

A TALE OF TWO SYSTEMS: A LOOK AT  
STATE EFFORTS TO INTEGRATE PRIMARY  
CARE AND BEHAVIORAL HEALTH IN  
SAFETY NET SETTINGS

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## EXECUTIVE SUMMARY

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**I**ntegrated behavioral health and primary care is often described as occurring when behavioral health specialty and general medical care providers work collaboratively to address both the physical and behavioral health needs of patients. States can foster the provision of integrated care for the underserved and develop models that may hold promise for broader application by developing policies that support integration through their safety net providers. Federal community health centers are uniquely positioned to partner with the community mental health system to deliver integrated care and to address behavioral health issues as part of a comprehensive medical home.

However, the key safety net systems for the delivery of primary care and behavioral health—community health centers and community mental health centers (CMHCs)—have developed largely in isolation from each other, with different mandates and different funding structures. While the two systems may be in the same community serving mostly the same population, the result can be fragmented systems in parallel and nonintegrated settings, creating challenges and barriers to integrated care. This report focuses on how two states have approached integration and provides useful lessons for other states seeking to integrate the two health care delivery systems. Recent work with Tennessee and Missouri—two states that are part of NASHP’s National Cooperative Agreement with the federal Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC)—helped identify efforts that focus on integrating primary care and behavioral health. Site visits to explore integration efforts in Tennessee and Missouri informed this analysis.

Some of the challenges to integrating care through safety net providers include:

- **Providing services to the uninsured.** While federal community health centers have a federal mandate backed with substantial funding to provide care regardless of a patient’s ability to pay, CMHCs do not and are not funded to provide the same level of coverage. Due to limited public funding, CMHCs must prioritize care for those with severe and persistent mental health illnesses first, unless others with less severe mental illnesses have health insurance coverage. As a result, the uninsured with mild to moderate mental illness are often referred to the local community health center. Consequently, depending on the diagnosis and health care coverage, there are different doors to services that create a significant barrier to integrated care.
- **Fragmented payment system.** Integrated care often involves the type of care coordination and provider collaboration that takes time and is not always billable through conventional fee-for-service systems.
- **Information sharing.** The smooth exchange of pertinent health information to and from a variety of sources is a key integration challenge.
- **Workforce issues.** The acute shortage of both behavioral health and primary care providers in many areas makes the provision of care, particularly integrated services, difficult. This problem is compounded by the fact that both primary care and behavioral health providers often are not trained or educated about how to work in an integrated setting, resulting in a disconnect between the two cultures of care.

In spite of these challenges and barriers, states have many opportunities to work with safety net systems to help bridge the gaps in primary care and behavioral health delivery systems and promote integration. Tennessee and Missouri have each leveraged their state roles to support integration in various ways.

### TENNESSEE

In 2006, Tennessee began to deliver Medicaid services through managed care organizations (MCO) responsible for both medical and behavioral health care, and has used many policy strategies to make progress toward reaching integration goals:

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**Payment Strategies.** Tennessee pays for certain billing codes for services related to Screening, Brief Intervention, Referral and Treatment (SBIRT), a screening tool effective in identifying behavioral health issues. The state also allows same-day billing, meaning a provider can bill for separate visits when a patient sees both their primary care and behavioral health providers on the same day. In addition, Tennessee has allowed the development of and payment for a new category of behavioral health workers, known as certified peer specialists.

**Contracting Strategies.** Tennessee managed care contracts explicitly require integration of medical and behavioral health care and set quality expectations for MCOs that require disease management programs for three behavioral health diagnoses. In addition, Tennessee requires National Committee for Quality Assurance (NCQA) certification for MCOs, which includes certain behavioral health assessments. In addition, the MCOs support the use of health information technology by reimbursing both parties that participate (calling and receiving) in telehealth and are working to expand access to behavioral health staff at federally qualified health centers (FQHCs).

**Regulatory Strategies.** In Tennessee, the Commissioner of the Department of Mental Health and Developmental Disabilities ruled that an FQHC or primary care clinic may deliver behavioral health services without being licensed as a CMHC.

**Cross-systems Strategies.** Tennessee's state agencies, as well as the MCOs, participate in regular meetings to discuss policies and issues that can improve various aspects of the delivery system, including integration. In addition, the Office of eHealth Initiatives is convening a stakeholder committee to address information-sharing across disciplines.

## MISSOURI

Missouri, for which current efforts toward integration date back to the state's Medicaid Reform Commission's report in 2005 and subsequent reforms, has also used a variety of tools to enhance integration:

**Legislative Funding Strategies.** The Behavioral Health and Primary Care Integration Pilot, which is conducted through the Department of Health, was allocated \$1.4 million by the Missouri legislature for the length of the three-year pilot. The pilot supports pairs of FQHCs and CMHCs working together to provide integrated care to patients, and currently Missouri agencies are working to identify sustainability strategies for the pilot. The legislature also provided funding for an investment in health information technology, partially to fund CyberAccess, an interactive web portal that provides real-time transmittal of health information for Medicaid and other state providers.

**Payment Strategies.** Missouri is supportive of same-day billing. While Missouri has not yet adopted the SBIRT codes, it is currently engaged in a five-year initiative to broaden availability of SBIRT across the state, including placing trained providers in FQHCs. As in Tennessee, Missouri supports telehealth; both providers participating (calling and receiving) are allowed to bill for the service. In addition, Missouri promotes the use of CyberAccess by offering Medicaid providers a payment when they log on and use the technology.

**Contracting Strategies.** Missouri's Chronic Care Improvement Program (CCIP) provides primary care case management to 180,000 Medicaid fee-for-service beneficiaries who have one or more of six specified chronic illnesses. While serious mental illness is not one of the covered diagnoses, the service does in fact manage the care of many people with mental illness due to the high rates of diabetes and pre-diabetes for people taking psychotropic medicine. In addition, Missouri has contracted out its Behavioral Pharmacy Management Program, which reviews Medicaid prescription patterns for over 400 mental health medications, compares these prescribing patterns to national best practices, and informs physicians about their patients' prescription refill status.

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**Regulatory Strategies.** The Department of Mental Health requires, and supports with funding, all CMHCs to provide clients with screenings to detect risk factors for certain chronic conditions.

**Cross-systems Strategies.** Many cross-agency and stakeholder meetings take place in Missouri between Medicaid, the Department of Mental Health, the Department of Health and Senior Services, the Primary Care Association, and the Missouri Coalition of Community Mental Health Centers.

## LESSONS LEARNED

While the two states' challenges and solutions differ, similar "lessons learned" emerged across the two states.

**Contracting strategies.** State Medicaid agencies can provide incentives for integration by setting behavioral health expectations in managed care and disease management contracts and aligning these expectations with payment strategies that reward performance.

**State and local champions.** In both states, it has been essential to have local or policy champions whose goal it is to integrate care. In Tennessee, in addition to leadership from Medicaid and Mental Health agencies, the state has a provider champion — Cherokee Health Systems — that is a nationally recognized model for primary care and behavioral health integration. Missouri has engaged state policy champions in the Medicaid and mental health agencies as well as the private sector to advance integration efforts.

**Flexibility.** Because "all health care is local," flexibility in making a health care system work for the individual setting and beneficiary is essential. In both Tennessee and Missouri, the flexibility state officials have shown is notable. In Tennessee, Medicaid MCOs are afforded latitude in designing and creating integrated networks of care and are free to implement payment innovations that support integrated care. Missouri state officials have provided flexibility at the provider level within state programs, including integration pilots and the Chronic Care Improvement Program.

