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The Impact of State Health Policies on Integrated Care at Health Centers

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The Impact of State Health Policies on Integrated Care at Health Centers

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In this document, unless otherwise noted, the term "health center" is used to refer to organizations that receive grants under the Health Center Program as authorized under Section 330 of the Public Health Service Act, as amended, (referred to as "Federally qualified health centers", "FQHCs" or "grantees") and FQHC Look-Alike organizations, which meet all the Health Center Program requirements but do not receive Health Center Program grants. It does not refer to health centers that are sponsored by tribal or Urban Indian Health Organizations, except for those that receive Health Center Program grant.

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Introduction

One national study found that 14 percent of adults experience co-morbid conditions, including a medical condition and a behavioral health disorder.¹ The proportion is greater for higher-need populations, such as Medicare-Medicaid dual eligible beneficiaries.² A behavioral health condition can impair an individual's ability to adhere to treatment protocols that manage their medical care; conversely, chronic medical conditions place patients at higher risk for depression and other behavioral health disorders.

A coordinated approach to care is the most effective way to address interrelated primary care and behavioral health needs. However, workforce shortages of behavioral health practitioners and continued constriction of the nation's behavioral health care system (Japsen, 2015) are resulting in decreased access to treatment. Additionally, and even when not preempted by federal law, various state policies can impair the ability of a health center to address the behavioral health care needs of their patients.

Federally qualified health centers (FQHCs) and FQHC Look-Alikes³ confront numerous challenges in the delivery of behavioral health care services. This paper explores the myriad opportunities and barriers at the federal, state, payer, and provider levels around the adoption of an integrated health care model. The discussion identifies state initiatives that have either enabled or discouraged the implementation of an integrated care approach, as well as recommendations based on feedback from the field⁴ and literature⁵.

Background

Congress has authorized, and federal and state agencies have implemented, various initiatives to encourage the integration of primary care and behavioral health services. For example, through the Affordable Care Act (ACA), Congress authorized the states to amend their Medicaid State Plans in order to offer "health home" services.⁶ Under the ACA's Medicaid Health Home program, states can provide enhanced care coordination for individuals with multiple chronic conditions (including mental health and

¹ Garfield, Rachel L. "Mental Health Financing in the United States: A Primer | The Henry J. Kaiser Family Foundation." *Kaiser Family Foundation - Health Policy Research, Analysis, Polling, Facts, Data and Journalism*, Apr. 2011. See p. 2.

² Kasper, Judy, et al. "Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending | The Henry J. Kaiser Family Foundation." *Kaiser Family Foundation - Health Policy Research, Analysis, Polling, Facts, Data and Journalism*, July 2010. See p. 1.

³ More information on the Health Center Program is available at <http://bphc.hrsa.gov/about/what-is-a-health-center/index.html> and Section 330 of the Public Health Service Act at [42 U.S.C. §254b](#).

⁴ In March 2016, Cherokee Health Systems (Cherokee) conducted an assessment of 500 policymakers, payers, providers, and stakeholders across all 50 states on issues pertaining to the implementation of a primary and behavioral integrated health care practice. Of the participants, 102 responded (34 policymakers/stakeholders, 17 payers, and 51 providers).

⁵ Cherokee conducted a review of literature, payer manuals, journal articles, published studies, and state Medicaid websites to inform this brief.

⁶ Patient Protection and Affordable Care Act (PPACA) § 2703, Pub. L. No. 111-148 (adding Social Security Act (SSA) § 1945).

substance use disorders). The law also provided for enhanced federal financial participation (FFP) in states' health home service expenditures during an initial two-year period.⁷

FQHCs, whose scope of project under Section 330 of the Public Health Service Act includes a comprehensive array of required or optional primary care, specialty, and enabling services, are uniquely situated to address the pressing need for primary care-behavioral health integration. Health centers are the quintessential "health homes" operating in underserved areas where access to behavioral health services is most lacking.⁸ The Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services (HHS) similarly signaled the importance of primary care-behavioral health integration in health centers by awarding a total of \$105.8 million in fiscal years 2014 and 2015 to support 433 health centers in this endeavor, and another \$94 million to 271 health centers in 2016 for Substance Abuse Service Expansion.⁹

Despite these initiatives, there are significant barriers to the expansion of the behavioral health workforce in health centers today. Clinician shortages are the most significant problem with severe implications. Data from the Substance Abuse and Mental Health Services Administration (SAMHSA) indicate that as of 2007, 55 percent of U.S. counties had not a single practicing psychiatrist, clinical psychologist, or licensed clinical social worker within their boundaries.¹⁰ Results from a recent national survey of health center clinical workforce experiences found that 56 percent of FQHCs have at least one vacancy for a behavioral health staff member. Furthermore, FQHCs reported psychiatrist and licensed clinical social worker vacancies as some of the most difficult to fill.¹¹

State policies concerning professional licensure and supervision exacerbate clinician shortages by making it more difficult for health centers to expand their

CONVERSATIONS WITH THE FIELD:

- **40 PERCENT AGREED THAT THERE IS AN INSUFFICIENT NUMBER OF TRAINED BEHAVIORAL WORKERS TO STAFF AN INTEGRATED PRACTICE**
- **23 PERCENT AGREED THAT THERE ARE INSUFFICIENT TRAINING OPPORTUNITIES FOR INTEGRATED CARE**
- **40 PERCENT AGREED THAT BILLING/REIMBURSEMENT SYSTEMS ARE NOT CONDUCIVE FOR INTEGRATED CARE**

Cherokee Health Systems. (March 2016). See footnote 4.

⁷ SSA § 1945(c)(1).

⁸ CMS. "State-by-State Health Home State Plan Amendment Matrix." *Medicaid.gov*, Apr. 2016. Available at <https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html>.

⁹ HRSA. "HRSA awards \$51.3 million in Affordable Care Act funding to support mental health and substance abuse treatment." *HRSA.gov Press Releases*, Nov. 6, 2014. Available at <http://www.hrsa.gov/about/news/pressreleases/141106behavioralhealth.html>.

HRSA. "HHS awards \$94 million to health centers to help treat the prescription opioid abuse and heroin epidemic in America." *HHS.gov News*, Mar. 11, 2016. Available at <http://www.hhs.gov/about/news/2016/03/11/hhs-awards-94-million-to-health-centers.html>.

¹⁰ SAMHSA. "Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues." *SAMHSA.gov*, Jan. 24, 2013. See p. 10. Available at <https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>.

¹¹ National Association of Community Health Centers (NACHC). "Staffing the Safety Net: Building the Primary Care Workforce at America's Health Centers." *NACHC.org*, Mar. 2016. Available at <http://bit.ly/nachcworkforce>.

behavioral health workforce. Many states have a siloed system of regulation under which two separate state agencies are responsible for licensing or certifying behavioral health clinicians, agencies and primary care providers. This can make it difficult for health center clinicians to obtain the certifications needed to furnish certain behavioral health services. In the 2015 National Association of Community Health Centers (NACHC) assessment of primary care associations (PCAs) concerning FQHC reimbursement, states' siloed licensure and certification systems for behavioral health were cited (second to workforce shortages) as the biggest obstacle to FQHCs' provision of behavioral health services, and were perceived as being in tension with initiatives such as health homes.¹² (See Exhibit A for examples of state-based initiatives.)

