Memorandum

To: Ming Wang, Program Administrator, Utah Department of Human Services
From: PATH Team at CLASP
Date: June 14, 2019
Re: Alternative Approaches to a Comprehensive Service Array

SUMMARY

Utah's PATH application calls for the introduction of changes to Medicaid financing that will cover clinical treatment, recovery support, prevention and promotion services for youth in transition. The initial proposal was to develop a bundled rate; however, at the May 21-22 site visit, the team determined based on feedback from the Medicaid office that other potential solutions merit consideration. This memo provides an overview of alternative approaches to structuring a comprehensive service array to help the team identify which approach(es) will be most successful for transition age youth in Utah.

The memo provides an overview and select examples of Patient Centered Medical Homes, Health Homes, and Accountable Communities for Health, three innovative healthcare system reform models that all seek to integrate some combination of physical health care, behavioral health care, and social services for different populations. This overview is followed by a description of key structures and practices that support these models. The memo concludes with some key takeaways and considerations for the Utah PATH team as you explore the viability of these options for meeting the needs of transition age youth in Utah.

Patient Centered Medical Homes (PCMH)

PCMH is a care delivery model intended to produce greater interaction between primary care physicians and their patients, particularly around chronic conditions. PCMHs are patient-centered and adopt a whole person approach, focused on the Triple Aim (improving the patient experience, the health of populations, and reducing the per capita cost of health care). For patients who experience behavioral health conditions, PCMHs can offer a primary care-based, collaborative approach to managing behavioral health conditions. The current iteration of PCMHs were developed in the context of Medicare, but two states have Medicaid PCMH pilots described below.

Colorado

Colorado is using an Accountable Care Collaborative (ACC) model to expand medical home services for their adult and pediatric Medicaid population. Under this model, primary care medical providers (PCMPs) contract with 7 regional care collaborative organizations (RCCOs) to provide medical home services to Medicaid enrollees. The goal of the ACC is to have every member linked with a primary care

medical provider (PCMP) as his or her central point of care, and the PCMPs are directly responsible for ensuring timely access to primary care for ACC members. PCMPs function as medical homes; they are also responsible for assessing members' nonmedical needs and helping them to access wraparound services such as housing assistance, long-term services and supports, behavioral health care, childcare, transportation, food assistance, and other community services. PCMPs may provide this support directly, or it may be provided by Regional Coordinated Care Organization (RCCO) care coordinators. The model has been linked to reduced readmissions post-hospitalization, reduced emergency room use, and reduced high-cost imaging services. The model has also been linked to cost reductions of $60/member/month for adults and $20/member/month for children.

New Jersey

In September, 2010 a state law (NJ P.L. 2010, Chapter 74) was passed directing Medicaid to establish a three-year pilot demonstration for medical homes focusing on the frail elderly and those with chronic diseases. In response to the legislation, the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) wrote a Memorandum of Agreement (MOA) requesting that the four Medicaid contracted managed care organizations (MCOs) in NJ participate in a pilot to enhance or create infrastructure, within their networks, for medical home services. Through a state plan amendment, New Jersey also has two behavioral health homes-one focused on Serious Mental Illness in adults and the other focused on Serious Emotional Disturbance in Children. The expectation for this model was that it would result in improved health outcomes for the consumer base, better quality of treatment, and improved cost effectiveness; improved consumer experience with care; and declines in the use of hospitals, emergency departments, and other costly inpatient care.

Health Homes

The Affordable Care Act (ACA)'s Health Home provision provides states with additional Federal funding (90% federal matching rate within the first 2 years of health home establishment) to pay for care management, coordination, and use of clinical information technologies by Medicaid providers. Health home models promote comprehensive, coordinated, team-based, and client-centered care and enhanced client experience and outcomes. Eligibility for receiving health home services includes having two or more chronic conditions, having one chronic condition and being at risk for another, or having a serious mental health condition. Health Homes are different from PCMHs because they are less prevention focused, their target populations typically have a higher level of need and they integrate not only physical and behavioral health care but also social services that are critical to their target populations.

California

California is engaged in a number of initiatives and pilots that have integration of physical and behavioral health care as a focus of that work. The following are three case studies from four geographically and culturally diverse county regions in CA.