**Strengthen the safety net.** In both Missouri and Tennessee, efforts to integrate have resulted in safety net providers having greater ability to serve patients in an integrated fashion. The safety net is uniquely positioned to integrate care through partnerships, and both states have encouraged these partnerships and supported both FQHCs and CMHCs through various initiatives.

**Multi-modal approach.** Tennessee and Missouri have taken advantage of a variety of opportunities to support FQHCs and CMHCs in providing integrated care. From these varied and incremental changes, an integrated system of care is beginning to emerge in both states.

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## INTRODUCTION

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States have a variety of tools, resources, and policy strategies available to them to promote the integration of behavioral health and primary care across safety net systems. While each state may differ in how it may approach integrating care to promote better health outcomes, lessons can be learned from states that have undertaken successful efforts.

In the National Academy for State Health Policy’s (NASHP) ongoing efforts to work with state policymakers on federal community health centers and medical home issues, the challenges of integrating behavioral health have surfaced repeatedly. Federal community health centers are in many respects uniquely positioned to partner with community mental health centers (CMHCs) to more seamlessly address behavioral health issues as part of a comprehensive medical home.

In addition, states have access to varied strategies and resources to support the integration of these two systems of care to better address the health needs of the underserved. Recent work with the states of Tennessee and Missouri helped identify efforts that focus on primary care and behavioral health integration by working closely with FQHCs in their states. Among other initiatives, Tennessee has integrated its Medicaid managed care contracting to “carve in” behavioral health services to its Medicaid program. Missouri has used a variety of tools to integrate care within both FQHCs and CMHCs. While employing different approaches, both states have succeeded in creating opportunities for integrated care.

There is no standard definition for integrated behavioral health and primary care. A recent report from the federal Agency for Healthcare Research and Quality (AHRQ) described integrated care as occurring when behavioral health specialty and general medical care providers work collaboratively to address both the physical and mental health needs of patients.<sup>2</sup>

The Institutes of Medicine<sup>3</sup>, the World Health Organization<sup>4</sup> and other leading health care institutions recommend that behavioral and physical health care be provided in this integrated, collaborative fashion. These recommendations are recognition of mounting research into the interrelated nature of mental, addictive and physical illness and treatment. The research indicates that people with a variety of common and costly health conditions, such as diabetes and heart disease, are prone to behavioral health disorders that can worsen the course of the underlying disease.<sup>5</sup>

Recent studies have also highlighted enormously disparate health outcomes for people with mental illness, many of whom are dying 25 years earlier than average due to non-mental illness-related health problems.<sup>6</sup>

Tennessee and Missouri have leveraged their state roles as legislators (making funding and policy decisions through the legislative process), payers (Medicaid), contractors (contracting with managed care or administrative services organizations), regulators (using state service regulations) and cross-systems collaborators and conveners (bringing together public and private stakeholders) to integrate care within their respective states. These efforts have been developed in collaboration and communication with FQHCs. This report provides a description of these states’ varied efforts, a summary of the strategies and resources used to

“Behavioral health care” is defined as the continuum of services for individuals at risk of, or suffering from, mental, addictive, or other behavioral health disorders.<sup>7</sup>

support integration, and concluding considerations for states seeking to better integrate primary care and behavioral health services for the underserved.

### **METHODOLOGY**

In order to explore how states are supporting integration, NASHP conducted site visits to Tennessee and Missouri—two states that NASHP is working with as a part of its National Cooperative Agreement with the federal Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Both states self identified as working to better support integration efforts. The NASHP team met with officials from Medicaid, Departments of Mental Health, Departments of Health, federally qualified health centers, primary care associations and offices, health plans, and other stakeholders. From these interviews and primary source materials, an analysis of state policy measures that support integrated care was conducted.

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## INTEGRATION: A TALE OF TWO SYSTEMS

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The integration of primary care and behavioral health is complex. It describes a range of practices and configurations of resources, taking into account provider practices, payers, community resources, and patient needs. While some primary care settings are able to provide on-site behavioral health specialty care, others may be able to provide only limited screening and referral to further behavioral health treatment. In addition, the key safety net providers for the delivery of primary care and behavioral health—community health centers and community mental health centers—have developed largely in isolation from each other, with different mandates and funding structures.

In the 1960s, Congress created what would become two significant programs in the public effort to improve access to care: community health centers<sup>8</sup> and community mental health centers (CMHCs).<sup>9</sup> Both health care models grew out of the era's war on poverty, the need to address the serious lack of health care resources in medically underserved urban and rural areas, and the recognition that a safety net for health care was needed for the country's most vulnerable and often most impoverished and disabled citizens.

The community health center model was largely supported through federal grant funds. Congress later passed legislation to provide favorable Medicaid and Medicare reimbursement rates (creating the Federally Qualified Health Center (FQHC) program) which has now become their most significant funding source.<sup>10</sup> The combination of federal grants and favorable reimbursement rates enables federal community health centers to meet their mission of caring for all those that enter their door, regardless of their ability to pay.

Community mental health centers, in contrast, have no dedicated federal grant funding and rely increasingly on public and private insurance coverage, and in particular, Medicaid, which generally has a richer benefit package for people with behavioral health needs than Medicare or private coverage. Medicaid, Medicare, and private coverage are all subject to the eligibility and medical necessity restrictions of various policies and state plans. Limited and fluctuating state, county, or local funding are often the only other resources available to pay for gaps in coverage or for services to people without insurance. Consequently, community mental health centers may have long waiting lists for the uninsured, or may refer patients with more acute needs to the local FQHC.

Because federal community health centers and CMHCs developed through distinct federal legislation and were funded through distinct grant resources and reimbursement methodologies, two distinct safety net systems were created, often in the same community and serving largely the same population. And while there are many instances of these two entities coming together to coordinate—and even integrate—care throughout the decades (there are excellent examples offered in this report), historically there has been no systemic imperative to do so. Services have been, and largely continue to be, delivered in parallel and un-integrated settings.

The integration of these two health care systems is a complex task. Challenges and barriers can include:

**The uninsured.** Community health centers have a federal mandate and a reimbursement model that supports provision of care to all, regardless of the ability to pay ('Look-alike' FQHCs have the same mandate but do not receive federal grants to care for the uninsured). Community mental health centers are not able to provide this same level of subsidized care. As a result, while the populations served in these two systems of care are similar, financing for services is not and this can be a significant barrier to integration

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of care. Coordination, seamless referrals, consultation, and co-location of services can be compromised when there are coverage gaps between systems.

**Fragmented payment systems.** Integrated behavioral health and primary care can often involve multi-disciplinary teams, care coordination, collaboration, and similar approaches that take time and are not always billable through conventional fee-for-service systems. Providers in Tennessee and Missouri, the subjects of this report, agreed that there needs to be a better way to finance an integrated model. In addition, many components of integrated care—behavioral health screening in the primary care setting, same-day billing for physical and behavioral health visits, and others—are often not reimbursable. Payments to providers in integrated settings can also be disallowed due to credentialing or licensing issues.

*“What is needed is openness to alternative funding mechanisms and then support for these policies through contract language.”*

Dennis Freeman, Chief Executive Officer  
of Cherokee Health Systems

**Sharing patient information.** Exchanging health information across providers is often a challenge and different standards and statutes can apply to behavioral health information, compounding the problem for integrated care.

