

Strategies for Promoting Provider Capacity for Physical and Mental Health Integration

Drawing from lessons learned in working with the nine states, IAP has developed resources that share insights and information in order to assist other states that are engaged in similar efforts. This resource provides strategies for promoting provider capacity for physical and mental health (PMH) integration.

Provider practices that have the capacity to effectively deliver integrated physical and mental health care feature service delivery strategies such as multidisciplinary teams, care coordination, clinical protocols, unified care planning, and use of integrated health data for quality measurement and care management. State Medicaid programs can use a variety of policy levers to help providers enhance their capacity to engage in these strategies, such as convening providers to identify and remove barriers, implementing Medicaid state plan and waiver authorities to support clinical care teams and care coordination, implementing flexible payment models through managed care contracting, and other policy approaches.

Participating IAP states used a number of these policy levers to promote provider capacity, focusing on areas of high state priority and/or particular challenges. This factsheet highlights several of these focus areas, and offers examples of strategies that states are using to address them.

SUPPORTING AND SUSTAINING CARE COORDINATION CAPACITY FOR PRIMARY CARE

Building and sustaining integrated care coordination capacity within primary care can be challenging due to budget and payment constraints, fee-for-service payment models, and the varying ability of primary care practices to incorporate new types of staff and work flows. The following are examples of strategies that states have used to support this work:

- **Vermont**, as part of its [Blueprint for Health](#) and in partnership with commercial payers, established [Community Health Teams \(CHTs\)](#) to support care coordination in primary care. CHTs may be co-located within a provider practice or centralized at a convenient location, and supplement services available in the practices to link patients with other needed behavioral, social, and economic services.
- **Connecticut's** Medicaid agency contracts with an Administrative Services Organization (ASO) to offer provider practices support to promote PMH integration expansion. Through the ASO, [Community Practice Transformation Specialist \(CPTS\)](#) teams work directly with participating practices to help them improve workflow and create consistent polices that result in better care coordination. The ASO also provides enhanced payments to providers as they embark on an 18-24 month "Glide Path" towards achieving the Patient Centered Medical Home Recognition.

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' unique commitment to support state Medicaid agency efforts toward system-wide payment reform and delivery system innovation. From April 2016-April 2017, the IAP provided nine state Medicaid agencies with technical support and resources to assist them in expanding or enhancing physical and mental health (PMH) integration efforts in their states. 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.

- **Over 25 states** have used the [Medicaid health home state plan option](#) to build care coordination capacity within or in partnership with primary care practices for individuals with chronic health conditions. The health home option enables states to develop more flexible payment methodologies, such as per member, per month models, that support both integrated care teams and care coordination capacity.
- **New York** and **Colorado** provide enhanced payments to primary care practices that meet certain requirements, including the ability to provide care coordination and integrated care.

PROMOTING PMH INTEGRATION IN FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

The FQHC encounter-driven prospective payment system methodology can present unique challenges to integrated care. Some states have FQHC billing rules that do not reimburse for same-day consultation with embedded behavioral health providers. Moreover, different billing strategies for behavioral health services (as part of the encounter rate, or separately as an additional payment) can also add complexity. States have deployed several strategies to address these challenges:

- **New Jersey** convened FQHCs to participate in extensive stakeholder activities to better identify the barriers faced by these practices to deliver more integrated care, including substance use services. The outcome of these activities led to expansions in the scope of work for FQHCs and clarification in billing (e.g. for group therapy) to support practice capacity to deliver more integrated care.
- **Minnesota's** [Federally Qualified Health Center Urban Health Network](#) (FUHN) is an integrated network of FQHCs that participates in [Minnesota's Integrated Health Partnerships](#) Initiative, a Medicaid shared savings model. Through this work, FUHN focused on building its provider capacity, including improved care coordination and data infrastructure.

BUILDING CAPACITY IN RURAL AREAS

Providing integrated care in rural practices can be a significant challenge for states, due to scarce resources and behavioral health workforce issues.