San Diego

San Diego's coalition of 16 private, nonprofit clinics provide primary care and behavioral health services to one in six San Diego County residents. The coalition has had initiatives to integrate behavioral and physical health care in place for nearly a decade, which began with a county

contract, supported by funding from the California Mental Health Services Act (MHSA). Integrated care in San Diego started with embedding behavioral health professionals in FQHCs to address the behavioral health needs of their patients. Funding was then procured from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to do "reverse integration," embedding primary care professionals in behavioral health programs to screen patients receiving specialty mental health treatment for serious physical illnesses, with a goal of reducing the 25-year mortality disparity for people with severe mental illness.

IEHP

Inland Empire Health Plan (IEHP) is a Medi-Cal managed care plan serving San Bernardino and Riverside Counties. IEHP recognizes the importance of integrated behavioral and physical health care; it is one of the first health plans to have a behavioral health department. To enable this integrated care, IEHP has created a secure portal where behavioral health care providers can deposit treatment plans, which include medication lists, for those beneficiaries for whom IEHP is the primary payer for behavioral health services. The beneficiaries' other treating providers can then view, download, or print those plans. To date, the portal supports one-way sharing of information from behavioral health care to physical health providers. It is separate from the providers' EHR systems; consequently, action outside of the EHR is required by both types of providers to assure the information is uploaded and subsequently accessed.

Alameda

Alameda's data sharing initiative focused on individuals with severe mental illness who frequently have chronic medical conditions and poor health outcomes. To address this health disparity, the county launched the "10 by 10" campaign in 2012 aimed at increasing life expectancy for mental health consumers by 10 years within 10 years. To support this effort, Alameda County has access to claims data for uninsured people because the county pays for their care. Under this initiative, providers exchange only data that can be shared legally in California without consent or authorization of the patient.

Tennessee

Cherokee Health Systems serves 13 counties in Tennessee and uses an integrated care model for patient care to bridge adult physical and behavioral healthcare. Integrated Care involves a team of primary care and behavioral health clinicians working together with patients and families to provide patient-centered care. This care may address mental health and substance misuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, and stress-related physical symptoms. This model presents patients and families with opportunities to become actively engaged in comprehensive healthcare, and their approach to wellness involves treating both the body and mind. During a typical visit using this approach, patients meet with several team members who partner with the patient to address their healthcare needs. The patient's primary care provider asks about their physical and behavioral health including the patient's mood, energy, sleep, and ways they deal with stress. The primary care provider may ask another team member, a behavioral health consultant (BHC), to offer additional assistance meeting the patient's healthcare goals. As a team, the patient, their primary care provider, and their BHC, will determine how to best help them reach their goals and develop a plan to help the patient succeed.

Minnesota

Since 2016, Minnesota has been implementing a behavioral health home model. This model provides an opportunity to build a person-centered system of care that achieves improved outcomes for individuals and reduced costs to the health care system. The health home model expands upon the concept of person-centered medical homes (health care homes in Minnesota) and makes a more concerted effort through design, policy levers and outcome measures to serve the whole person across primary care, mental health, substance use disorder treatment, long-term services and supports, and social service components of the health care delivery system. The goals of the health home framework are to: 1. Improve individual health outcomes (through preventative, routine treatment of health conditions). 2. Improve experience of care for the individual. 3. Improve the quality of life and wellness of the individual. 4. Reduce health care costs. Through the delivery of behavioral health home services, individuals have their comprehensive physical, behavioral health, and social service needs addressed in a coordinated manner. This includes a health wellness assessment and subsequent development of a health action plan to address chronic conditions, ongoing coordination of care between behavioral and physical health, and coordination with non-clinical services so that people have their health care coordinated with social and community supports. Services are reimbursed using a per member per month strategy.

Accountable Communities for Health (ACH)

The Accountable Health Communities Model is based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs. ACHs are responsible for the well-being of the entire population in a defined geographic area. ACHs support the integration of high-quality medical care, mental and behavioral health services, and social services for those in need of care, and supports community-wide prevention efforts to reduce inequities in the distribution of health and wellness. The ACH model helps communities strengthen existing collaborations and enhance their effectiveness through a focus on nine core elements: Mission, Multi-sectoral Partnership, Integrator Organization, Governance, Data and Indicators, Strategy and Implementation, Community Member Engagement, Communications, and Sustainable Financing.