The Search for a Common Definition of Integrated Care

Since 2005, behavioral health visits have grown by 187 percent, well outpacing growth in medical and dental visits.¹³ Accompanying this explosive growth in the provision of behavioral health care in the primary care setting, the lexicon associated with integration, or integrated care, varied widely. Stakeholders are likely to offer a wide range of definitions and descriptions of integration, such as: simply having access to a behavioral health expert through a formal referral process; the co-location of medical care providers and behavioral health specialists; or a "one-stop-shop" consisting of multidisciplinary care. In 2013, responding to this possible confusion, the Agency for Healthcare Research and Quality (AHRQ) commissioned a group of thought leaders to define integrated care. The group submitted the following definition:

The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related physical symptoms, and ineffective patterns of health care utilization (Peek, 2013).

Other studies and reports soon began to further define and refine integrated care. In *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment*, several key attributes were identified in a study of state strategies for integrating care that support the AHRQ definition (Bachrach, 2014), specifically:

- accountability for treating the whole person,
- aligned financial incentives,
- information sharing,
- up-to-date state licensing, credentialing, and billing regulations and procedures, and
- cross-system understanding.

¹² NACHC. "2015 Update on the Implementation of the FQHC Prospective Payment System (PPS) in the States: Results from NACHC's 2015 Annual Primary Care Association (PCA) Policy Assessment." *NACHC.org*, Dec. 2015.

¹³ Staff grew by 211% and patients grew by 222%, both higher than their medical and dental counterparts. See 2005 and 2015 Uniform Data Systems. Bureau of Primary Health Care, HRSA, DHHS.

Recognizing that successful integration cannot be achieved at the provider level without corresponding payer and policy changes, the Center for Health Care Strategies identified the following four requirements to effectively manage an integrated care system (Soper, 2016):

1. the need for specialized clinical expertise at the managed care health plan level,
2. state capacity for robust oversight and monitoring,
3. innovative strategies for advancing whole health care to address complex needs, and
4. mechanisms for achieving and monitoring provider and stakeholder support.

Other experts have promoted additional key elements, such as multidisciplinary teams who are accountable for providing a full range of supportive medical and behavioral health care services, mechanisms for identifying best practices, and rewarding high-quality care (Hamblin, 2011).

However, these additional attributes and recommended requirements are indicative of the varied definitions and approaches at the provider and state levels, which are further complicated by the wide variations in individual state oversight practices across the country. As a result, there is no national consensus on what constitutes the integration of primary and behavioral health care, with similar disagreements among state oversight agencies.

10 Services Essential to Integration:

Although confusion and competing agendas, policies, and practices have significantly impeded the widespread development of integrated care facilities, the following services are recommended as essential components of an integrated care model. They should be included in any definition of integrated care and in associated state and/or payer policy and benefit design discussions.

1. **Primary Care Visits** are typical primary care evaluation and management services where the patient is present and is seen by a primary care provider (PCP). The PCP is usually a physician, nurse practitioner, or physician assistant. Deductibles and/or co-payments apply according to the benefit package selected.
2. **Embedded Behaviorist Visits** are services provided with the patient present. These visits are coded as 96150–96155 services if there is a medical diagnosis. The behavioral health consultant (BHC) is usually a Ph.D. or LCSW, who sees the patient and addresses the specific concern or question raised by the PCP.
3. **Curbside Consultations** are where the PCP and the BHC consult on the care of a patient and jointly develop a treatment plan. Although no patient is present at the time of the curbside consultation, it is a critical component of the integrated care model.
4. **Psychiatric Consultations** take place when a psychiatrist is available in real-time to assist the PCP with medication management questions, issues, or concerns. The goal is to keep most of the behavioral health care within the purview of primary care to avoid a referral outside the system,

which could cause delays and noncompliance. The patient remains in the primary care exam room while the PCP steps out to consult with the psychiatrist in real-time.

5. **Psychiatric Medication Management** occurs when the psychiatrist needs additional “face-to-face” information from the patient while the patient is in the primary care exam room. Because the psychiatrist is generally off-site, telemedicine technology is used between the patient and the psychiatrist. This immediate access to psychiatric care avoids weeks or even months of waiting for an appointment with a psychiatrist. The psychiatrist will work with the patient and the PCP to develop a treatment plan for appropriately managing medication.
6. **BHC Follow-up Visits (15–30 minutes)** take place in some cases when the BHC needs to provide ongoing short-term care with the patient present. These are short visits that address initial needs the PCP has identified.
7. **Treatment Team Meetings** are not with a patient but with a multidisciplinary team of providers who discuss a patient’s case, and develop and implement treatment plans. The cases brought before the Treatment Team are most often extremely complex and require a multi-disciplinary approach to provide the best care.

8. **Clinical Pharmacists** play an important role in one-on-one or group patient education sessions (diabetes, Coumadin, etc.), medication compliance, and adverse medication interactions that reflect the often multiple and complex pharmaceutical regimens of patients. The clinical pharmacists work directly with patients and provide critical information to the PCP and BHC through a common electronic health record.

10
Services
Essential to
Integration

- Primary Care Visits
- Embedded Behaviorist Visits
- Curbside Consultations
- Psychiatric Consultations
- Psychiatric Medication Management
- BHC Follow-up Visits (15–30 minutes)
- Treatment Team Meetings
- Clinical Pharmacists
- Care Coordination
- Outreach and Patient Engagement

9. **Care Coordination** is most often carried out by nursing staff in the office. Working from various databases and patient registries, the staff person commonly contacts patients to fill gaps in care, arrange follow-up appointments, and schedule required preventive services.
10. **Outreach and Patient Engagement** reflects how most people characterize the embedded behaviorist model of integrated care noted above, but they often think that patient care ends when the patient leaves the facility and begins again when the patient returns. However, the “in-clinic” visit is only the starting point, as integrated care moves beyond the walls of the clinic and into the community. Patient engagement involves patients in their own care by providing services in the home or community, if such follow-up is required. It is in the community that the

multidisciplinary team reaches out to include community health coordinators (CHCs)¹⁴, sometimes referred to as case managers, and patient engagement specialists who work with patients in their home, school, or community. These specialists often find that a patient’s social determinants of health (such as unreliable transportation, lack of housing, food insecurity, social isolation) exacerbate the medical and/or psychological condition of a patient. By engaging patients in the community, CHCs can provide valuable information to the PCPs and BHCs, and needed services to the patients. CHCs are often equipped with smart phones and iPads in order to securely access patient health records.

Inside the Medicaid FQHC PPS

Each FQHC’s per-visit rate takes into account the costs associated with both (1) “Federally-qualified health center services” (“FQHC services”) and (2) “any other ambulatory services offered by a FQHC and which are otherwise included in the plan.” “FQHC services” includes those provided by physicians, midlevel clinicians (including nurse practitioners and physician assistants), licensed clinical social workers (LCSWs), and clinical psychologists, as well as services incident to those services. The services furnished by these clinicians are sometimes referred to as the “core” FQHC services. The term “any other ambulatory services” refers to any outpatient Medicaid services that are both listed in the Medicaid State plan and currently provided by a given FQHC.

In lieu of the PPS, the law authorizes States to include an alternative payment methodology (“APM”) to pay for “services described in section 1902(a)(2)(C)” (*i.e.*, “FQHC services” and “other ambulatory services”) in their State plan. In order for the APM to apply to an FQHC, the FQHC must have agreed and the APM must result in payments not less than the amount that the FQHC would have otherwise been paid under the statutory PPS approach.

