STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

Successful implementation of health care reform is heavily dependent on the actions taken by states and the coordination of efforts between federal and state officials. Communication and collaboration among federal and state leaders at a level beyond specific federally defined programs and policies is increasingly critical to align interests and maximize efforts to improve health system performance.

This *State Health Policy Briefing* captures key lessons and opportunities for alignment that surfaced during an August 2014 meeting of high-level federal and state leaders convened by NASHP with the support of The Commonwealth Fund. The meeting offered these officials the chance to learn and share strategies, initiatives, and opportunities to better integrate physical and behavioral health, and featured case studies from Arizona, Missouri, and Tennessee. The conversation spanned payment models, information and data sharing approaches, as well as operational strategies for achieving integration.

NATIONAL ACADEMY *for* STATE HEALTH POLICY

Briefing

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Promoting Physical and Behavioral Health Integration: Considerations for Aligning Federal and State Policy

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Federal and state policymakers are grappling with the challenges faced by those with physical and behavioral health co-morbidities, including shortened lifespans, functional impairments, and high health care expenses. Because greater integration of physical and behavioral health service delivery has the potential to improve outcomes while saving money, supporting integration at the financial and delivery levels is critical. Substantial opportunity exists for federal and state leaders to align approaches to support a range of integrated care models, from coordinated separate systems ("virtual co-location") to physical co-location and full financial and technical integration of physical and behavioral health services.

Designing Payment to Support Integration

Improved integration of physical and behavioral health services will require greater integration of payments for these services. Financial barriers including lack of support for behavioral health care management under fee-for-service reimbursement, siloed funding streams, and a lack of flexibility in existing payment models to support shared responsibility between physical and behavioral health care providers and team-based care have all contributed to fragmented service delivery.[4] Policymakers interested in supporting integration will need to consider strategies for financing, including new payment models to support innovative delivery designs and financial integration approaches at the health plan level. Several key themes emerged during the August 2014 meeting.

States can capitalize on a variety of federally backed policy levers to support the integration of funding for physical and behavioral health care services. Medicaid programs in particular —either alone or as part of multi-payer initiatives—offer substantial opportunity for financial and regulatory changes that can facilitate integration.

- The State Innovation Models (SIM) initiative launched by the CMS Innovation Center is a grant opportunity to promote multi-payer payment and delivery system reforms that can promote integration. **Minnesota** is using its SIM award to build Accountable Communities for Health that will help bridge the physical and behavioral health systems.[5]
- Section 1115 Medicaid demonstration waivers provide flexibility for Medicaid payment innovations. **New York** is operating a Delivery System Reform Incentive Payment (DSRIP) program within its Medicaid program under a Section 1115 waiver that will allow it to support infrastructure facilitating integration.[6]
- The Medicaid health homes state plan option provides eight quarters of enhanced federal matching funds to support health homes. **Iowa** is implementing plan-level Medicaid health homes that partner with community mental health centers to meet the whole-person needs of Medicaid beneficiaries.

> **The federal conversation has advanced to the point where CMS is pushing the states…we can no longer blame the feds for not having the content available to solve this.**
>
> ***– State Medicaid Official***

State Snapshot:
Arizona's Integrated Regional Behavioral Health Authority

Medicaid behavioral health benefits in Arizona are provided by the Division of Behavioral Health Services in Arizona's Department of Health under a contract with the state Medicaid agency. These carved out Medicaid behavioral benefits are administered by four community-based managed care organizations known as Regional Behavioral Health Authorities (RBHAs) that serve six geographic service areas.

Arizona is experimenting with an integrated care RBHA in Maricopa County. Under a model the state describes as "Recovery through Whole Health," adult Medicaid beneficiaries with serious mental illness enrolled in that authority will receive coordinated, integrated physical and behavioral health care services under one plan.

The integrated care RBHA in Maricopa County launched in April 2014 and is responsible for providing an integrated continuum of care delivered through a combination of health home approaches, community focused services and interventions and system-wide technology transfer.

Federal and state partners can facilitate a single point of financial accountability by collaborating to integrate funding for physical and behavioral health services. Payment models at both levels of government can be better configured to reduce fragmentation between physical and behavioral health delivery systems by:

- Re-thinking carve-outs of behavioral health in state Medicaid programs to better integrate funding streams;
- Considering transition steps to increasingly risk-based payments. Public payers can begin by focusing on concrete goals for integration with bonus payments; and
- Designing inclusive per-member per-month payments, allowing flexibility for integrated care models.

Operational considerations are critical as payers move toward more consolidated payment. Financing strategies may need to be coupled with other policy changes to ensure integrated funding streams can have the intended impact. As one meeting participant put it, policy challenges to co-location of services—restrictions on "who [which providers] can do what, when, and where"—could limit the opportunity to achieve full technical integration of physical and behavioral health teams.

