Medicaid
  - Risk score of 1.5 or more (PRISM)
  - Chronic illness and at risk for another

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Health Homes

- Based on Intensive Care Coordination
  - Will not duplicate or take place of other case mgmt. services
  - Person Centered
  - Health Action Plan (HAP)
  - “Glue” that integrates across care systems
- Qualified by the State
  - Lead Entity
  - Care Coordination Organizations are community based
- Challenges
Capitation through Health Plans for Dual Eligibles

- Federal demonstration project -- Full risk for all Medicare and Medicaid services
  - Mental Health
  - Chemical Dependency
  - Long Term Services and Supports
  - Medical
- Available in King and Snohomish Interagency Agreement
- Regence and United – apparently successful bidders
- Target to begin enrollment -- May 2014
  - Enrollment voluntary – passive enrollment

State Innovation Models- CMMI Planning Grant

- Under a CMMI planning grant, Washington state has been exploring how to better organize and align our healthcare system in an effort to improve health outcomes for all residents
- Behavioral health and whole person care has been a prime focus with a recognition of the need for:
  - Bi-directional and seamless integration of behavioral and physical health care and social supports for individuals with co-morbidities
  - Enhanced early disease prevention and mitigation strategies throughout the lifespan – toward accountable communities of care
Examples of Medical/BH Provider Creativity

- A large community mental health clinic has integrated mental health, chemical dependency services and primary care on site. They employ outpatient Care Teams to manage ongoing needs of clients, and deploy a mental health Advanced Registered Nurse Practitioner to local primary care clinics to consult on mental health, chemical dependency and pharmaceutical issues in health care settings.

- Mental health clinic is co-located with public health to enable case collaboration on social supports and community based needs.

- Primary care providers employ behavior health specialists, providing them access to electronic health care records to follow up with patients who need ongoing behavioral health services or referrals.

Provider Creativity

- Behavioral health clinicians available on-site at hospitals all day, five days a week.

- New Federally Qualified Health Center will open on the campus of a mental health clinic this fall.

- A mental health facility is undergoing new construction with primary care space included in the design.

- A new primary care clinic was sited adjacent to a Community Mental Health Center.

- State’s role – Minimize barriers and foster innovation.
New Certification Rules for Washington’s MH, CD, and Problem Gambling Treatment Programs

Washington updated regulations for chemical dependency, outpatient mental health, and problem gambling agencies in order to reduce administrative burden and improve care.

- Agencies providing these services must now be licensed as a “Behavioral Health Agency” and can choose the specific services they wish to be certified to offer.

- Agencies serving multiple populations may now have a single set of administrative rules and policies, a single clinical record for each client served, and a single integrated care plan.

- Agencies are no longer required to comply with rules that apply to services outside of the scope of the agency.

PROVIDER PERSPECTIVE: KITSAP MENTAL HEALTH SERVICES

Joe Roszak
Executive Director
Kitsap Mental Health Services
Kitsap County, Washington
Kitsap Mental Health Services
Bremerton, Washington

- Comprehensive behavioral health for 5000+ children, adults, older adults with acute or persistent Serious Mental Illness/Serious Emotional Disturbance
- Sole countywide community behavioral health agency
- Offer inpatient, outpatient, and residential services
- Operate as sub-capitated, at risk, Medicaid BH system
- Financial incentives of capitated, at risk system align to support provision of early, most appropriate level of care, and coordination of care with ancillary providers

Where We’ve Been

Building on an existing system of care for behavioral health and physical health to improve health of persons with SMI/SED

- 1978
  - KMHS mental health outpatient, inpatient, and residential treatment
- 1993
  - Co-occurring substance use disorder specialty program at KMHS
- 1995
  - KMHS Psychiatric consultant/brief interventionist at FQHC
- 2011
  - Co-locate PCP on KMHS campus
- 2012
  - CMS/CMMI Award
What We Wanted to Do