Policy Barriers and Opportunities

A number of obstacles are faced by health centers seeking to expand their behavioral health workforce and receive reimbursement under Medicaid¹⁵ for behavioral health services. Provided herein are examples of policies that have been implemented by some states to help health centers overcome those

¹⁴ Community health coordinators (CHCs), in this context, are similar to behavioral health case managers, but with an additional medical, integrated care orientation and training. CHCs assist patients in their homes or in a community setting with needs such as housing, transportation, food stamps, legal issues, behavioral health medications, etc. In addition to these more traditional behavioral health case management activities, they also assist patients with their medical needs. For example, CHCs may ask patients about their chronic medical conditions, assure access to medical prescriptions, ask about and take blood pressure readings, check weights, encourage exercise and fitness, assist with nutritious foods, help patients navigate the health care system, and arrange appointments with either behavioral health providers or medical providers who then integrate their care within the clinic. As a result, an individual with diabetes and major depression can receive assistance from a CHC to address needs in an integrated model of care.

¹⁵ In 1989, Congress defined a set of “federally-qualified health center services” in Medicaid and designated these as a required service for categorically needy individuals. In Section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000, Congress replaced the then-current system of reimbursing each FQHC for its reasonable cost of providing Medicaid covered services with a system that paid FQHCs on a per-visit basis. States were required to base the per-visit rate for each FQHC on an average of 100 percent of the FQHC’s reasonable cost of providing Medicaid covered services in fiscal years 1999 and 2000. Since the rate is set in advance of each year and is not subject to reconciliation, it is often referred to as a prospective payment system or “PPS” rate for FQHCs. For fiscal years after 2001, the law required that the PPS rates for each FQHC be “adjusted to take into account any increase or decrease in the scope of such services furnished by the center... during that fiscal year.” CMS has stated that States should allow rate adjustments to reflect changes in the “type, intensity, duration and/or amount” of services.

obstacles. As explained below, many of the policy choices that can either impede or facilitate the provision of behavioral health services in health centers lie within the discretion of each state government. (See Exhibit B for state-by-state information on these and related policies.)

The Scope of “Other Ambulatory Services”

The concept of “other ambulatory services” (as opposed to “core services”) in the Medicaid FQHC benefit is a critical one for purposes of understanding the Medicaid reimbursement policy choices—most within states’ control—that can either impede or facilitate the delivery of behavioral health in health centers.

As best practices evolve, many important Medicaid behavioral health services are provided by clinicians other than FQHC core services providers. Examples include addiction counseling, family counseling, crisis intervention services, peer support services, and psychiatric rehabilitation services. Under federal law, outpatient behavioral health services furnished by non-core clinicians should be included in the FQHC benefit and encompassed in the FQHC reimbursement methodology if the services are otherwise included in the state plan.

In reality, however, most states limit the extent to which non-core behavioral health services are included in the FQHC benefit. In some instances, states simply cover a very limited behavioral health benefit under their state plan. (Most Medicaid behavioral health services are optional to the state under federal law.)¹⁶

Even where FQHCs are authorized to furnish and bill for a behavioral health service as an “other ambulatory service,” some states do not meaningfully include the service in the Prospective Payment System (PPS) methodology. In order for a service to be included in the PPS methodology, the associated costs should be identified as allowable service costs on the FQHC cost report, and significant clinical events relating to the service should be identified as billable FQHC “visits” (see *infra.*) triggering a payment of the PPS rate. Some states effectively carve out some or all “other ambulatory services” from the PPS rate, and instead pay FQHCs for those services under the Medicaid fee schedule. Oklahoma, Massachusetts, and Arkansas are states that adopted this approach with respect to some or all Medicaid behavioral health services.¹⁷ The “carving out” of behavioral health or other types of non-core services from the FQHC reimbursement methodology is inconsistent with federal law, which requires states to develop a cost-related rate for the entire FQHC benefit (both “FQHC services” and “other ambulatory services”).¹⁸

“ARKANSAS IS ON THE CUSP OF MANAGED CARE WITH BEHAVIORAL HEALTH CARVED OUT...MY PERSONAL PREFERENCE WOULD BE FOR FQHCs AND CMHCs TO COME TOGETHER.”

-ARKANSAS HEALTH OFFICIAL

¹⁶ SSA § 1902(a)(10)(A) (incorporating by reference SSA § 1905(a)(1)-(5), (17), (21), and (28)) lists the required services for categorically needy individuals.

¹⁷ NACHC. “2015 Update on the Implementation of the FQHC Prospective Payment System (PPS) in the States: Results from NACHC’s 2015 Annual Primary Care Association (PCA) Policy Assessment.” *NACHC.org*, Dec. 2015. See pp. 4-5 and supporting data.

¹⁸ SSA § 1902(bb)(1).



TENNESSEE

Requires contracted Medicaid Managed Care Organizations to take responsibility for behavioral health coverage, which essentially shifts coverage from a “carve-out” model of care to a “carve-in” model.



TEXAS

Requires the reimbursement of providers through one contract, in addition to evidence demonstrating that health plans have integrated technical and care coordination systems (Soper, 2016).

The FQHC “Visit” Definition

Federal law requires that FQHCs be reimbursed on a per-visit basis, but each State defines the term “visit.” States establish which clinicians are qualified to furnish an FQHC visit; in which locations or under what modalities a visit may occur; how many and what types of billable FQHC visits a single patient may access in a single day; and whether group visits are recognized. As demonstrated below, each of these policy decisions can have a strong impact on whether FQHCs are reimbursed fairly for the provision of behavioral health services under Medicaid.

Behavioral Health “Carve-Outs”

Among the numerous issues adversely impacting integrated care, the most significant barrier is the “carve-out” of behavioral health coverage in 26 of the 35 states¹⁹ that utilize managed care to administer their Medicaid programs (Bachrach, 2014). A study commissioned by The Commonwealth Fund stated that even as the evidence mounts that “carve-outs” create barriers to care coordination and information sharing, state policies continue to favor the “carve-outs”. “Managed care organizations and payers of carved-out services benefit financially from diverting members to services for which they do not have financial responsibility, potentially resulting in unnecessary or inappropriate referrals and fragmented care delivery” (Bachrach, 2014). Even in states that “carve-in” behavioral health benefits, the MCOs are often permitted to “carve out” the benefits *internally*, thus requiring health centers to execute separate contracts for medical and behavioral care and to separate, and possibly differentiate, between medical and behavioral credentials and privileges. It is, therefore, essential to provide a complete “carve-in” or integration of behavioral and medical benefit design. That means medical and behavioral care providers should have the same contract, provider manual, and procedures for credentialing and privileging. Several states have enacted regulations for Medicaid managed care subcontracting arrangements to eliminate at least some of the service fragmentation.

¹⁹ A May 2016 review of state policies by Cherokee Health Systems revealed that 39 states utilize some form of managed care.

Coding

Some State Medicaid programs have recently made policy changes to enable them to pay primary care providers for care coordination and other targeted interventions in the behavioral health area, by adding new codes under the Medicaid fee schedules. Examples of new codes include codes for screening, brief intervention, and referral to treatment (SBIRT) for substance use disorders; and for health behavior assessment and intervention (HBAI).

HBAI services are psychological services provided to identify and modify biopsychosocial factors that affect a patient's physiological health, functioning and well-being. These codes for HBAI services are not applicable to services provided to treat mental illness or psychiatric conditions, for which a provider would use appropriate psychotherapy codes.

