BEHAVIORAL HEALTH-PRIMARY CARE INTEGRATION

LEARNING COLLABORATIVE

Health & Medicine
POLICY RESEARCH GROUP

POLICY LESSONS ON INTEGRATION FOR ILLINOIS

Introduction

For the past two years Health & Medicine's Center for Long-Term Care Reform has worked with a group of providers, consumers, and payers to identify actionable strategies to improve integration of behavioral health and primary care. While refining our six integration criteria and exploring ways to operationalize them in the real world, we identified numerous policy barriers to successful integration.

The policy analysis that arose from the Learning Collaborative's discussions intersects with the "Pillars of Reform" that Health & Medicine has been advocating for in coalition with state behavioral health advocates. In the 2017 Illinois legislative session, guided by the Six Pillars, we have supported bills to expand capacity for early identification and treatment, implement evidence-based First Episode Psychosis interventions, expand treatment alternatives to incarceration, and improve access to telepsychiatry. These issues are important parts of a high-functioning behavioral health care system, and a robust health advocacy community in Illinois has driven action on them through legislation. There has also been vigorous policy debate related specifically to integration of behavioral health and primary care, as advocates respond to the State's plans to implement Integrated Health Homes across Illinois as part of its Health & Human Services (HHS) Transformation.

The Learning Collaborative's convening and planning took place within the context of this statewide conversation about behavioral health reform. Distilling the responses of the Learning Collaborative members, this paper will offer our broad perspective on the policy needs for integration, focusing on three key areas related to integrated primary care and behavioral health in Illinois:

- Building capacity by reforming **regulations and reimbursement**
- Supporting data systems and **information exchange**
- Developing an adequate **workforce** for integrated care

Reimbursement and Regulation

Providers in Illinois have been calling for Medicaid rate increases to cover the true cost of services for people with mental illness and substance use disorder (SUD) for years. A 2016 report by the Illinois Partners for Human Services describes the position of mental health agencies: "Mental health providers indicate that the reimbursement rates are too low to enable a provider to meet need, develop staff, and improve programs." The Department of Healthcare and Family Services (HFS) has consistently opposed across-the-board increases to reimbursement rates for Medicaid behavioral health services, insisting that providers must adapt to quality-based payments.

We accept these positions--that rates need to increase and that across-the-board increases are out of the question--as the parameters for the discussion of reimbursement in this paper. In the longer-run we believe that much more research into the actual costs of effective, integrated behavioral health and primary care and into potential outcomes, including cost savings and cost avoidance, will be necessary to set rates that support optimal use of resources in the healthcare system.

In the meantime, a more incremental approach leads us to consider two strategies to adjusting reimbursement to cover costs and enable transition to value-based payments:

- targeted rate adjustments
- streamlining regulations to make more of every rate-dollar go to direct services rather than administration

Illinois has already recognized a role for targeted rate add-ons to maintain vital mental health services. In July 2016, the Department of Health Care and Family Services created Medicaid rate add-ons for psychiatry services. Until the Rauner administration eliminated them, Psychiatric Leadership Grants had covered the cost of psychiatry at community mental health centers, but were paid outside of rates. Those grants did not require providers to bill for specific services to receive grant funding, and they did not generate federal Medicaid matching payments. The new rate add-on takes the place of the grants, building a more realistic cost of psychiatry into the Medicaid rates though only temporarily unless they are extended in 2017. Hence, this is an example of a targeted rate adjustment that fills a need to maintain psychiatric capacity in the community and brings additional federal revenue into the state.

The Learning Collaborative's **Financial Sustainability Workgroup** is considering the question of how to measure the start-up costs, ongoing operational costs, and revenue cycles of integrated care. The Workgroup is launching a feasibility study to (1) establish the costs to design, start-up, and run an integrated model based at a behavioral health organization in a major urban setting, with primary care embedded; (2) optimize revenue streams; and (3) explore alternative payment arrangements, case rates, and administrative changes that are necessary to establish financially sustainable integrated services.