**Addressing workforce issues.** Distinct cultures of care between FQHCs and CMHCs make integrating care a challenge; for instance, the rapid pace of primary care can be a stark contrast to the traditional 50-minute hour of therapy in the behavioral health world. The use of paraprofessionals—common in the behavioral health setting—can be difficult to reimburse in a primary care site. Finally, the acute shortage of both behavioral health and primary care providers in many areas makes the provision of any kind of health service challenging, particularly for those services targeting low income populations. All of these issues require training, education and the development of a corps of integrated care professionals.

In spite of these challenges and barriers, states have many opportunities to work with FQHCs and CMHCs to help bridge the gaps in primary care and behavioral health delivery systems and promote integration. As legislators, payers, contractors, regulators, and collaborative partners, states can have a great deal of influence in shaping and enforcing policies to achieve these goals. Tennessee and Missouri have embarked on different courses to work toward a similar destination. There are many lessons for other states to learn from these states’ journey to integrated primary care and behavioral health for the underserved.

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## TENNESSEE

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In a five-year span of time, Tennessee has undergone tremendous changes in its public coverage of health care, including the restructuring of its Medicaid program (known as TennCare). These changes have had a pronounced effect on the state's primary care and behavioral health delivery systems. The restructuring has given Tennessee opportunities to begin on a new path toward an integrated model of health care.

### OVERVIEW OF THE TENNESSEE SYSTEM

Tennessee has operated TennCare under a Medicaid 1115 Waiver for more than 15 years, since moving more than 750,000 Tennesseans from fee-for-service to one of 12 managed care organizations in January 1994. The move was an ambitious plan to gain control of the spiraling costs of caring for those covered by Medicaid and for the uninsured. In this transition to managed care, TennCare coverage was extended to approximately 500,000 uninsured Tennesseans (on a sliding scale basis) regardless of their income or employment status, including those who were uninsurable because of pre-existing conditions. Coverage for behavioral health services remained a fee-for-service program for a few years longer, when it shifted to a managed behavioral health program.

Although TennCare enrollment held steady at about 1.3 million, costs increased rapidly, reaching nearly \$8.6 billion in Fiscal Year 2005.<sup>11</sup> In March 2005, in response to state budget shortfalls, low tax revenues, and legal difficulties, Tennessee received Centers for Medicare and Medicaid (CMS) approval to cut enrollment of up to 25 percent of beneficiaries and reduce coverage of benefits. As a result, 170,000 adult Tennesseans lost health insurance coverage, including 26,000 diagnosed with serious and persistent mental illness.<sup>12</sup>

Benefit coverage for the remaining adult beneficiaries was reduced; most notably, limits were placed on the number and kinds of prescription medications covered and filled each month (five), and inpatient and outpatient substance abuse services. Some services were completely eliminated, such as methadone clinic treatment.

For the 22 FQHCs in the state, the financial impact of the TennCare cuts meant that approximately 43,000 FQHC patients lost their Medicaid coverage resulting in a projected \$12 million per year revenue loss for FQHCs. Compounding this loss in revenue, an estimated 147,000 newly uninsured patients turned to the FQHCs for uncompensated care, at an estimated cost of nearly \$42 million per year. TennCare disenrollment had a cumulative financial impact on FQHCs that has been estimated at \$54 million per year.<sup>13</sup>

To help those who lost their TennCare coverage, the Tennessee General Assembly appropriated funds for the implementation of transitional safety net programs by creating separate initiatives to fund primary care and mental health services.<sup>14</sup> The Department of Health administers the Primary Care Safety Net funds, which reaches 23 Tennessee FQHCs, giving them \$6 million to expand health care services to uninsured adults.

The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) administers the Behavioral Health Safety Net program (formerly known as the Mental Health Safety Net) to help CMHCs provide core behavioral health services (\$11.5 million in 2006) and prescription assistance (\$33.4 million in 2006) to certain disenrolled, uninsured individuals with serious mental illness.<sup>15</sup>

### INTEGRATION LANDSCAPE IN TENNESSEE

Following the disenrollment and benefit cuts, TennCare stabilized and began to strategically plan and implement changes in the program designed to improve quality of care and assure ongoing financial stability. Integration of behavioral health was one of these changes. In 2006, TennCare issued a Request for Proposals

(RFP) to recruit new managed care organizations (MCOs) to the TennCare program, shifting full financial risk for caring for beneficiaries from TennCare to the MCOs.<sup>16</sup>

TennCare used this restructuring as an opportunity to reform its delivery system one region at a time. The initial RFP called for MCOs to integrate medical and behavioral health services for beneficiaries in the more densely populated middle area of Tennessee, with plans to expand to the east and west regions of the state by 2009 if the middle Tennessee pilot proved successful.

Previously, management and measurement of behavioral health care for TennCare beneficiaries was the responsibility of the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD). TDMHDD ran a large managed care division “carving out” behavioral health services to several behavioral health organizations as well as being responsible for licensing and administering contracts for 19 CMHCs<sup>17</sup> and five regional mental health institutions. The implication for providers in a “carve-out” arrangement is that the decision regarding who can be included in the provider network is often left up to the behavioral

### **Integration Champions: The Cherokee Health Systems**

One of the best-known and nationally recognized models for primary care and behavioral health integration is found in eastern Tennessee. Community mental health centers are the early roots of the Cherokee Health Systems, but now these CMHCs have entered into dual status as FQHCs. Cherokee operates 22 clinical sites in 15 Tennessee counties; 12 of these sites are fully integrated, with a licensed behavioral health consultant embedded as a member of the primary care team and linked through shared electronic medical records. This arrangement allows the primary care provider to conduct a physical assessment and then provide a “warm hand-off” to the behavioral health consultant for brief, targeted interventions that address the psychosocial aspects of primary care. A psychiatrist is available—generally off-site by telephone or via telehealth—for consultation. Like all members of the team, the psychiatrist has full access to an electronic medical record. In addition, the move to achieve FQHC status has given Cherokee Health Systems access to the federal 340B Drug Pricing Program allowing them to purchase pharmaceuticals at prices lower than the Medicaid rebate price and then pass savings on to its patients.<sup>18</sup>

In an innovative pilot recently approved by the state legislature, Cherokee Health Systems is extending this drug pricing and pharmacy service to sites through telepharmacy.<sup>19</sup> The telepharmacy pilot will allow them to address state regulations that require a pharmacist on site to dispense the medications and provide counseling to patients.

With this model of care, the Cherokee Health Systems has been able to document better health outcomes, increased patient compliance with health care (particularly for those who have severe mental illness), decreased referrals to specialty mental health care, and increased provider and patient satisfaction.<sup>20</sup>

Backed by data that supports these value-added services, Cherokee Health Systems has been an instrumental force in driving change toward an integrated behavioral health and primary care model. They are working with the Tennessee Primary Care Association, Tennessee Association of Mental Health Organizations, TDMHDD, TennCare and the TennCare MCOs to develop policies that enable and sustain this model. Cherokee consults and contracts with other practices, providing both financial and technical support linking practices with behavioral health services and has been a national voice on the importance of integrated care.

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health organizations. Also, if the network standards are restrictive, then FQHCs are not appropriately reimbursed. Thus, the change to a “carve in” model whereby the MCO administers and shares risk for both medical and behavioral health services was significant for FQHCs. In addition, while TDMHDD maintained the policy oversight for behavioral health services, operational oversight shifted from TDMHDD to TennCare as outlined in a Memorandum of Understanding between the two departments.

In 2007, two new MCOs were awarded capitated contracts and began providing both medical and behavioral health services to beneficiaries in middle Tennessee. Although the move to a “carve in” model received support from the Tennessee Primary Care Association, FQHCs, and other primary care providers, it initially was questioned by TDMHDD and opposed by many mental health providers due to concern that those with severe illnesses would fall through the cracks.