Albeit a major breakthrough for behavioral health integration, the recognition and availability of HBAI services and codes do not provide a complete solution. Despite HBAI codes being published in the *Federal Register* and accepted by the Center for Medicare & Medicaid Services (CMS) in 2002²⁰, HBAI services are optional under Medicaid, and twenty-one states still disallow the utilization of these codes. Similarly, only some private payers reimburse for HBAI services. Ergo, the use of HBAI codes can create confusion among health plans and payers, because their systems often deny such claims unless the HBAI codes are already approved for payment and there has already been a medical diagnosis. Furthermore, although HBAI services may be performed by defined types of providers, those services may not be included in a provider's scope of practice because that scope is defined by each state. These issues shed light on existing opportunities to improve the effectiveness of HBAI services and codes, such as taking measures to expand the types of providers who may provide HBAI services and encouraging consistency of coverage throughout the states.

It bears noting that these types of changes in Medicaid fee-for-service reimbursement do not automatically facilitate behavioral health in FQHCs, because under a typical PPS methodology, FQHCs are not reimbursed on the Medicaid fee schedule. In addition, the types of clinical activities reimbursed under these codes typically relate to types of care—for example, phone interactions and contacts with non-licensed clinical personnel—that in most States do not meet the criteria for an FQHC billable visit. In order for the addition of new fee-for-service billing codes that encourage primary care-behavioral health integration to be meaningfully included in the FQHC reimbursement methodology, the State must either: 1) have an effective FQHC scope change rate adjustment process in place so that costs associated with the newly-authorized clinical activities are embedded in a (higher) FQHC per-visit rate; or 2) reimburse FQHCs under an APM that is cost-based. Otherwise, the risk is that FQHCs' fixed PPS payments



WASHINGTON

Washington's Health Care Authority has recently launched in the primary care setting **SBIRT**, a set of brief interventions used to identify, reduce, or prevent substance use disorders. Washington's FQHC provider manual indicates that SBIRT interventions are an "encounter-eligible" service for FQHCs.

²⁰ See the "2002 Physician Fee Schedule", 66 Fed. Reg. 55245, 55463, 55499 (Nov. 1, 2001).

will not reflect the new costs associated with integrated care activities that do not trigger a visit. Alternatively, some State Medicaid programs require that FQHCs bill for such newly recognized integrated care activities on fee schedules that fall outside the PPS methodology, so that effectively, these activities are carved out of the PPS.

Confidentiality

Significant confusion persists over the requirements and prohibitions of the 42 C.F.R. Part 2 rule (“Part 2”), the federal regulations that govern the confidentiality of patient records pertaining to drug and substance abuse treatment. This rule prohibits the sharing of substance abuse records for the purposes of payment, treatment, and operations without the consent of the patient. Many health centers are not certain whether Part 2 applies to them, and they believe it presents a significant barrier to providing integrated care at their sites.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is developing language to clarify the confidentiality regulations governing the records of alcohol and drug abuse patients. In April 2016, the National Association of Community Health Centers (NACHC) submitted comments on the proposed rule. Recognizing that health centers play a significant role in treating individuals with substance abuse and related conditions, NACHC expressed support for SAMHSA’s efforts to (1) modernize Part 2 relative to confidentiality for the records of substance abuse patients without compromising that confidentiality by any of the proposed changes; (2) clarify that the definition does *not* apply to “general medical facilities” such as health centers and request that language be added to the regulation; and (3) address Health Information Exchange (HIE) data barriers (NACHC letter to SAMHSA dated April 11, 2016, and submitted via www.regulations.gov and www.NACHC.org).

If implemented, these regulatory clarifications are expected to address health centers’ concerns about this perceived barrier to integrated care. The comment period for the proposed rule changes ended on April 11, 2016, and, as of the date of this publication, comments are currently under review to develop the final rule. Unless otherwise noted by SAMHSA, the rule changes will be applicable 180 days after the publication of the final rule. In the interim, health centers may take the necessary steps to assure the confidentiality of all medical records by obtaining proper legal releases that will assure the confidential release of patient information and records.

Workforce

A well-trained workforce is critical to moving integrated care forward across the nation. Assessment respondents noted the challenges of finding well-trained and experienced behavioral health consultants, primary care physicians, and nurse practitioners/physician assistants, particularly in rural states. A recent national survey of health centers found that competitive salaries and benefit packages, as well as health centers oftentimes being located in impoverished or isolated areas, were the most highly rated challenges for clinical staff recruitment and retention efforts. While the majority of health centers report that they have hired someone who trained in their or another health center setting in the last two years, they indicate that departing clinical staff most frequently leave the health center for private primary care practices or hospitals.

There is a desperate need for initial and ongoing training of behavioral health consultants. This training is a critical need nationwide, as the demand for integrative services far exceeds the supply of well-trained staff. The Agency for Healthcare

“ESTABLISH BILLING REIMBURSEMENT FOR FQHCS TO USE COMMUNITY HEALTH WORKERS TO ASSIST WITH MEDICAL AND BEHAVIORAL CARE TO SUSTAIN THE SERVICE.”

-INDIANA PRIMARY CARE PROVIDER

Research and Quality tracks training programs whose mission is to meet this need for quality staff. Integrated care training programs can be found at <http://www.integrationacademy.ahrq.gov/education-workforce/programs>. In another recent report,²¹ NACHC highlighted six states that have recently provided funding to support the FQHC workforce.

Medicaid Reimbursement

Clinicians Who May Furnish Billable FQHC Visits

One of the most important policy changes that a State can make to facilitate Medicaid behavioral health services in FQHCs is to modify its “visit” definition to include non-core behavioral health clinicians, and to include clinicians who are in the course of pursuing licensure.

The Medicare program recognizes face-to-face encounters with one of the following FQHC core providers as billable: physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses, LCSWs, and clinical psychologists.²² Until recently, most State Medicaid programs hewed to Medicare’s limited set of billable providers.

Many States have expanded the list of behavioral health providers they recognize as qualified to provide a billable visit in the last several years. For example, in NACHC’s 2011 assessment of state policies, only four Primary Care Associations (PCAs) reported that their State recognized licensed professional counselor (LPC) encounters, whereas 19 PCAs reported that LPC visits were billable in 2015. Similarly,

Changing Landscape of Behavioral Health Providers Recognized for Billable Visits		
	2011	2015
Licensed Professional Counselors	4 <small>PCAs reported these providers as billable</small>	19 <small>PCAs reported these providers as billable</small>
Marriage and Family Therapists	2 <small>PCAs reported these providers as billable</small>	14 <small>PCAs reported these providers as billable</small>

²¹ NACHC. “State Strategies for Supporting Workforce Programs at Health Centers, Spotlight on the States #9.” NACHC.org, May 2016. Available at http://nachc.org/wp-content/uploads/2015/10/Spotlight-9_State-Funding-for-Workforce-050316.pdf.

²² 42 C.F.R. § 405.2463. In addition to face-to-face interactions with these “core” providers, Medicare also recognizes certain other types of visits, including transitional care management, diabetes self-management training, and medical nutrition therapy.

in 2011, only two PCAs reported that Marriage and Family Therapists (MFTs) could furnish a PPS encounter. In 2015, 14 PCAs reported that MFT visits were billable.²³

CONNECTICUT



The State of Connecticut recently expanded the “visit” definition to encourage the delivery of behavioral health services in FQHCs. In 2015, Connecticut formally recognized LPCs, MFTs, and alcohol and drug counselors as billable FQHC providers. In its new 2015 regulations, Connecticut also recognized a variety of behavioral health clinicians who are in the course of seeking licensure as billable FQHC providers.

