Integrated Care & State Policy in Tennessee:

Case Study of Cherokee Health Systems

NATIONAL ASSOCIATION OF Community Health Centers

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Introduction

With an organizational mission to "improve the quality of life for [their] patients through the blending of primary care, behavioral health and prevention services", Cherokee Health Systems fully embraces the practice of comprehensive, integrative medicine. Cherokee Health Systems has a decades-long history of perfecting the integrated care delivery model through its 45 clinical sites across 13 counties in eastern Tennessee. As both a Federally Qualified Health Center (FQHC) and a Community Mental Health Center serving over 24,653 Medicaid (TennCare) patients, Cherokee finds itself well-positioned to provide robust examples of challenges and successes in providing a seamless package of integrated care services to a community with complex needs.

Life in Tennessee

Stretching four hundred and forty miles from the Great Smoky Mountains on its Eastern border, to the great Mississippi River on its western, Tennessee was an unlikely candidate to be a hotbed of integrated care development in the nation. Appalachian culture, poverty and isolation conspired to make health care scarce, expensive and inaccessible. Siloed thinking and "turfism" between the mental health and primary care worlds were as ubiquitous as sweet tea and country ham. But something else was brewing in this proud southern state that bumped along near the bottom of almost every health metric known to mankind—a desperation to make things better, a desperation to ease behavioral health suffering, in short, a desperation for a better quality of life.

Cherokee Health Systems

And so, in the late 1960s, Cherokee Health Systems (Cherokee) was a tiny mental health provider with grand ideas. Nestled north to northeast of Knoxville in the eastern part of the state, Cherokee found itself smack dab in the middle of rural Appalachia. Shorter than its taller Great Smoky Mountain cousin to the southeast, Clinch Mountain rose above the lowland farms and rivers to almost perfectly bisect Cherokee's "service area" from north to south. The Holston River and the Tennessee Valley Authority conspired to create Cherokee Lake, jobs, and electricity. Tobacco was king, both growing it and using it. Guns and moonshine, a volatile mix, were sold discretely to only known customers from the trunks of Fords and Chevys at impromptu flea markets on Saturday nights. The opioid addiction curse, with its profound suffering, would not arrive at Cherokee's doorstep for another 50 years; but depression and related social problems blew across the Appalachian landscape like spring pollen—it was everywhere.

Journey to Integrated Care

Amidst these geographic and cultural obstacles, integrated health care took root in Tennessee, not by some grand concept or academic best practices, but by a sentence spoken by a patient. A young, newly-minted psychologist was treating a female patient at her primary care physician's office because of insufficient "mental health" space elsewhere in the community. The psychologist suggested that the woman could now shift her care to a newly opened mental health clinic. The woman politely said "Now, I like my family doctor's office you know." In East Tennessee language, that means "I'm not going to a mental health center, thank you very much. I'm staying right here in my family physician's office, and I prefer that you treat me in primary care." The integrated care seed was planted.

Patients preferred to receive all of their care at the office of their primary care provider, regardless of the physical and/or behavioral health diagnoses. The young psychologist realized that the people and conditions he saw in primary care were the same people and conditions he saw at the mental health center, but some patients preferred the primary care setting. What's more, those patients seemed to improve and recover better and quicker when the psychologist and the primary care provider worked together as part of a team. Listening to that first patient resulted in Cherokee eventually being called "the grandfather of integrated care."

Lessons Learned

1. Persistence, courage, and innovation. Health centers are already familiar with the "can't quit" attitude that is required at times when the going gets rough. The same applies for the work it will take to fully implement an integrated care model. It is also imperative that health centers not wait for the perfect situation to try new ideas. Cherokee follows the adage, "ready-fire-aim," which fosters a culture of innovation, experimentation and risk taking that are crucial to practice transformation.

2. Behavioral health professionals are a great asset in helping primary care patients manage complex medical conditions. Find and empower a clinical champion who understands this to get things done.