## **POLICY STRATEGIES THAT ENHANCE INTEGRATION**

Although significant state budget challenges exist, Tennessee has used many policy strategies to make progress toward reaching integration goals.

### **Payment strategies**

TennCare now operates a full risk-managed care delivery system that serves over 1.2 million beneficiaries. Although TennCare MCOs contract directly with providers, TennCare has used purchasing or contract language to set expectations for the MCOs around primary care and behavioral health care (see next section). This section discusses a number of other payment approaches that Tennessee uses to support integrated services.

**Paying for same-day primary care and behavioral health visits.** Patients who are able to see their primary care provider on the same day as their behavioral health provider are more likely to comply with treatment regimens. Tennessee is one of 29 states that reimburse providers for separate primary care and behavioral health visits on the same day.<sup>21</sup>

**Paying for screening codes.** In a primary care office or other medical setting, Screening, Brief Intervention and Referral to Treatment (SBIRT) is effective in identifying behavioral health issues that may need brief treatment or referral to specialty services. Primary care providers are much more likely to use this screening tool if they are able to bill for this practice. Billing codes have been developed for the various components of SBIRT, and are now recognized in Medicare, some state Medicaid programs (including TennCare), and some private health plans. Both MCOs interviewed for this report allow primary care providers to bill for certain screenings such as SBIRT.

On a related note, in 2009, nine FQHCs in Tennessee participated in “learning clusters,” to train providers on how to conduct SBIRT, including motivational interviews and referrals for follow-up care. This one-year program was a federal Substance Abuse and Mental Health Services Administration (SAMHSA) contract with the National Association of Community Health Centers (NACHC). NACHC worked with the TDMHDD Division of Alcohol and Drug Services (DADAS) to help educate providers and DADAS has been meeting with the MCOs to resolve some of the issues raised around billing for this screening.

**Paying for Certified Peer Specialists.** TDMHDD has led in efforts to develop and pay for a new category of behavioral health workers known as certified peer specialists. TDMHDD certifies and trains these non-licensed lay persons who have either experienced personally, or through a family member, a chronic mental illness. TDMHDD worked with TennCare to allow Medicaid payment for these services, which are recognized by SAMHSA as an evidence-based practice.

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Currently these peer specialists are found in the Cherokee Health Systems assisting patients with navigating Tennessee's healthcare system. Working under the supervision of licensed clinicians, these staff members assist in developing programming that increases the health literacy of patients and enhances their illness self-management skills. Grant funding from TDMHDD enabled Cherokee to get the program running. TDMHDD also negotiated payment rates with TennCare MCOs to provide additional support.

### **Contracting strategies**

The ability to shape the delivery of health care through purchasing language in managed care contracts is a strategy that has enabled TennCare to better integrate care for its beneficiaries. The upheaval of TennCare led to significant changes, including issuing RFPs that, for the first time, put MCOs at full financial risk for care. In addition, the move to a "carve-in" model shifted responsibility and oversight for behavioral health care from TDMHDD to TennCare. TDMHDD worked closely with TennCare to develop explicit contract language that framed expectations around behavioral health services and also participated in the interview and final selection process of the successful MCO proposals. During the interviews, prospective MCOs were given case examples of complex patients with physical and behavioral health needs and were asked how they would manage their care. TennCare plays an important role convening TDMHDD and the MCOs in regular meetings to promote communication and collaboration on integration goals.

#### *TennCare Expectations for MCOs*

With strong language woven throughout MCO contracts specifically instructing MCOs to integrate behavioral health and primary care for beneficiaries, TennCare has set expectations for MCOs but generally takes a "hands-off" approach overseeing the way MCOs manage services and provider networks. For instance, contract language requires MCOs "to encourage PCPs and other providers to use a screening tool prior approved in writing by the state as well as other mechanisms to facilitate early identification of behavioral health needs" but does not specify which tool the MCOs should use.<sup>22</sup>

**Setting quality expectations with contract language.** In 2006, Tennessee became the first state to require National Committee on Quality Assurance (NCQA) certification for all of its Medicaid MCOs.<sup>23</sup> NCQA certification includes certain behavioral health assessments. TennCare also is working to develop behavioral health quality measurements that would supplement the NCQA measures.

In October 2009, a report found that the Middle Tennessee MCOs performed very well on the 2008 national Medicaid average for measures related to behavioral health as well as drug and alcohol dependence treatment. Both of these MCOs had marked their one-year anniversary with TennCare in 2008 and both performed above average or exceeded expectations in behavioral health measures, including antidepressant medication management, follow-up care for children prescribed attention-deficit hyperactivity disorder medication, and follow up after hospitalization for mental illness.<sup>24</sup>

TennCare requires MCOs to support "disease management programs that support the continuity and coordination of covered physical and behavioral health services."<sup>25</sup> This has resulted in MCOs providing disease management of three behavioral health diagnoses (depression, schizophrenia and bipolar disorder). Consequently, the MCOs require primary care providers to screen for behavioral health conditions, substance abuse providers to screen for mental health illnesses, and mental health providers to screen for substance abuse disorders. With this type of "no wrong door" approach, TennCare and its MCO partners are identifying opportunities for intervention at an early stage in multiple disease processes with a focus on prevention rather than remedial treatment.

Talks are in place about how to reward plans that are developing innovative programs and achieving quality outcomes. These discussions include using default enrollment policies that assign new TennCare beneficiaries to plans which meet certain performance goals.

#### *MCO oversight of providers*

TennCare does not mandate that MCOs pay providers for specific behavioral health services, but TennCare officials also noted that they do not set up “barriers” for innovative care. According to TennCare, this allows MCOs the freedom to design a package of services within their risk agreement that meets integration goals.

**Supporting the use of health information technology.** Telehealth allows primary care providers the use of telecommunication technologies to obtain needed consultations from hard-to-reach psychiatry staff for assistance with patient care and is particularly helpful with medication management of psychotropic drugs.

- **Paying for calling and receiving fees:** The Tennessee Primary Care Association stated they have verbal commitment from all TennCare MCOs to reimburse for telehealth services for providers for both calling and receiving fees.<sup>26</sup>
- **Providing seed money to expand information exchange:** AmeriChoice is working with the Office of eHealth Initiatives to expand the availability of and access to telehealth for both behavioral health and medical services. This includes providing grants to the Tennessee Primary Care Association and Community Health Network to recruit specialists to accept TennCare beneficiaries and to participate in the network that allows telecommunication linkages between providers.

**Expanding access to behavioral health staff at FQHCs.** One of the managed care organizations, AmeriChoice, is working with the Tennessee Primary Care Association to increase the number of behavioral health consultants at some of the larger FQHCs. AmeriChoice maintains that “if the FQHCs are truly integrating care, the dollars are going to follow.”

- **Supporting the business case for integration:** AmeriChoice is helping FQHCs determine if they have enough volume/appointments to hire a behavioral health consultant to serve as a member of the primary care team.
- **Sustaining integration operations:** AmeriChoice is helping FQHCs negotiate some of the complex billing codes needed to sustain a behavioral health specialist.

Blue Cross stated they recently met with the Cherokee Health Systems to discuss their willingness to train behaviorists and primary care providers to work together in the primary care setting.

**Funding new payment models.** MCOs have shown some flexibility in working with at least one of their providers to develop an alternative funding model.

