IAP | Medicaid Innovation Accelerator Program

Key Considerations in Planning a Physical and Mental Health Integration Initiative

Over the course of 12 months, the Medicaid Innovation Accelerator Program (IAP) provided nine state teams with technical support and resources to assist them in expanding or enhancing physical and mental health (PMH) integration efforts in their states. Drawing from lessons learned in this work, the Medicaid IAP is developing resources such as this one to share insights and resources that may assist other states that are engaged in similar PMH integration work.

This resource document summarizes key considerations for states when planning a PMH integration approach by highlighting state examples, and providing additional tools and information in the accompanying Resource Appendix.

Key Considerations

Develop a working definition for integrated care. State policymakers may find it helpful early on to develop a working definition for "physical and mental health integration" that describes initial parameters and provides some context or level-setting. These state definitions vary widely, and need not be in final form or policy-ready: some state definitions are highly detailed documents that result from collaborative efforts with stakeholders, while others are brief and high-level, and may change or be expanded over time as the work evolves.

Strategies:

- Review existing definitions and frameworks for integrated care as a starting point for discussion.
- Use language that is understandable by both physical and behavioral health communities.
- Incorporate this task into stakeholder discussions as a way to create consensus and outline scope.

Supporting Physical and Mental Health Integration

In July 2014, the Centers for Medicare & Medicaid Services (CMS) launched a collaborative between the Center for Medicaid and CHIP Services and the Center for Medicare & Medicaid Innovation called the Medicaid Innovation Accelerator Program (IAP). The goals of IAP are to improve health and health care for Medicaid beneficiaries and to reduce associated costs by supporting states in their ongoing payment and delivery system reforms through targeted technical support. IAP represents CMS's unique commitment to support state Medicaid agency efforts toward system-wide payment reform and delivery system innovation. The Physical and Mental Health Integration program area began in April 2016. IAP is also working with states on other health care delivery system reform efforts in three additional program areas: improving care for Medicaid beneficiaries with complex care needs and high costs, promoting community integration via long-term services and supports, and reducing substance use disorders.

Identify integrated care needs and opportunities. PMH integration approaches can vary greatly, depending on the needs of the target population, their utilization patterns, and the particular opportunities presented to impact cost and outcomes. Gathering data to better identify and understand the needs of the target population is a critical early step.

Strategies:

- Gather claims, encounter, and other available data sources to better understand the populations who may benefit from an integrated approach.
- Analyze health care utilization patterns: where and from what kinds of providers the target population receives services, common diagnoses and comorbidities, key services and cost patterns.
- Note current use of care management or care coordination services, including via managed care entities, health homes, targeted case management, etc.
- Leverage analytic tools to identify and stratify the population, such as predictive modeling, clinical/diagnostic groups, and risk stratification.

Wisconsin: Leveraging Data

As part of its work with the National Governor's Association Policy Academy on Super-Utilizers, Wisconsin analyzed Medicaid claims data to better understand their high-cost, high-need population. Selection criteria included individuals not currently in a managed care environment, with "impactable" chronic health conditions and high emergency room usage as well as high claims costs. A deeper dive using the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system, indicated to the state that mental and/or behavioral health conditions were a common comorbidity among their super-utilizer population. The state mapped this information against other demographic information available through partners in public health to create a geo-map of the population. Based on this work, Wisconsin envisions the development of an integrated approach that can help to coordinate and address physical and behavioral health needs as well as social determinants of health.[1]

Understand existing service system capacity for integrated care. A state's Medicaid managed care vendors, health care systems, and individual providers may be engaged in integrated care models or pilots that can provide insight and direction in planning.

Strategies:

- Scan for existing operational or clinical expertise and capacity that can be leveraged to support integrated care.
- Analyze the integrated care capacity of safety net providers such as Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), and rural health clinics.
- Reach out to provider associations and advocacy/stakeholder organizations to better understand the healthcare system landscape.
- Consider use of assessment tools or surveys to ascertain provider capacity and readiness.
- Identify past or current projects and resources that support integrated care (e.g., Substance Use and Mental Health Services Administration Primary and Behavioral Health Care Integration grantees[2], health home providers).

Idaho: Gathering Baseline Data on Provider Capacity

Idaho's Department of Health and Welfare Division of Behavioral Health conducted on site surveys with 47 patient-centered medical home (PCMH) practices enrolled in the state's health home program, using the Integrated Practice Assessment Tool (IPAT). The IPAT categorizes practices along a continuum based on three key elements of integration: communication, physical proximity, and practice change. With this qualitative data, Idaho policy makers were able to better understand system capacity, and identify areas for additional technical assistance. The state used the information to work with its PCMH contractor to develop topics and curricula on behavioral health for future training. [3]

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[1]National Governor's Association, "Using Data to Better Serve the Most Complex Patients: Highlights from NGA's Intensive Work with Seven States," accessed May 31, 2017: https://www.nga.org/files/live/sites/NGA/files/pdf/2015/1509UsingDataBetterServeComplexPatients.pdf

[2]SAMHSA-HRSA Center for Integrated Health Solutions, "SAMHSA PBHCI Program," accessed June 2, 2017: http://www.integration.samhsa.gov/about-us/pbhci.

