MassHealth

# MassHealth Approaches to Behavioral Health Integration:

## *Integration through Innovation*

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Health Policy Commission
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# MassHealth Approaches to Behavioral Health Integration

- Overview
- MBHP Integrated Care Management Program
- Primary Care Payment Reform Initiative
- Duals Demonstration
- Next Steps

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# Overview

- 60% of Dually Eligible MassHealth members have a diagnosis of severe and persistent mental illness
- 20% of Children receiving Children's Behavioral Health Initiative (CBHI) Services have asthma; 8% have a heart condition
- Persons with chronic mental illness have shorter life spans by 15 years

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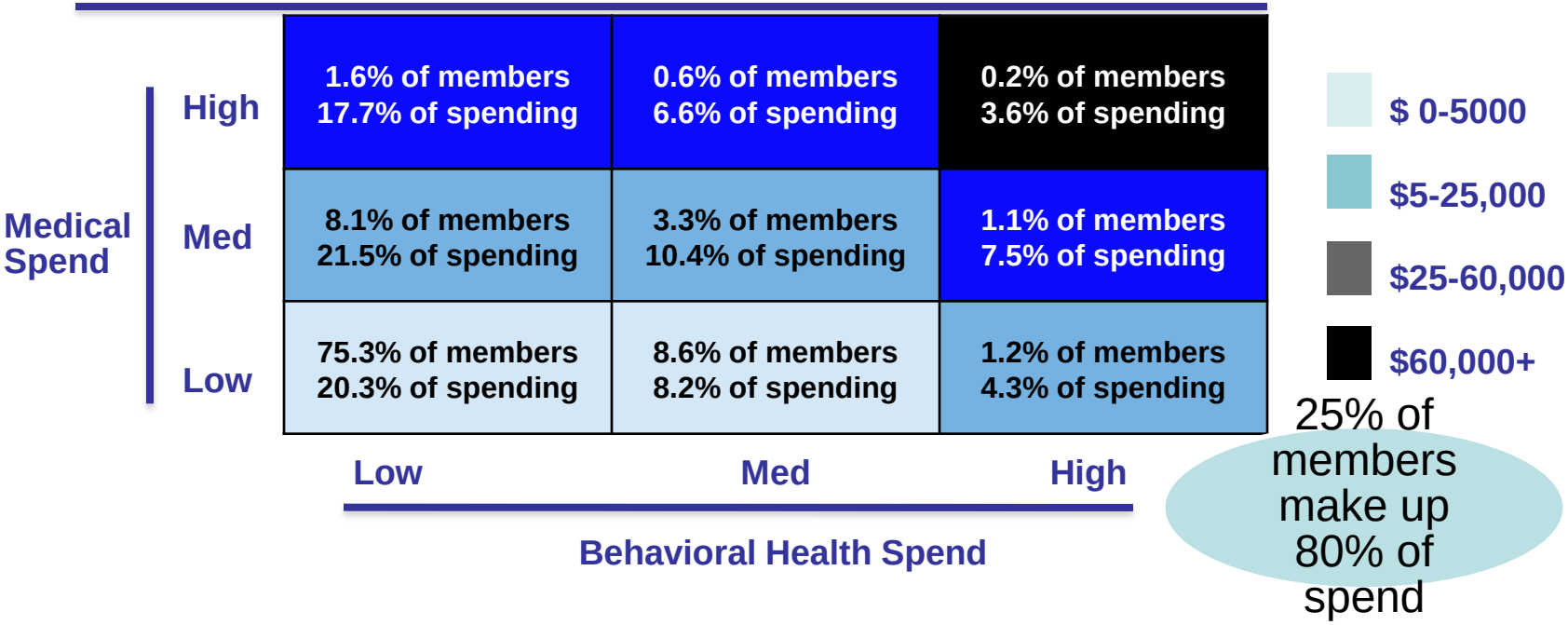
# Integrating Behavioral Health and enhancing Primary Care coordination will drive quality and efficiency for most expensive members in the PCC Plan

## Spending on members by medical and behavioral health costs



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# Barriers to Effective Integration

- Financial Barriers
- System Barriers
- Data Sharing
- Privacy Laws
- Provider Access/Training

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# MBHP Integrated Care Management Program (ICMP) – effective 10/1/12

- Provides direct care management service to PCC Plan members experiencing complex medical and/or behavioral health problems:
  - Team comprised of licensed, masters level clinicians and registered nurses (~40 staff members based regionally) who work with members on such things as access to appropriate medical and BH health care; adherence to prescribed Rx and treatment plans; co-occurring health problems and identification of behaviors that impact a health lifestyle
  - Enrollment (as of 4/1/13): 3,098 PCC Plan Members