Integrating physical and behavioral health into a broader system-wide shift toward population management and population-based payment models will require the attention of policymakers to a number of factors. For instance, the composition of the Medicaid population will be shifting beyond traditional Medicaid beneficiaries as many states expand their programs under the Affordable Care Act. Ensuring continuity of care for the newly eligible with physical and behavioral health co-morbidities will be critical for new payment and delivery models. Meeting participants also stressed the importance of understanding where funds are flowing and how they are being used for reasons of assuring program integrity.

State Snapshot:

Missouri's Medicaid Health Homes for Enrollees with Chronic Conditions

In 2011, Missouri became the first state to receive approval for a Medicaid State Plan Amendment to implement Health Homes under Section 2703 of the Affordable Care Act. The first Health Homes in the state went into operation on January 1, 2012.

According to CMS, the Health Home model is intended to "expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses." The whole-person approach extends to Medicaid beneficiaries with a serious mental illness who are eligible for Health Home Services.

In Missouri, Community Mental Health Centers (CMHCs) qualify as health homes. CMHCs serving as health homes co-locate services, providing comprehensive physical and behavioral health care to Medicaid patients.

Leveraging Data and Information

The collection and synthesis of physical and behavioral health data is a critical element of integration. Yet regulatory barriers, provider misperceptions of restrictions on information sharing or lack of experience in sharing data with other provider types, and a lack of information technology in behavioral health settings can all inhibit the use of data to facilitate integration. Federal and state policy is needed to support comprehensive strategies for the collection and exchange of physical and behavioral health information and create a more integrated delivery system.

> **"Data are powerful, but we have so much data and not enough *information*."**
> **– *State Medicaid Official***

Federal and state policy can support new approaches and tools for leveraging data. Purchasing strategies alone cannot build infrastructure. Policymakers at both levels need to develop complementary strategies for supporting telemedicine and telepsychiatry, as well as tools including all-payer claims databases (APCDs) and other data sources that can support effective utilization of behavioral health data in physical health settings and vice versa.

States are finding ways to convert data into useful information for physical and behavioral health providers. For instance, prescription drug diversion was a particular point of interest for meeting attendees, as many states are grappling with opioid and psychotherapeutic drug abuse issues.

- **Missouri** has used its data infrastructure to analyze pharmacy claims, alerting physicians whose prescribing patterns for mental health medications deviate from evidence-based practices.
- **New York's** Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) is a web tool that provides decision support and information derived from claims data to prescribing physicians; the tool has helped to reduce polypharmacy for children in the state.[7]

At the federal level, the Centers for Medicare & Medicaid Services (CMS) has highlighted strategies for reducing prescription drug diversion in Medicaid programs and areas for federal-state collaboration on the issue.[8]

Measurement strategies can help to drive integration. Federal and state purchasing strategies are shifting toward rewarding value, linking payment incentives to performance on quality indicators. If greater integration is an expected component of higher-value service delivery, measures used in new federal and state payment models can gauge the degree to which providers are implementing features of integrated care. Measures, particularly at the plan level, that span both systems may spur greater integration of physical and behavioral health data to satisfy reporting requirements.

- **Oregon's** Medicaid benefit is now managed by Coordinated Care Organizations that are held accountable based on a set of Medicaid incentive quality measures. Measures reflecting integration—such as a quality metric examining the percentage of children in state custody who receive a physical and mental health exam within 60 days—are encouraging connections between information technology systems and processes in the physical and behavioral health delivery systems.
- In **Colorado**, some Medicaid behavioral health providers are unable to access information compiled by the state's data analytics contractor directly, and partner with primary care medical homes to do so.

Ultimately, data collection and measurement strategies will need to draw on new data sources. Incorporating data drawn from sources beyond the medical—including social and human services datasets—will allow for a more comprehensive, whole-person perspective on beneficiaries with complex co-morbidities.

> **"Until you change the way providers are thinking about the way they're serving people, you're building infrastructure with no change."**
>
> ***– State Medicaid Official***

Making Integrated Care Delivery a Reality on the Ground

Even with sufficient financial and data supports, providers face challenges in integrating physical and behavioral health services. As providers take on greater responsibilities and engage with new partners, they may need to change office culture, redesign workflows, and build new skills and workforce capacity to meet the varied needs of patients with physical and behavioral comorbidities. Making integration a reality at the delivery level by moving toward models of coordinated care, co-location, or full systemic integration of physical and behavioral health services will require policy supports beyond the financial and technological. Participants at the August meeting identified key opportunities for federal and state partners to provide or sustain these supports.