- **Contract or global payment rates:** Blue Cross and AmeriChoice have collaborated with Cherokee Health Systems to negotiate a funding model—“contract rates” or global rates—that better support its integration model. According to Cherokee, fee for service reimbursement is a major disincentive to integrated care, which relies heavily on care coordination, team meetings and “non face-to-face” consultations. Contract rates are triggered when a provider sees the patient for the first time that month for a behavioral health visit. According to one MCO, paying Cherokee these rates are a “challenge.” But Cherokee’s success in negotiating contract rates comes from its leverage as a large provider with convincing outcome and cost data—leverage that other FQHCs in the state do not currently have. Consequently, other FQHCs do not receive contract rates, but as one MCO points out, the other FQHCs are not able or willing to emulate the Cherokee model.

- **Care management rates:** For physical health services, Cherokee negotiated a per-member-per-month care management fee in addition to its visit rates with Blue Cross; however, as with its other MCO contract, Cherokee bills for physical health services like other providers.<sup>27</sup>
- **Pay for performance:** Blue Cross is launching a pay-for-performance program for TennCare providers. Although specific behavioral health measures are not included in this first round, Blue Cross plans to look at performance measures such as emergency department utilization and HEDIS scores.

### Regulatory strategies

The transition to an integrated managed care model has presented challenges and opportunities for state agencies, MCOs, and providers regarding certain regulatory issues including credentialing and licensing. One policy that facilitated the transition was a determination by the Commissioner of TDMHDD that a FQHC or primary care clinic may deliver behavioral health services without being licensed as a CMHC.

Providers who work at primary care practices, including behavioral health specialists, need to be credentialed by the MCOs in order to receive Medicaid payment for services. For FQHCs, MCOs are likely to credential the health center rather than individual providers and ask the health center to periodically update their roster of credentialed providers. The Tennessee Primary Care Association and the FQHCs state that this MCO credentialing process has been slow and constrains their ability to provide and receive payment for behavioral health services at their practices. To compensate for the lag, MCOs must now reimburse retroactively to the date of credentialing. MCO representatives say they are actively seeking opportunities to improve their credentialing policies.

### Cross-systems strategies

The ability to convene stakeholders—particularly those from two distinct systems with different cultures of care—is an important strategy for states to help facilitate dialogue, gain insight, and inform policy decision-making. Tennessee has had some success at the state level in engaging stakeholders around primary care and behavioral health integration. At the practice level, Tennessee’s MCOs hold regular committee meetings—often with the larger practices—to discuss policies.

TennCare has just begun discussions with the three MCOs about how to collaborate toward a patient-centered medical home model, including the possibility of shifting care managers now housed at the MCOs to on-site at the practices. One MCO stated, “The good news is that the state is looking to us for new ideas.” TennCare sees the plans as the “content experts,” and the plans view the state’s role as convener as pivotal in order to garner buy-in around innovative options. TDMHDD also meets with the plans to discuss better ways to deliver integrated care, while discussing issues such as payment for behavioral codes in primary care and how to work with providers to help them access the codes.

The move to a carve-in managed care model has increased agency collaboration, resulting in shared resources and expertise on services that cross both medical and behavioral health issues. TDMHDD worked closely with TennCare during the transition and they continue to meet monthly. For instance, the TDMHDD Division of Alcohol and Drug Services has been working to educate Medicaid primary care providers about the value of linking with behavioral health services and to educate mental health and alcohol and drug providers about the importance of linking with FQHCs.

Tennessee’s Office of eHealth Initiatives is also convening a 30-member stakeholder committee to address information-sharing across disciplines. They have recently given a grant to one of the Tennessee regional

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health information organizations to conduct preliminary research on the kinds of laws that inhibit information exchange and the policy options needed to ensure exchange of information between primary care and behavioral health providers.

### **Summary of Key Integration Efforts in Tennessee**

Through a range of activities, Tennessee has succeeded in constructing a system of care for its Medicaid beneficiaries that provides elements of integrated care. These integration efforts include:

- “Carve-in” model of care requiring MCOs to provide for both physical and behavioral health care
- Payment for SBIRT to encourage primary care providers to screen for substance abuse problems
- Same-day billing for primary care and behavioral health visits
- Telehealth capability and payment support to enable remote psychiatric consultations in primary care settings
- Model integrated primary care and behavioral health systems (Cherokee Health)
- Co-location of behavioral health specialists at FQHCs
- Initiatives to address information-sharing across systems

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## MISSOURI

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Like Tennessee, Missouri has seen enormous changes in its Medicaid system over the past few years. As in many states, rapidly increasing costs led to a wholesale reconsideration of its Medicaid program. The subsequent transformation of Missouri's Medicaid program, still in its rollout stages, has also provided the state with opportunities to incorporate the latest thinking and practices in integrated behavioral health and primary care. As opposed to a single program, mandate, or transformative event, Missouri has taken an incremental and multi-faceted approach, identifying opportunities for change, making available key resources, and supporting productive partnerships in order to promote integration of care.

### OVERVIEW OF THE MISSOURI SYSTEM

Missouri is a geographically and demographically diverse state. While the central area of the state is generally characterized by cities, with an urban corridor created by U.S. Route 70 and the cities of Saint Louis, Columbia, and Kansas City, the rest of the state remains largely rural with few areas of urban concentration. As a result, Missouri's Medicaid system (known as MO HealthNet) has made strategic decisions to shape healthcare delivery and payment according to the various settings found across the state. Along Missouri's urban corridor, MO HealthNet is managing the care of Medicaid beneficiaries through multiple private managed care companies. In more rural areas of the state where the population base does not support managed care, MO HealthNet remains fee-for-service.

Across these two systems of care is the Chronic Care Improvement Program (CCIP), managed by APS, another managed care company. This program identifies MO HealthNet beneficiaries who have certain chronic diagnoses. Members enrolled in the CCIP program receive additional care management and coordination services to assist with management of these chronic conditions.

With a budget of more than \$5 billion, Missouri's MO HealthNet serves approximately 830,000 people across the state. Its Medicaid managed care program is a carve-in model and provides both physical and behavioral health services within a unified contract. MCOs generally subcontract these services, however. For children who have serious emotional disturbance, there is a formal "opt-out" procedure that, while seamless to the beneficiary, allows children to receive fee-for-service specialty care for their behavioral health needs.

Missouri's Department of Mental Health provides direct mental health services in 11 facilities across the state; most of these services consist of intermediate care and forensic beds. The Department of Mental Health in Missouri also contracts with 25 CMHCs. These contracts are flexible to allow the CMHCs to manage a mix of uninsured and Medicaid-funded clients. CMHCs can use their contract funds to either provide direct care to uninsured clients or to leverage Medicaid funding for MO HealthNet clients. For people with serious and persistent mental illness, Missouri CMHCs provide Comprehensive Psychiatric Services, which include housing, rehabilitation services, case management, and other specialty mental health services. CMHCs provide services to MO HealthNet beneficiaries in both managed and non-managed systems through fee-for-service payments.

In addition to the MO HealthNet program and Missouri's network of CMHCs, the state has 21 FQHCs and one migrant health center in both rural and urban areas, serving nearly 353,000 people per year. Missouri FQHCs and migrant health centers serve patients who are MO HealthNet beneficiaries, Medicare, private pay, as well as a large number of uninsured patients. Missouri's Primary Care Association works closely with MO HealthNet, the Missouri Department of Mental Health, and the Department of Health and Senior Services on various initiatives and specific projects.

