Massachusetts Healthcare Reform and Behavioral Health Integration

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Agenda

• MA Healthcare Reform and Behavioral Health Integration Landscape
• Behavioral Health Integration and the Patient-Centered Medical Home
• MassHealth health care reform initiatives
• MA Health Care Cost Containment Legislation 2012
• Summary
Behavioral Health Integration

Goal: Optimized access and engagement in coordinated care to achieve improved health outcomes, reduced costs

Behavioral health focus in primary care:
- Screening
- Behavioral health skills

Care coordination and information sharing
Care management
Community resources
## 2011 NCQA Standards

### I. Access and Continuity
- Access during and after office hours
- Electronic access
- Continuity
- Patient/Family Partnership
- Cultural/linguistic appropriate services
- Practice organization (team based care)

### II. Identify/Manage Patient Populations
- Electronic basic and clinical searchable data
- Comprehensive health assessment
- Use data for population management

### III. Plan and Manage Care
- Guidelines for important conditions
- Care management
- Medication management
- Electronic prescribing

### IV. Self Management Support
- Self care process
- Self-care plan & monitoring tools

### V. Track and Coordinate Care
- Test & referral tracking/follow-up
- Care transitions
- Referrals to community resources

### VI. Performance Measurement & QI
- Performance measurement
  - Prevention, chronic disease, overuse, utilization measures
  - Stratified for vulnerable pops.
- Patient/Family feedback
- Quality improvement
  - Patient/family involvement in QI
  - Improvement in health disparities
- Electronic reporting of performance measures
  - To consumers, health plans, public

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**Behavioral Health Focus**

**Optimized Access and Engagement**

**Community Resources**

**Care Coordination**

**Care Management**
MassHealth Care Delivery Transformation

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<thead>
<tr>
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Primary Care Payment Reform
One Care Program
Health Homes
Massachusetts Patient-Centered Medical Home Initiative

- Multi-payer, statewide initiative
- Sponsored by MA Health & Human Services, legislatively mandated
- 44 participating practices
- 3-year demonstration; Start: March 29, 2011
- Includes payment reform
- **Vision:** All MA primary care practices will be PCMHs by 2015
## Practice Redesign: Core Competencies

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<thead>
<tr>
<th>Core Competencies</th>
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<td>Patient/family centeredness</td>
<td>Self management support</td>
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<tr>
<td>Team based care</td>
<td>Patient and family education</td>
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<tr>
<td>Planned visits &amp; follow-up care</td>
<td>Shared decision making, patient action plans</td>
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<td>Registry use for population and patient management</td>
<td>Evidence based care</td>
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<td>Care coordination</td>
<td>Integration of QI</td>
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<td>Care management for high risk patients</td>
<td>Enhanced access</td>
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<td>Integration of behavioral health and primary care</td>
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Supporting Behavioral Health Integration in MA PCMHI

• Defined behavioral health integration:
  • Delineated elements of behavioral health integration
  • Recognized different approaches
• Administered practice self-assessment
• Developed a behavioral health integration toolkit
• Implementing integration toolkit
## Elements of Behavioral Health Integration

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<tr>
<th>Relationship &amp; Communication Practices</th>
<th>Patient Care and Population Impact</th>
<th>Community Integration</th>
<th>Care Management</th>
<th>Clinic System Integration</th>
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<tr>
<td>Triaged access</td>
<td>BH screening and referral</td>
<td>Self help &amp; community resource connections</td>
<td>Coordination of integrated treatment plan</td>
<td>Schedule accessibility</td>
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<td>Smooth hand-offs</td>
<td>BH skills used by primary care team</td>
<td>Specialty mental health &amp; substance use referral</td>
<td>Use of behavioral health skills</td>
<td>Program Integration</td>
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<tr>
<td>Team membership</td>
<td>Integrated clinical pathways</td>
<td>Community resources connections</td>
<td>Use of community resources</td>
<td>Health information exchange</td>
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<td>Program leadership</td>
<td>Health care team leader</td>
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<td>Coordinated scheduling and same day visits</td>
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<td>Sharing expertise</td>
<td>Family focused care</td>
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<td>Patient safety practices</td>
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<td>Patient feedback</td>
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<td>Supporting health behavior change</td>
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Behavioral Health Integration: Approaches and Elements

![Diagram showing the relationship between Patient Care and Population Impact, Community Integration, Care Management, and Clinic System Integration. The diagram includes categories such as Non-Co-located, Co-located, and Co-located & Fully Integrated. The central focus is on Relationship and Communication Practices.]
Practice Self-Assessment