Connecticut has also developed an FQHC-specific group behavioral health rate drawing on Medicare’s Resource Based Relative Value System for group visits. Group psychotherapy and smoking cessation visits are billable under the special rate, so long as the session includes a maximum of eight participants, lasts a minimum of 45 minutes, and is provided by one of the clinician types authorized in the regulations.

In 2015, Connecticut issued regulations that permit “license-eligible” clinicians to furnish billable encounters. License-eligible clinicians are individuals pursuing licensure as addiction counselors, dental hygienists, clinical psychologists, and marriage and family therapists (MFTs) whose education, training, skills and experience satisfy the licensure criteria, but who have not yet passed the licensure exam.

[Sources: Regulations of the Connecticut State Agencies §§ 17b-262-995(3)(A), 17b-262-995(25); §§ 17b-262-997(d), and 17b-262-1003(g).]

Same-Day Billable Visits

Another promising trend evident from NACHC’s annual look at state policy is the movement toward States recognizing same-day FQHC primary care and behavioral health visits as billable. Integrated care is best achieved when a health center can offer both primary care services and behavioral health services to a patient during a single appointment.

In this area, as with billable providers, many States have historically looked to Medicare as an example. Under Medicare rules, an FQHC can bill for more than one visit per day if (1) after the initial encounter, the patient suffers an illness or injury requiring additional treatment; or (2) the patient has a medical visit and a mental health visit on the same day.²⁴ Likely because of the Medicare precedent, recognition of same-day medical and behavioral health visits in State Medicaid programs has not been uncommon. Still, as of 2011, PCAs reported that this was the policy in only 30 States.²⁵

²³ NACHC. “2015 Update on the Implementation of the FQHC Prospective Payment System (PPS) in the States: Results from NACHC’s 2015 Annual Primary Care Association (PCA) Policy Assessment.” *NACHC.org*, Dec. 2015. See p. 4.

²⁴ 42 C.F.R. § 405.2463(c)(4). Notably, in its 2013 Notice of Proposed Rulemaking on its new Medicare prospective payment system (PPS) for FQHCs, CMS proposed to eliminate same-day billable medical and mental health visits, noting that claims data suggested that billing for same-day visits was a rare event for FQHCs, and the prohibition of same-day visits would not impede access to care. 78 Fed. Reg. 58393-58394 (Sept. 23, 2013). Commenters objected to this measure. In response, CMS reversed course, and the final rule that CMS promulgated in May 2014 allowed same-day medical and mental health visits. See 79 Fed. Reg. 25447 (May 2, 2014).

²⁵ NACHC. “Update on the Status of the Medicaid FQHC Prospective Payment System in the States.” *NACHC.org*, Nov. 2011. See pp. 32-34.

Four years later (2015), 36 PCAs reported that same-day medical and behavioral health visits were billable in their States.^{26, 27}

Group Billable Visits

Like the use of non-core clinicians, group behavioral health visits are important to health centers from the perspectives of both economic efficiency and keeping pace with best practices in behavioral health. Medicaid programs have understandably struggled with how to incorporate group visits into a PPS methodology, since the PPS visit is typically defined as a face-to-face, one-on-one interaction with a clinician.

In NACHC's 2015 assessment, PCAs from only nine States reported that Medicaid covered group FQHC behavioral health visits through a discrete payment (fee schedule or PPS). PCAs from 15 States reported that while group visits did not qualify as an FQHC visit, the associated costs are included as allowable costs in the FQHC cost report. Only three of the PCAs reported that their State paid the FQHC PPS rate for group visits.²⁸

One promising trend in this area is FQHC group therapy reimbursement methodologies that use a unique FQHC group encounter rate that is intended to correspond in some manner to the health center's costs, while also taking into account the lower cost per patient associated with group encounters.

Remote (or Telehealth) Visits²⁹

Another encouraging trend in some States is the move to facilitate behavioral health services in FQHCs by instituting more flexible standards for the modality of the FQHC visit.

The fact that many State Medicaid programs look to Medicare to define a FQHC visit has been a hindrance in the realm of telehealth. Under Medicare, a face-to-face interaction is required in order



NEW MEXICO

New Mexico uses the same telehealth framework as Medicare, with separate payments for the originating site and distant site, but recognize FQHCs as **both originating and distant site providers** and provide for the same type of reimbursement to the distant site provider (*i.e.*, the PPS or APM) that it would receive if the visit were furnished face-to-face.



ARKANSAS

Arkansas considers telehealth visits to be a **face-to-face** interaction for purposes of the FQHC billable visit definition.

²⁶ NACHC. "Medicaid Reimbursement for Multiple Same-Day Encounters: Florida's Experience – Emerging Issues #7." *NACHC.org*, Oct. 2012. Available at <http://nachc.org/wp-content/uploads/2015/11/Medicaid-Same-Day-Visits-FINAL.pdf>.

²⁷ NACHC. "2015 Update on the Implementation of the FQHC Prospective Payment System (PPS) in the States: Results from NACHC's 2015 Annual Primary Care Association (PCA) Policy Assessment." *NACHC.org*, Dec. 2015. See p. 4.

²⁸ NACHC. "2015 Update on the Implementation of the FQHC Prospective Payment System (PPS) in the States: Results from NACHC's 2015 Annual Primary Care Association (PCA) Policy Assessment." *NACHC.org*, Dec. 2015. (supporting data).

²⁹ NACHC. "State Trends that Impact the Use of Telehealth at Health Centers: Store-and-Forward and Remote Patient Monitoring, Emerging Issues #10." *NACHC.org*, Sep. 2015. Available at http://nachc.org/wp-content/uploads/2015/10/Emerging-Issues-10_Telehealth-Policies-091115.pdf.

to trigger a billable visit.³⁰ In addition, CMS has made clear that a remote interaction (even via live video) does not qualify as “face-to-face.” Moreover, FQHCs are not permitted under Medicare to receive payment for services furnished remotely under the discrete Medicare “telehealth services” Part B benefit.³¹ Under Medicare, telehealth includes an “originating site fee” (a small fee that is paid to a provider located in a Health Professional Shortage Area whose patient receives the telehealth service) in order to cover the technology costs associated with the service, and a “distant site fee” (the fee for the substantive service paid to the provider that furnishes the service remotely). FQHCs are eligible to serve under Medicare as telehealth “originating sites,” but not as telehealth “distant sites.”³²

The decision by Medicare and many State Medicaid programs to not count remote visits as billable has had a very limiting impact on behavioral health services in FQHCs, particularly in rural communities. Remote sessions with psychiatrists, psychologists or other behavioral health clinicians located at FQHC sites in more densely populated areas often represent the most viable means for an FQHC to provide services, such as psychotherapy and medication management. This is due to both behavioral clinician shortages in rural areas and the conduciveness of behavioral health services to remote modalities.