- Member Identification and Engagement:
  - Predictive modeling process using medical, behavioral health and pharmacy to stratify PCC Plan population to identify members eligible for ICMP; targeted mailings and outreach to inform eligible members of the program
  - Three tier approach to classify members based on health care needs and complexity (high, medium and low). Members assigned tier determines intervention approach

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# MBHP Integrated Care Management Program (ICMP)

- Member Identification and Engagement, con't:
  - Members engaged over the phone or in person and a care plan is established that addresses medical and behavioral health needs
  - ICMP connects with PCCs and BH providers (along with state agency case managers) to align service delivery with established clinical guidelines for such conditions depression, diabetes and asthma (top three actionable conditions that make up 50% of target population)

- Payment Structure:
  - Base Per Participant Per Month (PPPM) rate paid quarterly to MBHP for members engaged in ICMP
  - Care Management Program Performance Incentives: Reduction in Hospitalizations, Reduction in Polypsychopharmacy, Member Reports of Improved Health Outcomes (Member Experience and Health Related Quality of Life)

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# Primary Care Payment Reform Initiative

- The payment model allows a "bundled payment" for primary care and behavioral health, incentivizing integration
- We allow three "tiers" of primary care-behavioral health integration to encourage a range of providers to participate in the model
- Each "tier" has specific responsibilities on care delivery and delivery system transformation

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# Proposed Payment Structure

A

**Comprehensive Primary Care Payment**

- Risk-adjusted capitated payment **for primary care services**
- May include some behavioral health services

B

**Quality Incentive Payment**

- Annual incentive for quality performance, based on primary care performance

C

**Shared savings payment**

- Primary care providers share in savings on **non primary care spend**, including hospital and specialist services

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# A Comprehensive Primary Care Payment

**What is the purpose of this payment?**

- **Does not limit practices to revenue streams that are dependent on appointment volume or RVU's**
- **Gives practices the flexibility to provide care as the patient needs it**, without depending on fee for service billing codes. This may support expanding the care team, offering phone and email consultations, allowing group appointments, targeting appointment length to patient complexity, etc.
- **Allows a range** of primary care practice types and sizes to participate
- **Provides financial support for behavioral health integration** by including some outpatient behavioral health services in the CPCP
- **Ensures support and access for high-risk members through risk adjustment** based on age, sex, diagnoses, social status, comorbid conditions

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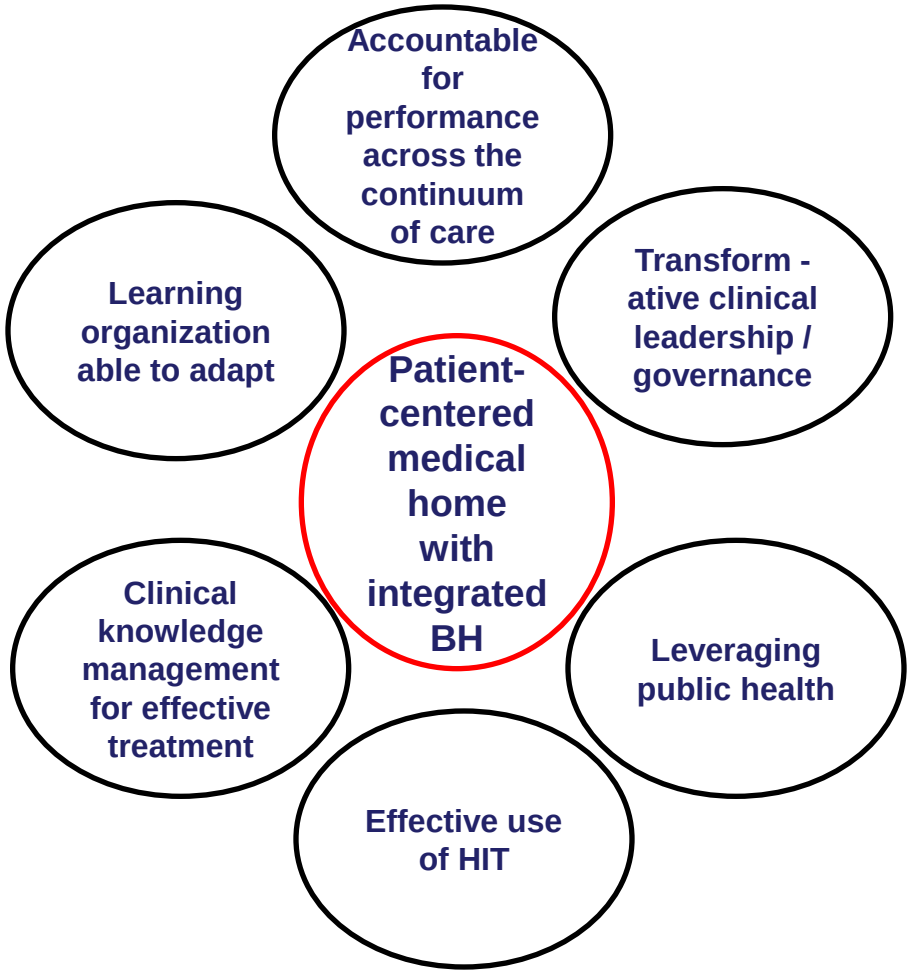
# Delivery Model is based on the Patient-Centered Medical Home Foundation