## INTEGRATION LANDSCAPE IN MISSOURI

Much of Missouri's current activity in the integration of behavioral and physical health care dates back to the 2005 state Medicaid Reform Commission and its subsequent report. The Commission, comprised of state legislators and policymakers, focused its work on nine critical areas:

- Establishing a health care environment that fosters wellness and prevention, emphasizing personal responsibility for behaviors related to health care;
- Exploring the expansion of coordinated care to other areas of the state and other Medicaid groups;
- Increasing provider participation and satisfaction;
- Emphasizing the importance of using technology for electronic health records and e-prescribing, tele-monitoring and telemedicine;
- Encouraging state departments to collaborate on mental health care issues;
- Examining opportunities to control long-term care costs;
- Continuing and expanding upon opportunities to utilize evidence-based practices related to prescription drugs, while exploring efforts to contain pharmacy costs;
- Improving the availability of quality health care; and,
- Providing access to health care based on need rather than eligibility category.<sup>28</sup>

The Commission report and subsequent legislation led to the creation of MO HealthNet, Missouri's new iteration of Medicaid in 2007. This report provided a foundation for Missouri to transform its Medicaid system from a claims payer to a purchaser and manager of quality care. Many of the Commission's recommendations led to new policies and practices that promote behavioral health and primary care integration or resulted in continued support for existing integrative practices.

Starting with the Medicaid Commission Report, Missouri's state-level integration effort is characterized by its multifaceted approach, which incorporates integration-supportive principles into a variety of state policy strategies. Missouri is in the process of implementing these diverse strategies across the MO HealthNet agency, the Department of Mental Health, and state Primary Care Office, housed within the Department of Health and Senior Services. These initiatives are often linked, sometimes loosely; communication flows across settings through frequent formal and informal exchange among state agencies, providers, and state provider associations. Using this approach, Missouri has been able to provide opportunities for integration of care across its health care safety net of services.

## POLICY STRATEGIES THAT ENHANCE INTEGRATION

Missouri has made use of limited resources to integrate care by recognizing and strategically employing the variety of state roles and tools at its disposal.

### Legislative strategies

The 2005 Medicaid Reform Commission was able to review all aspects of Missouri's Medicaid program and develop recommendations that then became actionable in subsequent legislation. Working through the legislature, funding to initiate programs to integrate health care was secured for several key integration initiatives. The Commission was a bi-partisan effort involving both legislators and executive branch agency directors. By prioritizing Medicaid reform at both the legislative and executive levels, these recommendations gained traction. Invested and knowledgeable legislators were then able to support recommendations in the Governor's budget for funding a behavioral health and primary care integration pilot and other supportive initiatives.

### *The Behavioral Health and Primary Care Integration Pilot*

Following on the heels of the Medicaid Reform Commission Report, the Missouri legislature allocated \$1.4 million to fund a three-year integration effort through the Department of Health. The pilot supports participants—pairs

of CMHCs and FQHCs—to work together, co-locate services, and provide integrated care to their respective patients. The pilot focuses equally on improving behavioral health care access to the general population and improving physical health care access for people with severe mental illness.

This pilot aligns closely with several recommendations in the 2005 Medicaid Reform Commission Report, including:

- Support approaches to strengthening the linkages between federally qualified health centers and community mental health centers (#8)
- Support a public health approach that emphasizes prevention, early intervention, and integration of primary care with behavioral health services (#9)

Seven joint projects submitted by pairs of CHMCs and FQHCs were funded; each of the FQHC/CMHC partners received \$100,000 for each of three years. FQHCs were required to open primary care clinics on-site at the CMHC's, at least on a part-time basis. CMHCs were required to provide behavioral health services on-site as part of a primary care team at the FQHCs. Initially, each FQHC/CMHC partnership was given the flexibility to design their own projects; the pilot has shifted over time to a more consistent service model for providing behavioral health services as part of the primary care services at the FQHCs.

The CMHCs provide mental health professional staff to the FQHCs. These behavioral consultants—typically master's level clinicians or psychologists—provide short-term treatment and consultation as part of the primary care team. If more specialized behavioral health services are needed, patients are referred to traditional in-house counseling services at the FQHC, if these are available, or to the partnering CMHC, especially if it is determined the individual is suffering from a serious mental illness. The behavioral consultants also engage in behavioral interventions, such as working with FQHC patients who have chronic conditions that has a behavioral component to treatment. The FQHC operates a primary care clinic on-site at the CMHC to improve access to high quality physical health care for the CMHC's clients with serious mental illness, the type of client who is typically underserved by the health care system.

Centers used the funding for a variety of projects. CMHCs needed start-up funding in order to renovate their facilities to provide suitable examination rooms with a water source for the primary care services. FQHCs are using funding to provide co-located behavioral health services to their patients. This may mean short-term intervention and referral for people with serious needs, a behavioral intervention for patients who need assistance with a physical condition, or “curbside consultation”—informal staff consults on behavioral issues. FQHCs involved in the project needed to apply for a change in scope in order to open a site within the partner community mental health clinic. Sites and participants mentioned the importance of having the behavioral consultant physically located within the primary care setting as an important component of the integration process.

While the project is funded currently through state general fund dollars, Missouri agencies are working to identify sustainability strategies, and are using their role as payer to explore specific options that can leverage Medicaid resources for sustainability.

**Supporting practices with technical assistance.** To help support practices, the Missouri Coalition of Community Mental Health Centers received a grant on behalf of the initiative from the Missouri Foundation for Health to fund a three-member technical assistance team. The technical assistance grant was accomplished through a partnership between the Missouri Coalition of Community Mental Health Centers, the Missouri Primary Care Association and the Missouri Department of Mental Health. The team provides project coordination, training, and technical assistance to FQHCs and CMHCs participating in the Behavioral Health and Primary Care Integration pilot.

Missouri's Primary Care Office (PCO) has also contracted with Ozarks Public Health Institute to create a comprehensive handbook targeting FQHCs entitled “*Integration of Mental Health into Primary Care, A Review of Literature and Practice Recommendations.*”<sup>29</sup> The handbook serves as a desk reference for physicians, offering latest best practices.

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**Funding health information technology: CyberAccess.** The Missouri legislature also provided funding for a significant investment in health information technology (HIT) for its health care beneficiaries. As part of a \$25 million funding package for HIT, the Missouri Legislature allocated \$3.4 million to fund CyberAccess, an interactive web portal that provides real-time transmittal of health information for MO HealthNet providers and other state-funded health care services. CyberAccess supports e-prescribing, allows practitioners to access a variety of health information about their patients, and permits providers to receive prior authorizations online. The tool lets providers—both FQHCs and CMHCs that participate in MO HealthNet—share medical information on patients, which is key to integration efforts.

### **Payment strategies**

Missouri has made efforts to have its payment policies dovetail with various integrated health care initiatives. In particular they are creating billing structures that will support the long-term sustainability of grant-funded pilot projects. The following represent some of the tools that Missouri has been using to sustain primary care and behavioral health integration:

**Paying for same-day primary care and behavioral health visits.** Same-day billing for behavioral health and primary care physician services is a crucial component to integration. As mentioned previously, in many states, same-day billing is disallowed. Although based in fraud prevention, the prohibition has the effect of curtailing the kind of unscheduled, consultative services that many integrated programs have come to rely upon as a key factor in providing comprehensive patient-centered care. The prohibition can also mean that a patient with travel barriers, child care issues, or work schedule conflicts is at best inconvenienced or, at worst, misses or never schedules another appointment.