This recent rate adjustment brings up another important issue--paying for non-billable services when they assist in one's treatment. For example, attempting to locate hard-to-reach individuals to engage them in treatment can be a necessary step to facilitate access to billable services, like counseling and psychiatry. The recent rate add-ons reflect recognition of the importance of psychiatric care in community-based settings: If we do not pay an adequate rate for psychiatry, people will lose access to community psychiatry, and instead turn to hospital emergency rooms or worse, find themselves in jails and prisons.

But for individuals for whom environmental and social factors, such as housing instability and prior bad experiences in the healthcare system, combine with symptoms of depression, anxiety, SUD, or

psychosis, having a psychiatrist available at a community mental health center is just not enough. Outreach in the field to first locate and engage with individuals, then building trust and assisting in the arrangement of appointments to receive treatment is a necessary step, but 'outreach' does not always result in a formal 'encounter' that can be recorded on a Medicaid claim.

Illinois has a long experience of using grants to supplement Medicaid psychiatry rates and now has a new experience with use rate add-ons. Grants allow more flexibility for providers, while rate add-ons bring more accountability through the billing process (along with federal matching funds). One of the promises of managed care is harnessing of the flexibility and accountability of capitated payments or per member per month payments that managed care organizations can use to pay for services tailored to the needs of their members, but that also exert a pressure to contain costs. This is a delicate balance, and the federal Center for Medicare and Medicaid services created new rules in 2016 that demand more accountability in the form of more rigorous collection and quality control of the encounter data that MCOs submit to States. Illinois has also made improving encounter data submission a priority by including encounter data submission rates in its algorithm to determine auto-assignment of members and per member per month payments to MCOs.

The preoccupation with encounter data is understandable. The capitated managed care model turns over many responsibilities to contracted MCOs. But the fundamental tasks of capitated rate setting--risk-adjustment, quality measurement and performance incentive development, and ensuring program integrity--all remain with the State. None of those jobs can be done well without accurate, timely data on the services and supplies that MCOs are purchasing for their members, linked to equally accurate and timely data on outcomes.

Yet MCOs and their networks of providers cannot do the job of providing quality, person-centered integrated health care to hard-to-reach members if they cannot build in some quantity of non-encounterable services, like outreach and engagement in communities. Thus a common challenge for the State, MCOs, providers, and consumers is to develop a method to account for the provision and outcomes of those non-encounterable outreach and engagement services to fine-tune the balance between flexibility and accountability in managed care.

MCOs and providers are already discussing ways to approach the issue of tracking and reimbursing non-encounterable services that will satisfy federal requirements, maintain adequate oversight of program integrity, and facilitate innovative strategies for care coordination for hard-to-reach, high need Medicaid members. We hope the Learning Collaborative can be a crucible for creative ideas as the State moves forward with the HHS Transformation.

However the provider and MCO rates are structured, the payments themselves should be spent on necessary services that lead to improved outcomes for members, with as little as possible diverted to administrative costs. Of course, some level of administrative activity is necessary for the operation of a complex delivery and payment system, and the costs of implementing State regulations that prevent waste and fraud are dollars well-spent. In conversations with Learning Collaborative members, however, we heard the frustration of behavioral health providers who absorb new regulatory requirements and pass on orders to staff to fulfill them. When there is no comprehensible explanation for how a new mandate helps actual clients from the State, the morale of the staff and the legitimacy of the leadership at the behavioral health provider are both eroded, making other projects (like the efforts to integrate primary care) more difficult. Moreover, a Human Resources director at one mental health center reported that it is most often those bureaucratic hoops themselves that departing employees cite in exit interviews as their main reason for leaving.

A few of those bureaucratic hurdles that stood out in conversations with Learning Collaborative members are:

- Multiple, duplicative training requirements from State agencies and MCOs. For example, there is no single, standardized cultural competency training, so staff must complete several similar but uncoordinated trainings for the State and for each MCO without gaining any additional skills and loosing billable service hours
- Double-entry and risk of errors in inputting mandated Mental Health Assessment Reports? that cannot share information with Electronic Health Records
- Multiple prior authorization and audit protocols from the Mental Health Collaborative (for fee-for-

Lessons from Missouri

The Learning Collaborative was fortunate to have access to expertise from our neighbors in Missouri who have been operating a Health Home program since 2011. When we asked leadership in Missouri's Medicaid agency to describe the operational challenges facing Health Home implementation, ongoing data exchange problems were high on their list:

- Even with an existing primary care data warehouse in place that could load data from FQHC EHRs, workflow and data mapping glitches often prevented EHR data from being transmitted properly. Providers who were not already connected to the primary care data warehouse faced even more IT demands, and many were not able to format and submit the necessary SQL files to the data warehouse on a timely basis.
- After noticing these challenges Missouri made a decision to direct a portion of the primary care health home (PCHH) per-member-per-month rate to provide quality coaching to the PCHH organizations to improve performance, including clinical data collection and reporting.

service Medicaid) and MCOs making it difficult to meet productivity and paperwork requirements

We list these not to catalog provider grievances, but to highlight the unintended consequences of regulations aimed at protecting consumers (by ensuring a well-trained workforce and access to services based on standardized assessments) and ensuring program integrity. Consumer protections and program integrity are necessary costs to the system, but the performance of the regulatory system must be optimized just as it is in the performance of the delivery system. The near-simultaneous launch of Integrated Health Homes, the Behavioral Health Transformation 1115 waiver, and new statewide managed care contracts is the perfect time to work with stakeholders to streamline State processes that could interfere with the goals of the Transformation.

Data exchange

The Learning Collaborative has produced a separate policy brief on data exchange, and here we will focus on the practical needs of providers to meet the IT demands of State reforms. The State's HHS Transformation will make Illinois the first state to provide Health Homes--a team-based clinical approach that builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses--to every Medicaid enrollee. Illinois' proposal for "Integrated Health Homes" is ambitious, and is predicated on the capacity of providers and MCOs to share information seamlessly across a comprehensive spectrum of services.

Learning Collaborative members described coordination tools they will need for the facilitation and sharing of member information to coordinate integrated care by multiple providers:

- Consistent business process--especially for patient referrals--and technology approaches to connect behavioral health, primary care, and specialty care
- Interoperability and safe data transfer of clinical information across the spectrum of care from hospitalization (and notice of admission, transfer, and discharge to community providers) to the sharing of performance metrics to track successes and shortcomings in the integration of behavioral health, primary care, and specialty care
- Funding that recognizes the costs of these critical needs
- A timeline that allows providers to meet the certification requirements of Integrated Health Homes in a timely manner

Coordinating Care After Crisis: Emergency Department Follow-up

A specific challenge that has come up in discussions of data exchange at the Learning Collaborative is care coordination following an Emergency Department (ED) visit for mental illness or substance use disorder that does *not* result in an inpatient admission. MCOs are not alerted to a member's ED visit until they receive a claim or a request for approval of admission. But if there is no admission, the member is effectively lost to the care coordination system, which should be triggering linkages to community resources to respond to the crisis factors that led the member to the ED to begin with. This is a major gap in information exchange and it interferes with other innovative strategies to coordinate care during psychiatric crises. For example, an MCO would not be informed immediately when a hospital, such as Learning Collaborative member Sinai Health System,deflects a patient from a costly and disruptive inpatient stay by referring her instead to an outpatient Crisis Stabilization Unit.

The National Committee for Quality Assurance has recognized the importance of follow-up after an ED visit, and has created new quality metrics to track the percentage of MCO members who receive follow-up within seven and 30 days of an ED visit for mental illness or substance use disorder. These metrics are used in certification and quality ratings of MCOs. The current system linking MCOs and providers, however, is not fully prepared for the data sharing requirements for meeting the expectations of these measures. Hospitals, MCOs, community-based primary care, and behavioral health providers need support to develop and implement technology and processes to communicate real time ED utilization data.

These are urgent needs for implementing Integrated Health Homes, accomplishing the Triple Aim, and generally coordinating care for people with mental illness. The Learning Collaborative's Data Exchange Workgroup is identifying clear, short term work-arounds to the above needs that have proven successful in other states. Long-term solutions to data exchange barriers will require funding and governance structures that give behavioral health providers the infrastructure and tools they will need to be accountable for quality care and to effectuate the integration of care efficiently, consistently, and successfully.