**PCMHI Foundation:**

12 capabilities: patient-centeredness, multidisciplinary team, registry use, care coordination and managed, enhanced access, etc.

**Integrated behavioral health:** behavioral health includes mental health care, unhealthy substance use diagnosis and treatment, and support to alter unhealthy lifestyles




**System wide impact:**

- Patient-centered outcomes
- Improved care coordination and patient experience
- Clinical integration and evidence based care
- Patient activation and increased health literacy
- Efficient and cost effective care
- Population health improvement

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# Primary Care or Behavioral Health Sites may be Locus of Care

- The Medical Home may be either the primary care practice site or the behavioral health site
- Practices may integrate behavioral health and primary care utilizing the following approaches:
  - Non- Co-located but Coordinated- Behavioral services by referral at separate location with formalized information exchange
  - Co-Located -By referral with formalized information exchange at medical home location
  - Fully Integrated- Part of the "Medical Home" team and based at the location. Primary care and behavioral health providers work side-by-side as part of the health care team

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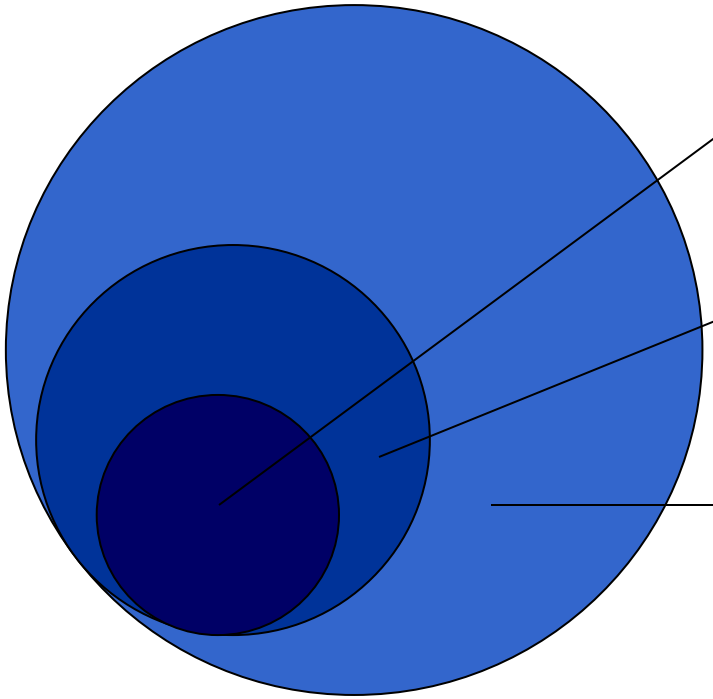
# Building 3 Behavioral Health Tiers into the CPCP



**Tier 1** - case management/coordination services; no fee-for-service billable services

**Tier 2** - brief interventions, screening/assessment/triage; fee-for-service billable outpatient BH services by master's & bachelor's level professionals

**Tier 3** - psychiatric assessments, medication management, psychotherapy; fee-for-service billable outpatient BH services provided by prescribing clinicians and psychotherapists

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# Example: Tier 1

- Multi-physician group of internists, family practitioners and nurse practitioners primarily serving adult patients
- Capable of providing all primary care services in the bundle
- Bill fee-for-service for other services provided
- Integration enhanced through:
  - Timely access to BH crisis screening/triage/services
  - Timely referral and access to routine outpatient BH services
  - Collateral contact and case consultation with other providers, including BH providers
  - Bridge consultation between inpatient/outpatient settings, including BH settings
  - Access to community support

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# Example: Tier 2

- Community health center comprised of pediatricians, family practitioners, internists and numerous specialty providers, including several master's level behavioral health professionals serving patients of all ages
- Capable of providing all primary care services in the bundle
- Bill fee-for-service for other services provided
- Integration and whole-health focus enhanced through:
  - Provision of BH crisis screening/triage/brief intervention services
  - Referral to and clinical bridge between PCP and other involved BH providers (therapists, psychiatrists)
  - Education and brief interventions for behavioral symptoms associated with physical health conditions
  - Assessment and monitoring of effectiveness of BH medication treatment being provided by PCP through the use of standardized, reliable and valid screening instruments