2012 - Whole Person Care

- Fully integrate mental health & substance use disorder treatment
- Tighter care coordination with patient’s PCP/health home
- Chronic disease self-management/health promotion programs
- Seamless transition of patients between levels and types of care
- Bi-directional primary care/behavioral health care model

right care, right place, right time to meet the Triple Aim

What’s Made It Possible

- Catchment Area sole provider
- Partners
- Staff
- Payment structure
  - Sub-capitation, at risk for mental health services
  - County flexible substance use disorder funding
- Waiver of State substance use disorder regulations
- Restructure to multi-disciplinary Care Teams
- CMS Innovation Center funding
  - Health information & data sharing
  - Cross-training
  - Bi-directional care model
What We Are Doing
Multidisciplinary Care Team Restructure

Patient

- SUD Co-occurring Professional
- Groups & Individual Interventions & Consultations
- Therapy & Care Coordination
- Primary care linkage
- Health Analytics
- Housing, Employment
- Evaluation, Treatment, Prescribing
- BH/Co-morbidity management
- S Psych Medical Provider
- S Psych Nurse
- NEW Medical Assistants

Team Caseload = 240

Health Analytics Inform Care

Shared Health Data Becomes Information
- Real time data informs TX
- Tighter care coordination with PCP’s, ED’s, hospitals

PATIENTS

Care Team
Medical Assistants

Onsite PCP

Community PCPs

HEALTH ANALYTICS

KMHS EHR

Measures

Care Management Reports

Patient Registries

PRISM

EDIE

HERO

HIE

Rx Monitoring

ED’s
Impacting Co-Morbidities

- Embed Substance Use Disorder Treatment agency-wide
  - **MH/SUD Integration**: cross-train all staff for fully integrated BH treatment
  - **New**: individual & population based approach; patient registries; Evidence Based Practices (PAM, WHAM). In process.
  - **Recovery model**: facilitates flow between PCP/CBHC sites for level of patient care needed to support recovery
  - **Prepare future workforce**: allied health/BH professions educated to provide whole person, integrated care

- Add Chronic Disease/Health Promotion Program Developer

- Add Bi-directional Care Model

- Workforce higher education

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Bi-directional Care Model

- **CBHC Psychiatric consultation** for all PCP’s supports rapid diagnostic, med management, training
- **CBHC BHP co-located in PCP offices** for low/moderate BH needs & to coordinate access as needed to specialty BH services
- **PCP co-located on CBHC** supports BH patients who prefer PCP services on BH site

- Supports seamless patient flow between systems of care as needed
- Increases patient information sharing for care coordination
- Natural occurrence of cross-training between disciplines
- PCP informs CBHC practice; CBHC informs PCP practice
- Provides right place, right care, right time and recovery model for SMI/SED patients

Community Based Primary Care Providers’ /Health Home

On Demand CMHC Psychiatric Consultancy & On-site BHP

Community Behavioral Health Center

Co-located PCP on CMHC campus
Silo’s Challenge Integration

- Artificial, forced, internal silos due to funding
- Integrated care requires a regulatory and data system environment that expects integration
- Need a payment system that braids all 3 facets of physical, mental, substance use disorder treatment
- The better we do our work, the harder to maintain silos.
- To integrate care, we must eliminate silo’s.

Additional Information

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Questions and Answers

Questions for the presenters?
Please type them into the chat box now!

Additional Resources

- NASHP has launched an Integrated Delivery Systems Toolkit:
- The toolkit is hosted on the State Refor(u)m website and offers:
  - Opportunities to ask questions and carry on the discussion after each webinar
  - Materials and recordings from each webinar
  - Themes that emerge from each post-webinar consultation call
  - Additional resources and documents relevant to each webinar’s subject matter
Thank You!

Please fill out your evaluations!
Fostering Integrated Delivery Systems with Effective State Health Policy
NASHP Project Team
Please feel free to contact us with any questions!

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For additional resources, visit statereforum.org and nashp.org/projects/integrated-delivery-systems