[3]Idaho Department of Health and Welfare, "Executive Summary: Behavioral Health Integration Survey," accessed May 31, 2017: http://ship.idaho.gov/Portals/93/Documents/BHI/0104163rdDraftExecSummaryBHI%20Survey.pdf.

Work across state silos. Barriers and silos found in delivery systems can be reinforced by state agency divisions. In planning an integrated care approach, it can be particularly important to foster meaningful cross-agency collaboration. Equally important is to leverage internal expertise and relationships with other systems and services. Workgroups with diverse policy, clinical, and operational perspectives can create a better product and improve the odds for successful implementation.

Strategies:

- Medicaid and behavioral health leadership are critical to the success of an integrated care initiative: consider a joint accountability structure for the workgroup.
- Anticipate how proposed delivery system changes may impact Medicaid and other state agency oversight, reimbursement, contracting, quality improvement, and other state functions, and design membership accordingly.
- Consider the use of a charter that delineates the role of agency partners, including available staff, other resources, and timelines.
- Review and update work group composition as project matures and moves into implementation phase.
- Flag regulatory, licensing, and other policies that may perpetuate barriers to integrated care, and can benefit from cross-agency problem-solving.

Indiana: Cross-Agency Strategic Planning

Indiana launched the Primary Care and Behavioral Health Integration initiative under the authority of the Indiana Family and Social Services Administration (FSSA), in partnership with the Indiana State Department of Health (ISDH), to develop the state's strategic plan for the integration of physical and behavioral health care services. [4] The agencies formed a State Integration Team, drawing members from both ISDH and FSSA, including the Office of Medicaid Policy and Planning and the Division of Mental Health and Addiction. Team composition reflected common goals, a common population, existing relationships with key providers, and the authority to drive policy. The initiative has thus far created a strategic plan for integration in Indiana, including certification standards for Integrated Care Entities, focusing on safety net providers such as FQHCs and CMHCs.

Engage Stakeholders. State PMH integration initiatives aim to fundamentally change how care is delivered, making early engagement of diverse stakeholders an important part of planning. Individuals who receive services are uniquely positioned to identify gaps, barriers, and potential solutions; they can also help to create a "market" for a new approach to care. Providers have important insight into workflow, workforce, administrative barriers and related issues that can be critical to initiative design. Managed care organizations bring their own innovations to the table, understand their provider networks, and in many states are important drivers of integration efforts.

Strategies:

- Make the case for integrated care: articulate why it is a "win-win."
- Use data to frame discussions and inform stakeholders.
- Build in ample time and human resources to effectively engage stakeholders.
- Provide leadership roles for stakeholders to bolster meaningful participation and buy-in.

Illinois: Engaging stakeholders

More than 2,000 stakeholders in Illinois helped shape that state's approach to improving behavioral health services and integrating physical and behavioral health. State policy makers convened eleven focus groups in five regions across the state as part of the planning process, as well as numerous town halls. Through the state's State Innovation Model work, providers, payers, and agency staff convened a behavioral health integration workgroup that met for five months to further analyze the state's strategies for integrated care. Illinois compiled the information gleaned from each part of this extensive stakeholder process to inform the state's overarching behavioral health strategies, many of which were ultimately included in Illinois' Behavioral Health Transformation Section 1115 Waiver application.[5]

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[4]Indiana Family and Social Services Administration, "Indiana Primary Care and Behavioral Health Integration (IPCBHI) Initiative," accessed May 30, 2017: http://www.in.gov/fssa/dmha/2897.htm.

[5]Illinois Department of Healthcare and Family Services, "Illinois' Behavioral Health Transformation Section 1115 Demonstration Waiver," accessed May 30, 2017: https://www.illinois.gov/hfs/SiteCollectionDocuments/20160826%201115%20Waiver%20for%20Public%20Comment%20vF.pdf Conclusion

Conclusion

The experiences of states engaged in the complex work of planning a PMH integration initiative indicate that: articulating the basic features of the state's vision; using data and other information; identifying existing capacity; convening a diverse and empowered work group; and investing in stakeholder engagement can all contribute to a successful and comprehensive planning process. Additional resources, including links to relevant materials divided by topic and other state examples, can be found in the accompanying Resource Appendix.

Appendix: Annotated Bibliography and Links to Additional Resources

Developing a working definition for integrated care:

- The Washington Bree Collaborative released a report, Behavioral Health Integration Report and Recommendations, for that state's integration initiative. The report is framed around eight common elements that provide a minimum standard of integrated care: the integrated care team, access to care, information sharing, practice access to psychiatric services, operational systems and workflows, evidence-based treatments, patient involvement in care, and data for quality improvement.