3. Make training a priority. Focus on recruiting and training behavioral health consultants (BHCs). Keep in mind, not every behavioral health professional is a good fit in primary care, as few are trained in professional schools to do this kind of work. In addition to training for BHCs, appropriate trainings should be provided to PCPs, nursing staff, and front desk staff.

4. More people receive care for psychiatric services in primary care than they do from specialty behavioral health professionals. Furthermore, most referrals from primary care to outside behavioral health services fail to connect. So, make sure your behaviorists are embedded in close proximity to your PCPs.

5. Address your systems to ensure that they support your integrated care model. Through its journey, Cherokee made sure the electronic health record was integrated and had strong behavioral health templates.

6. Explicitly recognize the potential big-picture outcomes. Integrated care expands the scope and effectiveness of the patient centered medical home (PCMH), and facilitates achieving recognition from NCQA. As value-based contracts increase and become more common, integrated care needs to expand outside the clinic walls to include patient engagement in the community and schools.

Tennessee State Policy and Integrated Care

From those early days**,** Cherokee evolved from a small mental health center to a "stand-alone" primary care provider to, eventually, a Federally-Qualified Health Center (FQHC) and Community Mental Health Center—merging the missions of both. Cherokee embarked on an aggressive growth strategy over the years, with 26 "bricks and mortar" clinics and 23 telemedicine clinics extending from the Smoky Mountains to the Mississippi River. This expansion was mainly an effort to extend integrated care into underserved communities, in addition to acknowledging and addressing strategic concerns about managed care and its potential impact on the organization and its patients. Cherokee was thus forced to navigate a rocky state managed care policy in order to protect and advance the integrated care mission.

Tennessee's Managed Care Program

TennCare, the state's early Medicaid managed care program, began on January 1, 1994. Chaos immediately ensued. TennCare's newly developed computer system was installed nine months past the legislative deadline. The Tennessee Justice Center sued the state over proposed changes to the TennCare waiver. McKinsey and Company then released a report that showed a significant increase in costs driven by pharmaceuticals, professional services, outpatient services, and increases in enrollment. Then the state developed a new behavioral health "carve-out" plan that contracted with several for-profit behavioral health organizations (BHOs) to administer behavioral health benefits *separate from* medical benefits, thereby ensuring short-term stock increases and long-term fragmentation of primary and behavioral health care.

In November of 2004, Governor Phil Bredesen announced plans to dissolve TennCare and return to Medicaid. He blamed increasing costs, reduced federal funding, and ongoing litigation. He backed off on his plan when litigation was dropped or postponed. In January of 2005, Governor Bredesen announced plans for a major overhaul of TennCare by dropping nearly 323,000 adults from the program and by limiting benefits for an additional 396,000 adults. In September of 2005, he announced $5.7 million in grants to safety net providers—faith-based, community-based, and rural health centers and FQHCs—in an effort to ease the transition and effects from the disenrollment process.

From 2005 to 2015, TennCare continued its steady march toward cost savings, benefit revisions and cuts, managed care organization (MCO) consolidation, federal waivers, and litigation. The eventual "elimination" of the behavioral health "carve-out" technically integrated behavioral and medical benefits within the MCOs, while still allowing "internal" carve-outs to continue.

It was amidst this chaos and confusion that Cherokee and the TPCA embarked on a strategy to secure significant changes that would enhance integrated care efforts across the state. The strategy was simply to assure the *quality* and *financial sustainability* of integrated care. To accomplish this goal, policy

changes needed to eliminate the behavioral health "carve-out" while permitting payments for same day visits; payments for Health and Behavior Codes 96150–96155; and prospective payment system (PPS) reimbursement for behavioral health visits.

Payments for Same Day Visits

The Cherokee model embeds a behavioral health consultant (BHC) on the primary care team who is usually a Ph.D. or LCSW, so it is common for a patient to see *both* the primary care provider (MD or NP) *and* a behaviorist on the same day. It was thus essential to pay for same day visits.