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# Example: Tier 3

- A community mental health center comprised of psychiatrists, psychologists, therapists, case managers and peer support specialists serving adults with serious and persistent mental illness, many with co-occurring substance use disorders
- Recently hired a family practice nurse practitioner and registered nurse
- Capable of providing all primary care services in the bundle
- Bill fee-for-service for other services provided, including other BH services provided
- Integration and whole-health focus enhanced through:
  - Psychiatric assessments
  - Medication management
  - Medical psychotherapy
  - Medication groups
  - All psychotherapy services

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# Massachusetts Duals Demonstration

- **Demonstration purpose***:* To identify, support and evaluate person-centered models that integrate acute care, behavioral health, and long-term services and supports
- **Target population***:* 111,000 dual eligibles ages 21-64 with full MassHealth and Medicare benefits:
  - Over two-thirds of the target population has a behavioral health diagnosis
  - Approximately 50% have a chronic medical diagnosis
  - 8% have an intellectual or developmental disability
  - Approximately 25% use LTSS
  - 96% in the community, 4% in a long-term facility



Note: Target population information is based on analysis of CY2010 data.

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# Integration through Covered Services

- **Covered Services**: Integrated Care Organizations (ICOs) will provide full range of medical, behavioral health and LTSS needs:
  - Medicare Services: All Part A, Part B, and Part D services
  - Medicaid State Plan Services*
  - Additional Behavioral Health Diversionary Services, covered today in MassHealth PCC Plan and MCOs, but not FFS
    - e.g.: Community crisis stabilization, Community Support Program, acute treatment and clinical support services for substance abuse, psychiatric day treatment
  - Additional Community Support Services, e.g. peer support, Community Health Workers, respite
- **Global Payment**: Under global payment model, ICOs have flexibility to cover added services, designed to advance wellness, recovery, self-management of chronic conditions, independent living, and as alternatives to high-cost acute and long-term institutional services



*Excluding certain services provided by other state agencies: Targeted Case Management, Department of Mental Health Rehabilitation Option, and Intermediate Care Facility services

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# Integration through Person-Centered Planning

- Duals Demonstration care model focuses on a identifying the full range of a person's needs, and an individualized, integrated plan for addressing them
- **Comprehensive Assessment:** ICO undertakes, with the member, a comprehensive assessment of the member's:
  - Medical, behavioral health and LTSS needs
  - Strengths, goals, preferences
- **Individualized Care Plan:** Developed with the member, based on comprehensive assessment:
  - Flexibility to use diversionary BH services and additional community support services
  - Addresses full range of a member's needs
- **Interdisciplinary Care Team:** Includes primary care provider, care coordinator, and others identified by the member, such as:
  - Behavioral health provider
  - State agency case manager
  - Peers/advocates
  - Caregivers/family

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# Integration through Support for PCP/BH Practice Transformation

- Duals Demonstration will support development of practices that have the capabilities of patient-centered medical homes, health homes, or other integrated models:
  - Leverages Massachusetts PCMHI, PCPR, and Health Homes initiatives
- **Support for Practices**: ICOs required to identify practices' baseline capabilities and promote advances toward fully integrated primary care and behavioral health care delivery, including through:
  - Training in care model, practice-based care coordination, etc.
  - Alternative payment methodologies, such as bundled payments, global payments, shared savings/shared risk
- **Learning Collaboratives**: Trainings for ICO staff and providers, offered by MassHealth, will further support practice development by addressing topics such as:
  - Cultural competence in serving individuals with disabilities
  - Recovery model, Independent Living Philosophy, and Self-determination model

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# Quality Measurement to Ensure Integration

- Duals Demonstration includes a robust quality measurement strategy that will further support care integration, including:
  - Quality withhold measures
  - Additional measures for ongoing ICO performance monitoring and outcomes
- ICOs will be required to report on common measure sets consistent with Medicare requirements:
  - HEDIS, HOS, CAPHS, and all current Part D metrics
- ICOs also must report on additional measures identified by MassHealth as key to Demonstration goals, and pertinent to the target population such as:
  - Screening, appropriate care, follow-up for behavioral health
  - Person-centered care planning, management, transitions
  - Access to care, including ADA compliance

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# Next Steps

- MassHealth will be evaluating the progress of these programs as they are implemented and established
- Key activities include:
  - **Common reporting** on processes and outcomes related to access, referral and screening
  - **Measuring impact** of increased integration will include increased use of BH services in PCC settings
  - **Measuring coordination of care** as the "space between" to determine best model for members and providers
  - **Identifying best models** for use of care coordinators, parent partners, health navigators and peers who can support professionals providing direct care
  - **Measuring overall cost impact** within and outside of health care delivery system