In recent years, a growing number of State Medicaid programs have introduced measures for paying for remote services in FQHCs. Those policies are in fact the most beneficial to FQHCs, as they allow health centers with both rural and urban sites to have patients at one site receive services from clinicians at another, and receive two separate payments to cover the technology and the service.³³

The Impact of Changes to Medicaid Reimbursement

The types of policy changes described above (changes to the FQHC visit definition) enable health centers to receive fair reimbursement for significant behavioral health clinical “touches.” The policy initiatives described in this section, by contrast, allow health centers to receive additional reimbursement for the types of care coordination and wraparound support that is not typically billable. This support is critical in helping patients manage behavioral health conditions in the primary care setting and manage transitions between care settings.

Recognition of FQHCs as Medicaid “Health Homes”

The ACA health home option gives States a powerful tool for facilitating more effective integration of primary care and behavioral health services. Under Section 2703, States may choose to amend their State plans to offer health home services to Medicaid beneficiaries with certain chronic conditions,

³⁰ 42 C.F.R. 405.2463.

³¹ The provision of telehealth services in a “distant site” is limited to certain clinical services (Social Security Act § 1834(m)(4)(F)) and to certain rendering “physicians” and other “practitioners” who bill under Medicare Part B. SSA § 1834(m)(4)(E); CMS, Final Rule, Medicare FQHC PPS, 79 Fed. Reg. at 27135 (May 2, 2014) (explaining CMS’ conclusion that a physician or practitioner employed by and working in an FQHC may not bill Medicare Part B for a telehealth distant site service).

³² 79 Fed. Reg. 27135-27136.

³³ Even in states whose State Medicaid programs have policies that permit FQHC telehealth billing, such as New Mexico, the fact that Medicare does not recognize telehealth encounters is an obstacle for health centers, particularly given that some of their highest-need patients are Medicare-Medicaid dual eligible beneficiaries.

including mental health and substance use disorders.³⁴ States may choose which of these conditions to cover in their health home program. To qualify for health home services, the Medicaid beneficiary must have two chronic health conditions; have one chronic condition and be at risk for another; or have one serious and persistent mental health condition.

The ACA health home services are care management, care coordination, transitional care from inpatient to outpatient or community settings, family support, referral to community and social support services, and the use of health information technology (HIT) to link services.³⁵ Most States have chosen to use a per-member-per-month payment methodology for health home services.

The law provides for eight calendar quarters of enhanced federal match (90 percent), instead of the standard federal medical assistance rate, for States that provide Medicaid health home services.³⁶

Of the 22 States that have health home programs in place as of April 2016, nine specifically designated health centers as health home providers.³⁷ Several other States use health home provider criteria that do not specifically name, but do not exclude, FQHCs³⁸.

The option of being reimbursed outside the FQHC benefit for these services is particularly helpful to health centers because some States do not have a mechanism for health centers to request “change in scope” rate adjustments for increases in the intensity of care coordination and other clinical activities not typically associated with face-to-face visits.



MICHIGAN

A program recently implemented in Michigan is an example of a health home design that uses FQHCs to address the needs of individuals with behavioral health disorders. The “MI Care Team” health home program, which took effect on July 1, 2016, targets individuals with depression or anxiety as well as a diagnosis of asthma, diabetes, hypertension, heart disease, or COPD. MI Care Team will rely exclusively on FQHCs and Tribal Health Centers as health homes. A diverse care team, ranging from physicians to community health workers, will be responsible for carrying out a range of services, from referral tracking and medication monitoring, to patient and family support and assistance with transitions between care settings. Payment to the health home will be in the form of a one-time “Health Action Plan” rate, to be paid for the first month that the beneficiary participates in the program; and an ongoing monthly care coordination payment (provided that some qualifying health home activity occurs during the month).

³⁴ Letter to State Medicaid Directors from Cindy Mann, Director, Center for Medicaid, CHIP and Survey & Certification, Nov. 16, 2010, re: *Health Homes for Enrollees with Chronic Conditions* (hereinafter, “State Medicaid Director Letter”). The chronic conditions listed in the statute are mental health conditions, substance use disorders, asthma, diabetes, heart disease, and being overweight (with body mass index over 25).

³⁵ PPACA § 2703, SSA § 1945(h)(4)(B).

³⁶ SSA § 1945(c)(1).

³⁷ CMS. “State-by-State Health Home State Plan Amendment Matrix.” *Medicaid.gov*, Apr. 2016. Available at <https://www.medicare.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html>

³⁸ NACHC. “Section 2703 Health Homes and Health Centers: Providing Care for Chronic Conditions, Emerging Issues #9.” *NACHC.org*, Apr. 2015. Available at http://nachc.org/wp-content/uploads/2015/10/Emerging-Issues-9_2703-Health-Homes-FINAL.pdf.

State Law Licensure and Scope of Practice Issues

Licensing and Credentialing

FQHCs Licensing

Even if a given ambulatory behavioral health service is listed in the State Plan, many states impose licensure rules that make it difficult for FQHCs to provide the service as an “other ambulatory service” under Medicaid without seeking a separate (non-FQHC) license. This problem is particularly pronounced in behavioral health, given the historically siloed state regulation of behavioral health services and medical services. Ohio, for example, offers a “community mental health agency” (CMHA) services Medicaid benefit. Only licensed CMHAs are qualified to furnish Medicaid CMHA services. FQHCs are effectively foreclosed from providing these services under Medicaid unless an FQHC is independently licensed as a CMHA.³⁹ While some of the components of “CMHA services,” such as counseling services, are independently available under the FQHC benefit, other components, such as crisis intervention and community psychiatric support services, are not. It is also common for states to require a specialized credential for addiction service providers, impeding FQHCs from providing this service as an “other ambulatory” service.



NEW YORK

New York requires clinic sites to be licensed by the Department of Health, the Office of Mental Health, and/or the Office of Substance Abuse Services in order to provide those respective services. Recently, however, the state developed several models for providing integrated care under certain thresholds (Sachs Policy Group, 2016).

Separate licensing and credentialing of behavioral health providers and primary care providers presents significant barriers. States typically structure separate oversight agencies for behavioral health and/or substance abuse, medical health, and Medicaid. As a result, states license and credential the providers separately. Many MCOs also have separate credentialing procedures.

Provider Licensure and Scope of Practice

There are two main types of limitations that state regulatory authorities impose on health professionals. The first are licensure requirements—the qualifications required to obtain and maintain a license from the state.⁴⁰ These requirements typically include a minimum level of education, a period of supervised practice, and a passing score on a licensure exam. A state’s scope of practice rules for a health profession places limitations on the licensed clinician’s activities.⁴¹

³⁹ Ohio Admin. Code §§ 5160-27-01 through 5160-27-07.

⁴⁰ Heisler, Elayne and Bagalman, Erin. “The Mental Health Workforce: A Primer.” *Congressional Research Service*, Oct. 18, 2013. See p.3.

⁴¹ NACHC. “Increasing the Workforce Capacity of Health Centers: Reimbursement and Scope of Practice, State Policy Report #54.” *NACHC.org*, Apr. 2015. Available at <http://nachc.org/wp-content/uploads/2015/10/6-19-15-NACHCWorkforce-Reimbursement-SOP-Brief-FINAL.pdf>.



MISSOURI

Missouri's use of FQHCs in the health home program offers a different perspective of a primary care-oriented health home program that emphasizes behavioral health integration. FQHCs are the chief providers in the state's primary care health home program. While the program targets only beneficiaries with chronic medical conditions, it allows payment, as part of health home benefit, for "behavioral health consultants" to provide behavioral health problems.