• Goals:
  • Establish practice baseline and track progress of integration over time
  • Highlight common gaps in integration to help drive curriculum and technical assistance

• Methodology:
  • Administered through “Survey Monkey”
  • Ideally completed by the primary care team in conjunction with collaborating behavioral health providers

• Results:
  • 96% response rate
### Survey Results: Strengths

#### Relationship & Communication Practices
- 88% report that PCPs are comfortable requesting advice from behavioral health providers

#### Patient Care & Population Impact
- 85% of pediatric practices routinely meet MA Medicaid BH screening requirements
- 86% have some, if not all, care team members trained in patient activation
- 86% will at least sometimes refer patients with unhealthy lifestyles to BH service providers

#### Community Integration
- 86% reported the ability to provide linkages that facilitate the connection of patients with community resources
- 75% reported protocols for referrals and information-sharing with an array of mental health and substance abuse specialty services

#### Care Management
- 90% of respondents report that clinical care managers are aware of BH-focused community resources and refer patients to them at least sometimes
70% of practices screen for depression and alcohol but most do not screen routinely

Patients are routinely screened prior to or during annual physical exams with a standardized tool for both depression and alcohol
Patient Care and Population Impact Domain Practice Examples

• Depression screening protocol
  • All diabetic patients screened every 6-months with PHQ2; all non-diabetics screened annually
  • If positive screen, receive PHQ9, and then connected immediately with social worker if positive

• Referring patients with unhealthy lifestyle factors to social worker directly after PCP visits

• Primary care and BH providers trained in motivational interviewing
Community Integration Domain

The seven elements of integration within the Community Integration domain focus on referral to and connection with behavioral health resources in the practice's community. Engagement with the community-based behavioral health resources that exist outside of the primary care setting assists the patient in maintaining their emotional health in between primary care visits.
Implementing the Toolkit

• Conducting the self-assessment prior to using the toolkit focuses attention on areas for improvement and prioritizes toolkit utilization

• Providing support through medical home facilitation allows practices to make best use of the toolkit

• Barriers impede integration implementation despite toolkit:
  • Perceived and real regulatory barriers
  • Lack of partnerships with behavioral health providers
  • Payment model does not support integration
MassHealth Care Delivery Transformation

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Primary Care Payment Reform
One Care Program
Health Homes
Primary Care Payment Reform (PCPR)

• Scaling up: Eligible providers- all Medicaid Primary Care Clinician Plan providers
• Clinical Model: PCMH with behavioral health integration
• RFA released Spring, 2013
• Qualified practices notified, October, 2013
• Official launch, March 2014
## Payment Reform

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<tr>
<td>• Fee for service</td>
<td>• Risk-adjusted capitation:</td>
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<tr>
<td>• Start-up infrastructure payments</td>
<td>✓ Primary care outpatient</td>
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<tr>
<td>• Prospective Payments</td>
<td>✓ Behavioral health outpatient</td>
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<td>✓ Medical Home activities</td>
<td>• Three shared-savings / risk tracks available</td>
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<tr>
<td>✓ Clinical care management</td>
<td>• Quality performance is part of payment</td>
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<td>• Shared savings</td>
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PCPR Clinical Care Delivery Transformation

- Accountable for performance across the continuum of care
- Learning organization able to adapt
- Clinical knowledge management for effective treatment
- Transformative clinical leadership / governance
- Leveraging public health
- Effective use of HIT

PCMH with integrated BH
Primary Care Payment Reform: Transformation Support

- Curriculum based on participant readiness review
- Focus on BH integration

- Member roster list
- ED utilization
- High risk members
- Raw claims feed

- Participant feedback on program implementation
- Quality reporting assistance

- Targeted technical assistance for qualified participants

Learning collaborative

Data reports

Stakeholder meetings

Technical assistance
Duals Demonstration:

MassHealth

plus

Medicare

One insurance program

Focused on person-centered care
Target Populations for One Care

Adults with:

- Physical disabilities
- Intellectual or developmental disabilities
- Disabilities who are experiencing chronic homelessness
- Serious mental illness
- Multiple chronic illness or functional and cognitive limitations
- Substance use disorders
Target Population Snapshot