The policy on same-day billing in Missouri remains unclear for many providers, but discussions between and amongst the Department of Mental Health, MO HealthNet, and the Primary Care Association appear to be making progress. Although, there is currently no official regulatory barrier to same-day billing, claims do get rejected and the various Medicaid managed companies may have policies or interpretations that result in denials. Officially, however, MO HealthNet is supportive of same-day billing, and continuing discussion on the issue appears to be helping to remove roadblocks.

**Paying for screening codes.** Although Missouri has not yet adopted and begun payment for SBIRT codes, it is currently engaged in a five-year Substance Abuse and Mental Health Services Administration (SAMHSA) initiative to broaden the availability of SBIRT across the state. The SAMHSA grant focuses on training and placement of behavioral providers (Health Coaches) in primary care and ER settings, including placement in FQHCs. Although the need for these codes is critical to sustaining this service, there is some resistance to implementation because of added costs.

**Paying for behavioral health consultation codes.** The Centers for Medicare and Medicaid Services recently approved a set of codes that allows billing for behavioral health services targeted to an underlying physical diagnosis; no mental illness diagnosis is required for these codes.<sup>30</sup>

For this reason, these codes can be very useful in integrated health care settings, such as FQHCs with a co-located behavioral consultants. The codes allow providers (generally, psychologists) to implement and support behavioral care plans for people with chronic illnesses. While Missouri has not yet made the decision to “turn on” these codes in its MO HealthNet program, discussions about it are underway among various state agencies as part of an overall sustainability strategy under its Behavioral Health Integration Pilot.

**Supporting the use of health information technology.** Missouri has paid for telehealth for psychiatry consults as a Medicaid benefit for about three years. Both participating providers (calling and receiving) are allowed to bill

for the service, providing an incentive for both the primary care doctor and the psychiatric professional. Many FQHCs in Missouri are now employing this technology to provide services to more rural areas of the state.

Missouri promotes and encourages the use of its CyberAccess service to its MO HealthNet providers. Providers are paid a fee to log on to CyberAccess, MO HealthNet's HIPAA-compliant portal, and utilize the care plan for MO HealthNet beneficiaries. This "pay-to-play" policy gives providers incentives to use the electronic health record and, because a variety of information is available through CyberAccess, including pharmacy and mental health, providers are able to integrate and coordinate care more effectively.

**Funding Psychosocial Rehabilitation Services.** Missouri has explicitly integrated health care coordination as a component of Psychosocial Rehabilitation Services, its community support program for people with mental illness. A recent communication to providers of this service offered guidance on how to modify the focus of service so that it includes the added component of wellness and recovery, including health. The letter to providers includes an integrated definition of wellness as "*(a) lifestyle (that) incorporates a self-defined balance of healthy habits such as adequate rest, exercise, nutrition, productivity, social contact/supportive relationships and engagement in meaningful productive activity/occupation.*"<sup>31</sup>

The letter specifically instructs MO HealthNet community mental health providers to bill for services to promote health and wellness, as opposed to a strict focus on traditional mental health rehabilitative needs that included a large percentage of leisure, social, or recreational activities.

**Paying for integrated nursing care.** Missouri pays CMHCs to provide onsite primary care nursing services to their clients. This is in addition to the Behavioral Health and Primary Care Integration Pilot effort. Nurses are on site and able to provide routine check-ups, screenings, and other primary care functions to patients with serious mental illness.

### Contracting strategies

As purchasers of health care, states can structure contracting language for MCOs, providers, and other organizations to support the integration of care.

**Targeting chronic care support.** Missouri has a major initiative tied to MO HealthNet, the Chronic Care Improvement Program, which provides primary care case management to approximately 180,000 MO HealthNet fee-for-service beneficiaries who have one or more of six specified chronic illnesses. MO HealthNet contracts with APS, a disease and care management company, to oversee the program, which combines disease management and electronic health tools to manage the care of people with these chronic illnesses. Services and information across physical and mental health settings are integrated through the electronic health record, and all parties with an appropriate interest in the information can access it. Behavioral health services are integrated in the approach. Although serious mental illness is not one of the diagnoses that allows for eligibility into the program, the service is in fact managing the care of many people with mental illness due to the high rates of diabetes and pre-diabetes for people taking psychotropic medications. Under the program, any provider, including both FQHCs and CMHCs, can become a medical home for people with complex needs. Current usage indicates that approximately 10 percent of people in the Chronic Care Improvement Program have identified a CMHC as their health care home.

In typical PCCM programs, a Primary Care Provider (PCP) receives a monthly case management fee for each enrolled Medicaid beneficiary (enrollee) in addition to fee-for-service reimbursement for all services provided by the PCP to enrollees. In return, the PCP is responsible for providing primary care and managing access to other providers. The Medicaid agency will not pay for services provided to enrollees by a provider other than the PCP without the approval of the PCP.

**Providing support for behavioral pharmacy management.** Missouri has contracted with Care Management Technologies to direct its Behavioral Pharmacy Management Program. The program reviews MO HealthNet prescription patterns for over 400 mental health medications, and compares these prescribing patterns to national best practice guidelines. The program also informs physicians when their patient has not refilled a prescription and physicians receive regular information regarding mental health best practice guidelines. The program serves as a guide for primary care physicians, many of whom do not have a particular specialty in behavioral health, but prescribe frequently for these conditions.

### Regulatory strategies

The Department of Mental Health, in its role as regulator, requires that all CMHCs provide clients with screenings for risk factors for certain chronic conditions. This requirement is facilitated by the ability to bill for health-related coordination services under Missouri's Psychosocial Rehabilitation Services option, and by the funding and placement of nurses in all CMHCs.

### Cross-systems strategies

Missouri has crossed agency boundaries with its multi-modal approach to integrating behavioral health and primary care services. Regular meetings between MO HealthNet, the Department of Mental Health, the Department of Health and Senior Services, Missouri Primary Care Association, and Missouri Coalition of Community Mental Health Centers provide Missouri with a regular flow of information, trouble-shooting opportunities, and needs assessment for integration.

Missouri's Department of Mental Health was instrumental in convening stakeholders in support of integration activities. Leadership within that department reached out to both the FQHC and the CMHC communities. Historically, these two provider communities have viewed each other with some distrust and as competitors for scarce state dollars. Across states, CMHCs typically look upon the FQHC cost-settled budgeting process and liability protections as unfair advantage, while FQHCs—whose mission requires serving the uninsured—often feel that CMHCs might “cherry pick” Medicaid recipients and refer the uninsured to the local FQHC. These and other issues have kept the two provider groups from working together. Missouri's role as a convener across these two interest groups was an important lever; rather than competing for funding before the legislature, the groups were successful when they came together to make the case for funding an integration initiative in the wake of the Medicaid Reform Commission report.

Missouri's convener role continues as it develops solutions and work-arounds for various problems encountered on the road to integrating the FQHC and CMHC sites. For instance, Missouri officials discovered that due to state law, funding FQHC integration grants through

#### Summary of Key Integration Efforts in Missouri

- Training primary care providers to screen for substance abuse problems
- Behavioral Health and Primary Care Integration Pilot
- Same-day billing for primary care and behavioral health visits
- CyberAccess: integrated health information
- Telehealth capability and payment support to enable remote psychiatric consultations in primary care settings
- Nurse Liaisons in CMHCs to screen for health problems
- Physical health screen requirements for Psychosocial Rehab Programs
- Chronic Care Improvement Program to care for complex patients
- Primary Care Office publication, *Integration of Mental Health into Primary Care, A Review of Literature and Practice Recommendations*

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its Department of Social Services would avoid impact to the FQHCs' cost-based reimbursement, making participation in the project much more attractive to these providers. Discussions continue, as noted, on multiple billing issues, such as health behavioral assessment codes and SBIRT, billing supports that may ultimately make the difference in sustainable integrated services.