- In **Hawaii**, where many primary care practices are located in remote areas across its islands, the state's [long term vision for integrated care](#) includes multiple supports for rural practices, such as regional care teams, remote psychiatric consultation for primary care providers, and provider training and support to improve primary care capacity to treat behavioral health conditions. For example, providers are able to use telebehavioral health to provide counseling services to members and consult with specialists via videoconferencing.
- The states of **Arkansas**, **Indiana**, **Louisiana**, and **Maine** have also implemented regulations to allow physician-patient relationships and evaluations to be established via real-time telehealth technologies.
- In **Washington**, primary care providers work with an embedded behavioral health coordinator and a remote consulting psychiatrist who is also available for telepsychiatry services as necessary. The initiative began as a pilot and has expanded throughout the state, supporting both rural and urban practice settings.

LEVERAGING MEDICAID MANAGED CARE

States looking for ideas on how to better use Medicaid managed care contracts to promote integrated care capacity within the provider network of a managed care organization (MCO) have a number of strategies to consider:

- **Tennessee's**, [MCO Statewide Contract](#) incorporates language on integrated care capacity, directing plans to develop policies and procedures to support key components, including screening tools, exchange of information, care coordination, population health, and monitoring of outcomes.
- **Colorado**, as part of a statewide initiative to promote access to integrated physical and mental health care for all Coloradans, secured agreements with commercial managed care plans to pay primary care providers using alternative payment methodologies. They did this to align across payers and provide additional resources for integrated care transformation activities. Depending on the particular arrangement between the payer and the provider practice, the insurer's payment might provide extra funds for care coordination or investments in health information technology, including incentive payments for reporting data, or offer bonuses for quality performance.
- **New York** is driving integrated care capacity in numerous ways, including through carved-in and specialty MCO models. Health plans interested in participating in these integrated models must be certified through a [Request for Qualifications](#) (RFQ) process. The RFQ describes how plans must support provider capacity for integrated care, such as:

- Required provider training on screening, brief intervention, and referral to treatment (SBIRT),
- Screening for depression in primary care,
- Identification of individuals experiencing a first psychotic episode, and
- Specific support for the [Collaborative Care model](#), an evidence-based practice for treating depression and other common behavioral health conditions in primary care.

BUILDING DATA USE AND DATA SHARING CAPACITY

Integrated care across physical and behavioral health can be limited by privacy and technological constraints, as well as lack of expertise in effectively incorporating data into practice work flows. To overcome some of these challenges:

- **New York’s** [Health Home Patient Information Sharing Consent](#) is an example of a single consent form that covers the entirety of an individual’s medical record, including information protected by 42 CFR part 2 and state laws that are more stringent.
- **New Hampshire** is using its Section 1115 Delivery System Reform Incentive Program waiver to promote primary and mental health integration. As part of these reforms, regionally based networks of providers called Integrated Delivery Networks will use comprehensive assessments to support integrated care planning. Standardized data extracted from these assessments will be available electronically to participating providers using a web-supported platform.
- Through **Colorado’s** [State Innovation Model](#) grant, the state supports clinical health information technology advisors to assist provider practices in making changes to promote PMH integration. The state’s health information exchange (HIE), CORHIO, has also made data support for integrated care a top priority. The CORHIO [report](#), “Supporting Integration of Behavioral Health Care through Health Information Exchange,” outlines the importance and merit of HIE for integration, its current project plan, and recommendations for improvement.

SUPPORTING AND SUSTAINING PROVIDER CULTURE CHANGE

States can engage providers in care transformation by providing coaching and other clinical supports:

- In **Arizona**, the state’s HIE (formerly Health E-Connection, now known as Health Current) partnered with two Medicaid managed care plans, Mercy Care Plan and Mercy Maricopa Integrated Care, to implement the [Practice Innovation Institute](#) (PII), a [Transforming Clinical Practice Initiative](#). The PII helps providers prepare to participate in value-based payment programs, including support for more integrated and coordinated care.
- [Washington’s Practice Transformation Hub](#) offers resources to practices that support the state’s “Healthier Washington” vision, which includes accelerating the uptake of integrated behavioral health strategies.

States across the country have initiated payment and delivery system reforms to support care that can effectively and seamlessly address both physical and behavioral health needs. To ensure the success of these models, states’ policy makers need to consider how they can support building provider capacity to implement these reforms. The strategies and examples in this factsheet are a starting point for states as they start to think about how best to support their providers with integration efforts.



CONTACT: Additional information on the IAP PMH Integration program, including materials from national webinars, is available on the [Medicaid IAP PMH Integration webpage](#).