Policies promoting integration must include supports for changing provider and health system culture. Re-designing care delivery to meet the needs of patients with physical and behavioral health co-morbidities will require new relationships between providers and a new concept of shared accountability for the whole person. In the long-term, a dialogue between state and federal partners and medical educators can help prepare providers for this cultural shift. Meeting participants agreed that provider training on implementing new care

models such as the patient-centered medical home must be designed to make primary care physicians comfortable approaching behavioral health issues, particularly for patients with less severe behavioral health conditions

Some federal initiatives are aimed at helping spur the needed cultural and technical changes in the provider community. For instance, the Substance Abuse and Mental Health Services Administration has launched a Recovery to Practice initiative designed to encourage a recovery-oriented philosophy in the culture and practice of mental health professionals, while the Center for Integrated Health Solutions offers providers technical assistance to support integration.[9] [10]

Both levels of government need to consider opportunities for building new partnerships and strengthening existing relationships. In particular, local partners can be critical for ensuring that integration of service delivery is a reality. Meeting participants specifically suggested the need for strong connections to a variety of partners, including:

- The mental health crisis system, including mobile crisis teams;
- Community mental health centers;
- Prison systems; and
- American Indian tribes.

One state official noted that state leaders often have limited influence over the public mental health system, which may be rooted at the local or county level, underscoring the importance of strong intergovernmental relationships.

Care coordination and case management programs at the federal and state level can be simplified and streamlined. Meeting participants agreed that helping patients with physical and behavioral health co-morbidities navigate the health system is critical. Yet the patchwork of federal case management and care coordination definitions poses challenges to the workforce most directly engaged in facilitating more integrated service delivery. Countless forms of case management and care coordination correspond to care silos and complicate the training and coordination of care coordinators. Noting that there are care coordinators in managed care organizations, health homes, mental health centers, and other entities, one meeting attendee commented "we're crawling in care coordinators." A clearer federal vision and guidance on the relationships of different forms of care coordination could help states develop more coherent coordination strategies.

In some circumstances, integration may be easier to achieve virtually than through co-location. Existing facilities may face practical constraints including space limitations and differences in provider culture. For instance, many primary care physicians may prefer

State Snapshot:

Tennessee's Integrated Medicaid Managed Care Organizations

TennCare, Tennessee's Medicaid managed care program, is one of the oldest such programs in the country and it enrolls the state's entire Medicaid population in one of nine managed care plans. Beginning in 2007, Tennessee began combining physical and behavioral health services (as well as long-term services and supports) in managed care contracts, a process the state completed in 2009. All managed care plans now integrate physical and behavioral benefits.

Beyond requiring coverage of both physical and behavioral health care services, managed care contracts under TennCare include several provisions promoting integration, such as requirements that managed care organizations:

- Coordinate care among primary care, behavioral health, specialty, and long-term care providers;
- Integrate data from interoperable physical and behavioral health information systems;
- Risk stratify members with co-morbid physical and behavioral conditions for complex case management; and
- Develop policies and procedures ensuring a full continuum of physical, behavioral, and long-term care services.

not to practice in community mental health centers. Shortages of mental health professionals in some communities may also render virtual integration more practical than on-site integration. Policymakers at the state and federal levels must be mindful of the need for policy approaches that are flexible enough to accommodate multiple models of integration.

Moving Forward

Several concrete suggestions emerged from the August 2014 meeting.

- Federal behavioral health block grants could be made less prescriptive, offering states greater flexibility to achieve specified outcomes.
- States can build on and work with efforts by the Veterans Administration to braid different funding streams and link data sets.
- Federal and state policies recognizing and supporting telehealth services can advance the virtual co-location of behavioral and physical health services.
- Integration initiatives launching in states can bring in federal partners to listen and learn about states' approaches early on, enabling closer collaboration as initiatives evolve.
- Data must be useful to providers. The inclusion of Medicare data in the information states are offering providers to support integration would make physical and behavioral health providers alike more apt to use it.

Conclusion

Greater integration of physical and behavioral health services is critical for meeting the unique needs of patients with physical and behavioral health co-morbidities. Federal and state health policy will need to operate in concert to effectively support this goal. Both levels of government must explore new strategies for incorporating integration into the new generation of value-based payment models each is rolling out. Information and data supports being put into place in conjunction with the implementation of these models can further support this goal, introducing usable behavioral health data into medical settings and vice versa. Yet realizing a more integrated system and helping patients navigate available physical and behavioral health supports will require key shifts in the health care workforce's training and culture. To meet these challenges and take advantage of these opportunities, the federal government and the states can together construct a comprehensive, coherent policy framework supporting integration.

Endnotes

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