- New Hampshire has developed a set of core competencies for the state's Integrated Delivery Networks (IDNs), as outlined in their Project and Metrics Specification Guide. Through the core competency project, each IDN supports its network practices to achieve coordinated care designation; practices must also use a standardized assessment for care planning and population management. New Hampshire's Section 1115 Demonstration Waiver provides further detail on how the state is defining and building IDNs.

- The Lexicon for Behavioral Health and Primary Care Integration, developed with support from the Agency for Healthcare Research and Quality (AHRQ), is a functional definition for behavioral health and primary care integration, developed through a consensus process by a team of national experts.

- The World Health Organization (WHO) offers a Framework on integrated people-centered health services that includes a definition and key elements of integrated health care delivery.

- The Four Quadrant Model describes integration based on physical and mental health complexity on an axis of low-to-high risk.

- Physical and Behavioral Health Integration: State Policy Approaches to Support Key Infrastructure is a brief developed by the NASHP that reviews varying approaches and key elements for integrated care delivery.

Identifying integrated care needs and opportunities:

- The Medicaid Innovation Accelerator Program (IAP) program area on Medicaid Beneficiaries with Complex Care Needs (BCN) released a national dissemination webinar titled, Identification and Stratification of Medicaid Beneficiaries with Complex Care Needs and High Costs, which discusses key themes and perspectives from the field about identifying complex populations.

- The National Governor's Association released a report, "Using Data to Better Serve the Most Complex Patients: Highlights from NGA's Intensive Work with Seven States," based on its work with states in the Super-Utilizers Policy Academy. The report focuses on lessons learned from states regarding common characteristics of super-utilizers, identifying and targeting this specific population, and assessing outcomes of state efforts.

- The National Academy of State Health Policy released a report, Understanding Medicaid Claims and Encounter Data and Their Use in Payment Reform, which provides background on using and analyzing claims and encounter data to identify high-need, high-cost individuals and promote care coordination.

Understanding existing system capacity for integrated care:

- CThe Integrated Practice Assessment Tool (IPAT) is a series of questions in the model of a decision tree that places practices on one of the six levels of integration as defined by the Substance Abuse and Mental Health Services Administration- Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions issue brief, A Standard Framework for Levels of Integrated Healthcare. More information on Idaho's use of the IPAT can be found in the state's behavioral health integration survey executive summary.

- The SAMHSA-HRSA Center for Integrated Health Solutions has a web page dedicated to Assessment Tools for Organizations Integrating Primary Care and Behavioral Health. A variety of assessments and tools are provided to help organizations understand where they are on the integration continuum and what resources or capacity is still needed.

Working across state silos:

- The Indiana Primary Care and Behavioral Health Integration (IPCBHI) Initiative was launched in 2012 as a partnership between the Indiana Family and Social Services Administration and the Indiana State Department of Health to formulate a statewide strategy for the integration of primary and behavioral health care. The website provides information on this effort, including information about the State Integration Team composition and roles.

- New York's Integrated Licensure Project was a four-year collaboration between the Office of Mental Health, Office for Alcoholism and Substance Abuse Services, and Department of Health that resulted in a unified licensing application and administrative standards for a range of outpatient physical and behavioral health services. The project also developed a "licensing threshold" option that allows licensed providers to offer services usually licensed by sister agencies if they stay within a certain service percentage, as outlined in the New York DSRIP Project Licensure Thresholds Guidance.

- Cross-Agency Collaboration: Integrating Pediatric Mental and Physical Health is a conference session from the 2016 NASHP Annual State Health Policy Conference. It includes presentations from Vermont, Missouri, and New Mexico presenting examples of cross-agency programs that address the integration needs of children and youth.

Engaging stakeholders:

- Illinois' Behavioral Health Transformation Section 1115 Demonstration Waiver application outlines the state's vision for an integrated behavioral and physical health delivery system, including an extensive stakeholder process that informed their design and strategy.

- The state of New Jersey partnered with the Rutgers Biomedical and Health Sciences (RBHS) Working Group to develop recommendations on addressing the needs of the state's high Medicaid utilizers. The report, Analysis and Recommendations for Medicaid High Utilizers in New Jersey, combined quantitative analysis of Medicaid claims and encounter data with engagement of key stakeholders to formulate recommendations, the first of which was the integration of physical and behavioral health care.

- The second section of AHRQ's Designing and Implementing Medicaid Disease and Care Management Programs Guide, Engaging Stakeholders in a Care Management Program, emphasizes the importance of stakeholder support in the design and assessment of a Medicaid managed care program. The section offers broadly applicable guidance on identifying and developing relationships with active and influential stakeholders, and constructing stakeholder messaging to successfully demonstrate program value.

CONTACT: If your state is interested in learning more about the Medicaid IAP PMH Integration Program, email MedicaidIAP@cms.hhs.gov. Additional information on the IAP PMH Integration program, including materials from national webinars, is available on the Medicaid IAP PMH Integration webpage.