Workforce

Training

Early in the process of building the Learning Collaborative, we agreed that Health Homes were the right foundation from which to build integrated care models. We turned to states that had been implementing Health Homes under Section 2703 of the Affordable Care Act for lessons that could guide Illinois. Many of these lessons were about the Health Home workforce.

When the Learning Collaborative spoke with leadership from Missouri's Health Homes program, we heard about their experience with the training needs of nurse care managers and community support specialists, who had not been accustomed to working closely together and did not understand one another's different skillsets and approaches to care. In preparation for working together in an integrated team, nurses at one Missouri Health Home site train behavioral health staff on chronic medical illness, while nurses receive training on motivational interviewing and other social work interventions. In addition to ongoing clinical staff training, Missouri also invested in training health home provider leadership to transition from fee-for-service reimbursement, giving them time to "practice" managing per member per month payments before launch. An extensive array of training resources for Missouri Primary Care Health Homes and Community Mental Health Center Healthcare Homes are available on the Department of Mental Health's website.

The theme of training for both leadership and staff was echoed in our conversations with Washington State, which requires a two-day training for all health home sites to prepare them to provide the mandated services and screenings, use the designated data systems to track outcomes, and complete Health Action Plans for their members.

We followed-up with the Missouri Health Home team after Illinois announced that it would be launching Integrated Health Homes statewide. We asked what they would do differently if they were starting the Health Home program today. They responded that, "the biggest thing we could have done differently is reduce the maximum caseload sizes for the Nurse Care Managers (NCM)." Missouri set their Health Care Home payments based on a ratio of one NCM for every 250 Health Care Home members, but "providers overwhelmingly state that number is too high." However, the State cannot reduce caseload sizes without increasing the PMPM, and as we know in Illinois rate increases are challenging for state budgets. Missouri had a way out of this problem that is not available to Illinois, because Missouri applied for and received funding to pilot Certified Community Behavioral Health Clinics (CCBHC). Most of the Health Care Homes, which are led by Community Mental Health Centers, will become CCBHCs, and their Nurse Care Manager costs will be covered under the new prospective payment system. Illinois did not apply to test CCBHCs, so it is imperative that we set appropriate, sustainable caseload sizes and PMPM rates for Integrated Health Homes from the start.

Peer Recovery Support Specialists

The Learning Collaborative has been a provider-centric project, with most members representing either community-based behavioral health agencies or FQHCs. Over the course of many meetings and conversations and one large public forum, we have learned to be more and more inclusive of the consumer voice. At our public events we have tried to highlight that voice by inviting people with disclosed mental illness to participate and share their stories and their distinct expertise navigating Medicaid. Further, in our policy and advocacy work, we have tried to consistently emphasize the

importance of peer recovery support in integrated care. Peer recovery support is a one-on-one relationship between a consumer, especially those who historically have not been well reached by health care providers, and a lay professional who shares the same diagnosis. These professionals act as trusted and motivating role models assisting others to develop recovery plans, navigate the health care system, and identify community resources.

SAMHSA and CMS have been promoting the use of peer services since 2007, and peer services are one of the nine required CCBHC services. Although Illinois is not using CCBHCs, the Learning Collaborative adopted a revised version of the CCBHC required services as the "Core Services" for integrated care in its Six Criteria for integration. As in the case of other clinical and administrative staff, training for peer recovery support specialists and the Integrated Health Home team members they work with will be crucial to building effective integrated care in Illinois.

Conclusion

This paper describes three out of the innumerable, complex, and inter-related policy challenges for integrated behavioral health and primary care in Illinois. These are the issues that we heard rising up from the voices in our Learning Collaborative, and we also believe that these are issues that stakeholders and decision-makers with diverse interests and perspectives can work on together towards prudent compromises. It is this broad stakeholder engagement that the Learning Collaborative believes will drive state, local, and system-level policy and practice reforms to advance the goals of effective integration and improved health outcomes for people with mental illness and substance use disorder. We have learned from our internal work with Learning Collaborative members and from our the public discourse among our Engaged Audience and Policy Forum participants that listening and learning together is a strong foundation for practical, impactful change. We hope to contribute to a spirit of listening and learning in all that we do, and look forward to continuing a productive conversation based on readers' responses to these policy lessons from our Learning Collaborative.

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