Vermont

The Integrated Communities Care Management Learning Collaborative is a health service area-level rapid cycle quality improvement initiative with the goal of improving cross-organization care coordination and care management. Teams from most Blueprint communities participate in a learning collaborative, then use the Integrated Communities Care Management tools to implement the process in their communities. This initiative is a partnership of the Blueprint for Health, Vermont's Accountable Care Organizations, the Agency of Human Services, commercial insurance providers, community based social services organizations, and many others working together to improve outcomes for individuals with complex needs.

California

The California Accountable Communities for Health Initiative (CACHI) was established to lead efforts to modernize the health system and build a healthier California. The initiative aims to transform the health of entire communities, not just individual patients. By bringing together valuable community institutions – hospitals, public health, schools, public safety agencies, parks, and local businesses – along with local

residents, the initiative's goal is to create a new vision for a health system that is capable of fundamentally changing health outcomes by aligning interventions for maximum impact, promoting prevention, and organizing resources to focus on the most effective strategies. Through this effort, the initiative also aims to move closer to making health equity among all community members a reality in California.

Supporting Structures and Practices

Accountable Care Organizations (ACOs)

ACOs are provider-led organizations that manage the full continuum of care and are accountable for the overall costs and quality of care for a defined patient population. A central design element of ACOs is a shared savings mechanism, where ACOs can receive fee for service payment and share in the savings achieved relative to risk adjusted, pre-specified spending targets for their patient population; alternatively, payment can be partially or fully capitated, with ACOs sharing in both risks and gains. PCMHs, Health Homes, and ACHs typically are housed within or implemented in close partnership with ACOs. Thus an existing ACO structure is critical to effectively implementing any of these models.

Care Coordination

Care coordination is also central to each of the three models described. Care coordination models are often used to integrate physical and behavioral health care, or support a provider network that includes community-based and government providers. Care coordination involves deliberately organizing patient care activities and sharing information among all the participants and information systems concerned with a patient's care to achieve safer and more effective care. Typically, care coordination happens at the patient or practitioner level, rather than the agency or systems level.

Care coordination addresses several gaps in the current health care system. Current health care systems are often disjointed, and processes vary among and between primary care sites and specialty sites. Patients are often unclear about why they are being referred from primary care to a specialist, how to make appointments, and what to do after seeing a specialist. Specialists do not consistently receive clear reasons for the referral or adequate information on tests that have already been done. Primary care physicians do not often receive information about what happened in a referral visit. Referral staff deal with many different processes and lost information, which means that care is less efficient. These challenges create gaps and patients are at risk of falling through the cracks.

Care coordination strategies involve broad approaches (teamwork, care management, medication management, health information technology, patient centered medical homes) that are commonly used to improve health care delivery generally as well as specific care coordination activities (establishing accountability and agreeing on responsibility for patient care, communicating/sharing knowledge, helping with care transitions, assessing patient needs and goals, creating a proactive care plan, monitoring and follow-up, including responding to changes in patients' needs, supporting patients' self-management goals, linking to community resources, and working to align resources with patient and population needs).

Alternative Models: Key Takeaways and Considerations

- Patient-Centered Medical Homes, Health Homes, and Accountable Communities for Health are alternative healthcare system reform models that may garner more support from Utah's

Medicaid stakeholders than a bundled rate.

- All three models focus on reorganizing and coordinating delivery of the existing service array; the reorganization and coordination (rather than payment structure) drive change in cost, quality, and outcomes.
- Utah already had an ACO infrastructure in place in 13 counties, with additional managed care enrollment planned as Medicaid expansion rolls out.
- These models potentially align well with existing and planned physical health/behavioral health integration efforts in the state.
- Several of the state examples described demonstrate how they have been able to tweak these models to focus on specific populations by age and broaden eligibility criteria, with early evidence in some states of substantial cost reductions.
- Depending on which of these three options the Utah team were to pursue, a waiver application might still be necessary-to implement one of these models with a focus on transition age youth and to respond to the broad range of triggering events that we identified during the site visit.
- It is also unclear whether Utah would be fully eligible for the enhanced federal match rates associated with some of these models in the context of a partial expansion.
- Care coordination strategies are subject to many challenges, including data interoperability between physical and behavioral health or government and non-governmental data systems. Convincing providers to access a separate or additional portal for care coordination can be challenging; effectively integrating substance abuse providers into care coordination arrangements has proven difficult because of heightened data sharing restrictions.
- Once the team has identified which of these models has the greatest potential to meet the needs of transition age youth in Utah, a key next step will be to discuss these options with Utah Medicaid stakeholders to explore interest and support for the selected option.