In NACHC's 2015 assessment, many PCAs indicated that state law licensure and scope of practice rules were a significant hurdle that health centers faced in seeking to furnish and get paid for behavioral health services. In many states, the licensure of behavioral health clinicians is carried out by a separate state agency from the state Medicaid agency, and in some states, county or regional authorities manage the certification of community behavioral health facilities. Some states require specialized credentials for behavioral health clinicians (particularly substance treatment providers and providers of SBIRT) that impede otherwise-qualified clinicians within the primary care setting from providing substance use disorder interventions as part of an integrated care model.

Allowing Pre-License Clinicians to Furnish Medicaid Services

State licensure rules for LCSWs and clinical psychologists, among others, typically require an extensive period of clinical supervision before attaining licensure. Clinicians who are on the path to licensure are a valuable resource, and largely untapped by state Medicaid programs. Behavioral health clinician shortages in FQHCs would be mitigated if state Medicaid programs allowed pre-licensure clinicians to furnish FQHC visits.

Allowing Behavioral Health Clinicians to Enroll in Medicaid

In some States, the Medicaid program does not permit behavioral health clinicians such as LCSWs or clinical psychologists to enroll independently in the Medicaid program.⁴² Instead, these clinicians (whether they work in FQHCs or other settings) are required to work under the general supervision of a physician, and the physician is listed as the rendering provider on claim forms. This is a disincentive to the provision of behavioral health services such as counseling.

Expanding Prescribing Authority for Midlevel Clinicians

In many states, prescribing authority for midlevel clinicians (such as nurse practitioners (NPs), physician assistants (PAs), and Advanced Psychiatric Nurses) is limited and subject to strict supervision requirements.

The scope of practice for nurse practitioners is a particularly debated issue. Many FQHCs, particularly those in rural areas, rely heavily on NPs to assess behavioral health issues and to prescribe behavioral health medications. The American Association of Nurse Practitioners reports that 22 states recognize full practice authority for NPs, including prescribing authority. In some states, decision makers have

⁴² Under Florida's Medicaid program, for example, LCSWs and clinical psychologists cannot obtain Medicaid provider numbers in conjunction with providing services in a FQHCs. Therefore, each claim for services furnished by an LCSW or clinical psychologist must bear a physician's provider number, as evidence that the behavioral health clinician was working under the supervision of the physician. Florida Agency for Health Care Administration. "Federally Qualified Health Center Services Coverage and Limitations Handbook." See p. 2-5. Available at http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_08_080401_FQHC_ver1_2.pdf.

been urged to liberalize the limitations on NP prescribing authority; there appears to be a trend in this direction nationwide.

Conclusion

There is definitive universal interest among patients, policymakers, payers, and providers to pursue the integration of primary and behavioral health care. Because of the documented benefits from existing integrated care efforts, many states are enacting policies to promote and support integration, including piloting new initiatives. The barriers and solutions so thoroughly discussed in this report provide a template for much of what is needed to effectively integrate and provide behavioral health care in a primary care setting.

Health centers are taking a leading role in many of the initiatives at the federal and state levels, seeking to promote a more whole-person approach to care by integrating behavioral health services in the primary care setting. But health centers face undeniable challenges—chiefly in the form of clinician shortages, Medicaid reimbursement limitations, and State licensing and scope of practice limitations—in cultivating the behavioral health workforce needed to make these models successful.

Exhibit A

State Integrated Care Initiatives

An examination of the trends, obstacles, and opportunities identified the following state examples of integrated care initiatives.

California—The Inland Empire Health Plan has implemented a large innovative pilot program to integrate services at the point of care. Serving more than 1.4 million patients in a large two-county area, the pilot includes at least 1,400 primary care practitioners and 400 behavioral health providers. The plan provides intensive coaching and consultation to the 31 pilot sites and reimburses for two services delivered on the same day, even though the Medicaid plan does not mandate it (Gilbert, 2016).

Colorado—The 2012 Colorado study, “*Blueprint for Promoting Integrated Care Sustainability*,” reported that 78 percent of the sites providing integrated care are sustaining their efforts with grant funds, and only 21 percent of their total costs are covered by generated revenue (The Colorado Health Foundation, 2012). The state plans to consolidate behavioral health and medical health plans under one administrative entity on July 1, 2017. The new model will reportedly continue to reimburse behavioral health services under a capitated rate, while medical services will be paid through a FFS system (Mandros, 2015).

Delaware—A recent state report identified several key barriers that discourage the implementation of integrated care. These include the current FFS environment, behavioral health workforce shortage, a common health record for both primary and behavioral health, and a need for more training for providers and clinicians (DCHI, 2016).

Florida—In 2014 the state released a competitive procurement that allowed specialty plans to bid on acute care contracts. Magellan was initially chosen to serve as the fully integrated plan in eight of the eleven regions, and the company now has contracts with 20 FQHCs in the state. A representative from the state’s primary care association said that the FQHCs want to provide as many services as they can in order to treat the whole person. There is a cautious optimism about the future of value-based contracting, and payers in the state are now starting to initiate some conversations about how to proceed (Soper, 2016) (Browning, 2016).

Georgia—In an effort to quantify the return on investment (ROI) from an integrated care approach, a recent state report notes that the implementation of integrated care should include training and psychiatric consultation to primary care providers. The report also suggests that changes in the process of care or in outcome measures should be included when measuring the ROI. The report identifies process measures as emergency room utilization, hospitalizations, pharmacological use, and adherence to treatment (Custer, 2015).

Hawaii—The Hawaii Health Care Innovations (HHCI) Models Project received feedback from stakeholders suggesting that many primary care providers are not screening for behavioral health and substance abuse issues, because there is a lack of behavioral health training and resources for providers

in the state. Yet an estimated 60 to 70 percent of the services for mild-to-moderate mental health conditions are treated in primary care settings. Furthermore, a State Innovations Model study found that 34 percent of hospitalizations in the last reporting year included a co-existing mental health condition, which accounted for more than \$482 million in costs (HHCI, 2015).

Idaho—A recently released U.S. Department of Health and Human Services report states that two million low-income uninsured people with substance abuse and/or mental health diagnoses live in states that have not expanded Medicaid. According to this report, Idaho has the highest percentage (39 percent) of residents that fall into this population (Matthews, 2016).

Iowa—The state recently adopted managed care to focus on integrating physical health, behavioral health, and long-term care with the appropriate services and supports. The state chose to partner with Amerigroup, AmeriHealth Caritas, UnitedHealthcare, and Wellcare. The Iowa Primary Care Association has been very active in funding the training and support services for both health centers and behavioral health providers, to encourage and enable the integration of primary and behavioral health care services.

Kansas—The state initiated managed care in 2013 with KanCare, which carved-in behavioral health and consolidated all Medicaid fiscal and contract management functions under the Kansas Department of Health and Environment (Bachrach, 2014). KanCare utilizes a comprehensive managed care “carve-in” to cover all primary care, behavioral health, and long-term care services and supports. The state selected key measures from the National Outcome Measurement System (NOMS), Healthcare Effectiveness Data and Information Set (HEDIS), and various psychosocial indicators (Soper, 2016). Many of the health centers in the state have benefited from the visionary leadership of the Topeka-based Sunflower Foundation, which has identified integrated care as a funding focus, and the work of the Kansas Association of the Medically Underserved.