• Over two-thirds of the target population with a behavioral health diagnosis
• Approximately 50% with a chronic medical diagnosis
• 8% with an intellectual or developmental disability
• Approximately 25% using Long Term Services & Supports (LTSS)
• More than two-thirds fall into more than one category
• 96% in the community, not a long-term facility
One Care Clinical Model: Integrated Care

- **Person-centered planning**, with integration across medical, behavioral health and long term services and support needs
- **Integrated Care Plans** directed by the enrollee, informed by comprehensive in-person assessment of medical, behavioral, and functional needs
- **Interdisciplinary Care Teams**, with Care Coordinators and Long Term Supports (LTS) Coordinators
- Integrated Medicare and MassHealth benefits
Payment to One Care Plans

- Prospective global payment to provide comprehensive, seamless coverage
  - Three capitation payments:
    1. CMS for Medicare Parts A/B
    2. CMS Part D
    3. MassHealth
  - Adjustment for risk differences across plans
- Payment model includes quality withholds and incentives
- Plans to use alternative payment methodologies in provider contracts, including shared savings
MassHealth Health Homes
For Members with Severe and Persistent Mental Illness

• Increased funding to Medicaid providers who offer “health homes” model to persons with multiple chronic illnesses

• Health homes services (defined by ACA):
  • Comprehensive care management
  • Care coordination and health promotion
  • Comprehensive transitional care
  • Patient and family support
  • Referral to community and social services
  • Use of HIT to link services, as feasible and appropriate
MA Health Care Cost Containment Legislation 2012

• Health Policy Commission
  • PCMH and ACO certification programs
    • Behavioral health integration an important part of these

• Behavioral Health Integration Taskforce
  • “a special task force to examine behavioral, substance use disorder, and mental health treatment, service delivery, integration of behavioral health with primary care, and behavioral, substance use disorder and mental health reimbursement systems.”
Behavioral Health Integration Taskforce: Barriers to Integration

- Reimbursement issues
- Outdated regulations, based on separate systems of care
- Difficulty accessing behavioral treatment
- Need for significant training/education for PCPS and BH providers
- Lack of interoperability and connection of BH system to Electronic records
- Privacy concerns, real and perceived
Taskforce Recommendations – Delivery Model

Move toward emerging, evidenced-based models of integration. Core components:

- Patient-centered
- Choice in integrated model
- Peer supports
- Screening
- Care Teams
- Behavioral Health Consultations, including curbsides
- Care coordination
- Prevention and wellness
- Evaluation of outcomes & cost-effectiveness
Taskforce Recommendations: Reimbursement

- Move to alternative payment methodologies that include integrated behavioral health services
- Ensure reimbursement for behavioral health screening for all children across all payers.
  - Reimburse for post-partum depression screening at 0-6 mos well child visits
  - Reimburse for both behavioral health and substance use screenings in same visit
- Reimburse for peer supports as a standard of care.
- Reimbursement should cover costs of implementation of evidence-based new models and other innovations
Taskforce Recommendations: Reimbursement continued

• Require commercial insurers to pay for outpatient methadone treatment services
• Ensure insurers’ compliance with mental health parity
• Include standardized quality and financial measures in payment models to assess integration level and impact
  • Tie payments to quality and include reporting transparency to limit incentive to limit care
• Transparency of medical necessity; expansion to recovery and LTSS services
• No prior authorization for inpatient psych, detox or clinical stabilization units
Taskforce Recommendations: Reimbursement continued

• MA DPH and MassHealth should expand its current efforts to review regulations to identify and remove barriers to integration
  • E.g. Provider and site specific payment structures and payment equity.
• Waive pre-approval requirement for first visits to non-emergency behavioral health services to allow same day primary care-bh referrals and brief interventions.
• Ensure funding for MCPAP
  • Contribution from commercial insurers for the percentage of their members who benefit from the program.
Taskforce Recommendations

• Privacy
• Education and Training
• Workforce Development
• Health Policy Commission should be charged with overseeing taskforce recommendations’ implementation evaluation and making further recommendations, as appropriate

Summary: MA Behavioral Health Integration

- MA Healthcare reform initiatives focus on integrated care
- Prompted, supported by ACA and MA Healthcare Reform Legislation
- Behavioral Health screening, including SBIRT, an important part of integrated care
- Need for systemic change highlighted by Taskforce – will it happen?
Acknowledgements

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• Members of the MassHealth Primary Care Payment Reform Clinical Workgroup
• MassHealth PCPR, health homes and One Care project teams
• MA PCMHI practices and their patients

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