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## KEY THEMES AND LESSONS LEARNED

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Tennessee and Missouri are very different states. While Tennessee has embraced a carve-in managed care system for all of its Medicaid beneficiaries, Missouri has contracted with MCOs, administrative service organizations, and retains a fee-for-service system in some parts of the state. Likewise, these states' solutions for supporting integrated care are different, but key themes across the two states emerged and are summarized below.

**Identify and engage expertise.** Both states recognize the importance of engaging expertise from the private sector in order to promote integration. Tennessee has been open to and has actively sought input and insight by MCOs, the Tennessee Primary Care Association, Tennessee Association of Mental Health Organizations, and CMHCs and FQHCs, whom the state agencies refer to as their “content experts.” Tennessee, through a collaborative RFP process that involved both Medicaid and mental health input, sought out MCOs that were able to demonstrate a commitment to integrative practices.

In Missouri, state officials sought out private vendors to manage integrated care for complex populations with chronic illnesses. State officials also deferred to the expertise of FQHCs and CMHCs in initiating the behavioral health primary care pilot work, and drew lessons from this work to inform pilot activities.

Both state governments, by identifying where and when external expertise from providers and plans were needed, were able to promote integration efforts in their safety net programs.

**Identify and engage champions.** Both states have strong state and local leadership that has promoted progress toward integration goals. In addition to leadership from TennCare and TMHDD, Cherokee Health System has been a local champion in working with state officials, the primary care association, MCOs, and others, and has been pushing to spread its model even without dedicated funding. Cherokee has consulted and arranged with non-Cherokee FQHCs for access to behavioral health providers in order to start up new integration efforts. For instance, Cherokee pays for a psychologist to work part-time on the primary care team at the Matthew Walker Clinic, a non-Cherokee FQHC in Nashville.

Missouri has been adept at engaging both state policy champions (within MO HealthNet, the Department of Health and Senior Services, and the Department of Mental Health) and private sector leaders who became active in the state's integration efforts. Important for Missouri's efforts, champions of integration came from all points on the spectrum of integration. MO HealthNet promoted integration efforts for its Medicaid beneficiaries, including those with chronic care illnesses; the Department of Mental Health was instrumental in bringing together a variety of stakeholders to obtain funding for pilot efforts that could also improve services for people with serious mental illness. The Department of Health and Senior Services provided leadership in promoting specific learning opportunities for primary care providers. Leaders representing safety net services were engaged throughout to ensure local and statewide participation .

**Flexibility is important.** Both Tennessee and Missouri's integration efforts are notable for the flexibility state officials have shown in making the health care system work for the individual practice setting and for the beneficiary. Missouri's integration pilot was shaped by allowing the FQHC/CMHC partnerships the discretion to develop programs tailored for individual sites and community resources. The CCIP program allows any provider to become the health care home for a MO HealthNet beneficiary, whether that site is an FQHC or CMHC. An inclusive and flexible definition for psychosocial rehab services provides incentives for providers to include health care in that ser-

*“The more you tell people how to do something, the less likely they are to do it.”*  
Missouri state official

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vice spectrum. Missouri has found that implementation of integrated care means using the tools and resources available while consistently focusing on the individual, regardless of setting, provider, or diagnosis.

After an MCO selection process that included an explicit behavioral health framework, Tennessee afforded the selected MCOs wide latitude in designing and creating integrated networks of care. MCOs were therefore free to implement payment innovations (such as contract rates with one provider) that supported integrated care.

**Focus strategies to strengthen the safety net.** Both Missouri's and Tennessee's efforts have given safety net providers a greater ability to serve their patients in an integrated and holistic fashion. Various initiatives undertaken by the state of Missouri have provided support and resources to both CMHCs and FQHCs in the state. These resources were not necessarily developed at the same time by the same state agencies, but the overall impact on safety net providers is significant. Likewise in Tennessee, safety net providers are supported through the availability of SBIRT and same-day billing and Peer Supports services that promote integration.

**Take a multi-modal approach.** As discussed, both Tennessee and Missouri have taken advantage of a variety of opportunities and strategies to support FQHCs and CMHCs in providing more integrated care. From these varied and incremental changes, an integrated system of care is beginning to emerge. Patients who obtain access to care at FQHCs in these states are now more likely to experience care that addresses their behavioral health needs as well as their physical care. Many with significant behavioral health needs are now able to obtain access to coordinated health care, either directly through CMHCs in Missouri, or through a carve-in system of care in Tennessee.

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## CONCLUSION

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Tennessee and Missouri have different approaches in their journey toward a common destination: patient-centered medical homes that integrate primary care and behavioral health. Tennessee's approach followed a fiscal crisis within its Medicaid program that led to the disenrollment of tens of thousands, many with severe mental illnesses. The urgent need to restructure Medicaid led to an opportunity to build an integrated framework that brought together state Medicaid and mental health agencies. This collaboration led to contract language that provides clear expectations for MCOs. Tennessee benefits from having local champions to keep the wheels moving toward integration. In addition to state leadership, having a nationally recognized FQHC/CMHC leader in Cherokee Health and an active primary care association provides expertise and advocacy in pushing for changes.

Like TennCare, Missouri Medicaid also is undergoing extensive restructuring in its conversion to MO HealthNet. The state has taken advantage of this transition to weave integrated care principles and policies throughout its changing system of health care. Rather than a single major initiative, Missouri has chosen to use resources strategically, employing a variety of tactics with cumulative effect. Missouri's Medicaid office, its Department of Mental Health, Department of Health and Senior Services and its Primary Care Office are all involved in the effort. The result is a system of safety net providers—in both primary and behavioral health care settings—that now have access to tools that allow them to treat the whole person and a window of opportunity to change the larger delivery system as well.

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## ENDNOTES

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- 1 The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.
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- 8 In 1996, the Health Centers Consolidation Act combined community, migrant, homeless, and public housing health centers—under one umbrella, in section 330 of the Public Health Service Act. This law provided federal grants to health centers that meet certain statutory requirements.
- 9 CMHCs were created through the Community Mental Health Centers Construction Act of 1963. The program was changed significantly in 1981, when the Omnibus Budget Reconciliation Act converted the program into a block grant to states and reduced available funding.
- 10 OBRA 1989 created the federally qualified health center program. The FQHC applies to 3 types of clinics: Community health centers that meet certain criteria under the Medicare and Medicaid programs and receive federal grant funds under the Health Center Program, Section 330 of the Public Health Service Act; Look-Alike Health Centers that are public and private non-profit clinics that meet all the Health Center Criteria but do not receive federal grant funding; and Tribal or Urban Indian Federally Qualified Health Centers that are outpatient health programs or facilities operated by tribal or urban Indian organizations. FQHCs described in this paper do not include tribal FQHCs.
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- 15 FQHCs do not receive any of the Behavior Health Safety Net funds.
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- 27 The MCOs reimburse the FQHCs either on a capitated (risk) basis considering adverse selection factors or on a cost-related basis and are required to report this information at least annually to TennCare. Each quarter, FQHCs are required to report the number of actual visits and the corresponding MCO payments for services provided to TennCare beneficiaries. TennCare then makes quarterly “wrap-around” payments to the FQHCs for the difference between the MCO payment received and the adjusted prospective payment rate for the FQHCs. Please see <http://www.tn.gov/tenncare/forms/opchapter4.pdf> for more information.
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