Louisiana— On December 1, 2015, the state’s MCOs (Aetna, Amerigroup, AmeriHealth Caritas, UnitedHealthcare, and Louisiana Healthcare Connections) carved-in behavioral health. The state had issued a request for proposals (RFP) earlier in 2015 to continue the behavioral health “carve-out” contract. However, the state decided after receiving the bids to move to the “carve-in” option (Mandros, 2015).

Maryland—In 2015, the state’s Medicaid agency and the Behavioral Health Administration began working jointly with Value Options to “carve-out” behavioral health and substance abuse services under an Administrative Services Organization (ASO) arrangement (McMahon, 2015). Part of the payment will be driven by outcome measures such as the percentage of patients with an annual primary care visit and hospital readmission rates (Bachrach, 2014).

Minnesota—In 2009, the state piloted the Preferred Integrated Network (PIN) project to address the premature morbidity of persons with severe medical illnesses described in the 2006 Parks report. Parks designed the report to demonstrate the integration of physical and behavioral health services within a MCO and its coordination with county services. In 2015, an evaluation of this pilot project identified key recommendations in the areas of Program Model Improvements and Data Infrastructure and Movement

Toward Outcome-Based Care. The recommendations included (1) aligning future integrated services with a nationally recognized best practice model, and (2) shifting the use of data from a focus on compliance to a focus on accountability (Desert Vista Consulting; Human Services Research Institute, 2015).

Nebraska—The state plans to integrate primary care, behavioral health care, and pharmacy services in 2017 through a managed care arrangement. The Department of Health and Human Services runs Heritage Health, the state's managed care program. In April 2016, Heritage Health chose Nebraska Total Care, UnitedHealthcare Community Plan, and Wellcare of Nebraska to cover Nebraska Medicaid members (Associated Press, 2016).

New Mexico— The MCO must maintain financial responsibility for the 2014 implementation of a full “carve-in”, which includes prohibiting subcontracts with Behavioral Health Organizations (BHOs) on an at-risk basis (Bachrach, 2014).

New York—In 2015, the state implemented a hybrid managed care model in two parts. One option integrates all Medicaid behavioral health care services previously provided through the FFS payment system into ten Medicaid plans. All ten plans in New York City manage behavioral health themselves or contract with a BHO. The other option is to apply to serve on a Health and Recovery Plan (HARP) that will serve as a separate line of business for each designated health plan (Soper, 2016). If a provider site chooses to integrate primary and behavioral health, the state’s Medicaid Redesign Team has identified five models to choose from: (1) Licensure Threshold; (2) DSRIP Project 3.a.i; (3) Integrated Outpatient Services; (4) Collaborative Care; and (5) Multiple Licensure. Each model varies in relation to the licensure from three state agencies—the Department of Health, the Office of Mental Health, and the Office of Alcoholism and Substance Abuse Services—which have varying oversight responsibilities, billing systems, and utilization limits (Sachs Policy Group, 2016).

Washington—By 2020 the state plans to blend mental health, addiction, and physical health services through integrated managed care plans. Previously, all three categories of care were managed in their own distinct systems (Bachrach, 2014).

Exhibit B

State-by-State Initiatives Impacting Integrated Care

State	State Medicaid Expansion (Kaiser Family Foundation, 2016)	Managed Care (Kaiser Family Foundation, 2015)	Same Day Billing (SAMHSA-HRSA CIHS, n.d.)	H&B Assessment Codes (SAMHSA-HRSA CIHS, n.d.)	Telehealth Reimbursement (NACHC, 2015)
Alabama	No	No	No	No	FFS
Alaska	Yes	No	Yes	Yes	No
Arizona	Yes	Yes	No	Yes	FFS (AHCCCS)
Arkansas	Yes	No	No	No	No
California	Yes	Yes	No	Yes	PPS
Colorado	Yes	Yes	Yes	No	Other ⁴³
Connecticut	Yes	No	Yes	No	No
Delaware	Yes	Yes	Yes	Yes	FFS (DDHSS, 2012)
Florida	No	Yes	Yes	No	No
Georgia	No	Yes	Yes	No	PPS
Hawaii	Yes	Yes	Yes	Yes	No
Idaho	No	No	Yes	Yes	PPS
Illinois	Yes	Yes	Yes	No	Other ⁴⁴
Indiana	Yes	Yes	Yes	No	PPS
Iowa	Yes	Yes	No	Yes	FFS (IDHS, 2015)
Kansas	No	Yes	Yes	Yes	No
Kentucky	Yes	Yes	Yes	Yes	PPS (KLRC)
Louisiana	Yes	Yes	No	Yes	Other ⁴⁵
Maine	No	No	Yes	Yes	PPS
Maryland	Yes	Yes	Yes	No	Other (MDHMH, 2014)
Massachusetts	Yes	Yes	Yes	No	No
Michigan	Yes	Yes	Yes	No	PPS
Minnesota	Yes	Yes	Yes	Yes	Other ⁴⁶
Mississippi	No	Yes	Yes	No	Other
Missouri	No	Yes	Yes	No	PPS

⁴³ Colorado Medicaid only reimburses for home telehealth services provided to patients who meet specific criteria that include chronic illness, recipient of home health services, hospitalization history, and meeting the criteria for monitoring equipment (Capistrant, 2015).

⁴⁴ Illinois Medicaid managed care coverage of telehealth-based services is another opportunity for providers. While the covered services under the FFS basic benefit require an “interactive telecommunication system,” the Illinois Model Managed Care Organization Contract allows Medicaid plans an option to offer expanded benefits, such as telemedicine services (Freerks, 2016).

⁴⁵ Telemedicine—only one party may bill. The distant service provider can bill, but not the host site provider (NACHC, 2015).

⁴⁶ Effective January 1, 2016, MHCP allows payment for expanded telemedicine services. Authorized originating sites include rural health clinics and FQHCs (MDHS, 2016).

Montana	Yes	Yes	Yes	Yes	PPS
Nebraska	No	Yes	Yes	No	PPS
Nevada	Yes	Yes	No	Yes	FFS
New Hampshire	Yes	Yes	Yes	No	No
New Jersey	Yes	Yes	Yes	Yes	No
New Mexico	Yes	Yes	Yes	Yes	PPS
New York	Yes	Yes	Yes	Yes	No
North Carolina	No	No	Yes	Yes	Yes
North Dakota	Yes	Yes	Yes	Yes	Other (NDDHS, 2015)
Ohio	Yes	Yes	Yes	No	No
Oklahoma	No	No	Yes	No	PPS & FFS
Oregon	Yes	Yes	Yes	Yes	FFS
Pennsylvania	Yes	Yes	Yes	No	No
Rhode Island	Yes	Yes	Yes	Yes	No
South Carolina	No	Yes	Yes	Yes	PPS
South Dakota	No	No	Yes	Yes	Other (SDDSS, 2016)
Tennessee	No	Yes	Yes	Yes	Other
Texas	No	Yes	Yes	No	PPS
Utah	No	Yes	No	Yes	No
Vermont	Yes	Yes	Yes	Yes	Other (VTGA, 2012)
Virginia	No	No	No	Yes	FFS
Washington	Yes	Yes	Yes	No	FFS (WSHCA, 2015)
West Virginia	Yes	Yes	Yes	Yes	FFS
Wisconsin	No	Yes	Yes	Yes	PPS
Wyoming	No	No	Yes	No	Other (EqualityCare, 2007)

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