Payments for Health and Behavioral Assessment (HBA) Codes

Even though HBA codes were included in the Current Procedural Terminology (CPT) manual in 2002, many states have not implemented them. HBA codes are used to bill for services provided to patients who are *not* diagnosed with a *behavioral health* condition, but who can benefit from behavioral health assessments and interventions for a *physical* health problem. In these cases, a behaviorist will use the 96150 to 96155 CPT codes. These codes were created specifically for behaviorists who see patients diagnosed with physical health conditions.

The first two codes (96150 and 96151) are assessment codes. The last four codes (96152–96155) are used for the prevention, intervention, treatment, or management of a physical health problem. Typically, these diverse interventions can include cognitive-behavioral techniques, coping skills, conflict resolution skills, smoking cessation, and relaxation skills. The codes are used by non-physicians such as psychologists, social workers, counselors, and others in behavioral health disciplines. Thus, in an integrated care model where patients present with multiple diagnoses, it is important that behaviorists are able to bill for both psychological and physical health assessments and interventions.

The TPCA and Cherokee met with policy officials from TennCare and explained the integrated care model and the importance of same day visits and the HBA codes. They cited the CPT manual and approval by Medicare. After a brief 30 minutes of discussion, one official said, "This makes sense, I think we should do it." Just like that. It was not a hard sell. TennCare approved multiple visits on the same day and the HBA codes shortly thereafter.

Prospective Payments for Behavioral Health Visits

Around 2011, the TPCA convened a PPS task force consisting of representatives from Tennessee FQHCs that included Cherokee's Chief Financial Officer, with the original purpose of "speeding up" PPS payments to the FQHCs. As the demand for behavioral health visits at FQHCs increased, the PPS task force shifted its focus to obtaining PPS payments for behavioral health visits. A long and slow slog began with PPS that entailed meeting upon meeting and proposal upon proposal. Only in early 2016 had the proposal neared a state of completion. The final version would allow health centers to include behavioral health visits (and receive PPS payment for those visits) upon completing a change in scope for service(s) and/or location(s). Final language is expected to be approved in the summer of 2016. These situations all demonstrate the critical importance of leadership at the state primary care association level and strong collaborations with FQHCs.

Shifting from Behavioral Health "Carve-Out" to "Carve-In"

By 2014, integrated care was being discussed extensively throughout Tennessee and across the nation. TennCare officials realized that the "carve-out" model (in which behavioral health benefits are managed by a separate BHO) had fragmented care, reduced quality, duplicated credentialing (or in some cases refused to credential providers not covered by BHO benefits), and increased costs of care and administration. Thus, TennCare officials required the contracted Medicaid MCOs to combine medical and behavioral health coverage ("carve-in" behavioral health). Although the "carve-in" was a step in the right direction, the MCOs were still permitted to "carve-out" the behavioral health coverage *internally* through a dedicated behavioral health division or through a behavioral health subsidiary.

Value-Based Contracts

Driven by the Triple Aim, 2015 saw a major shift from fee-for-service contracts to value-based contracts. The new value-based contracts included upside and downside risk for cost and quality measures (HEDIS and/or UDS metrics). The implementation of strong financial incentives are achieving an increase in data sharing by the MCOs with the FQHCs (including claims data "dumps" or reports); an increased focus on population health management and patient engagement; and the integration of medical and behavioral health benefit structures. Cherokee has also made it a point to consistently work with MCO Medical Directors during contract negotiations and care management strategies.

Conclusion

New value-based contracts are being introduced rapidly as the payment and health care reforms described above take effect in Tennessee. These payment structures are expected to *enhance* and *support* Cherokee's integrated care model as payments shift from the existing fee-for-service paradigm to performance-based payments; these payments are premised on meeting certain negotiated quality of care thresholds (for HEDIS or UDS measures) and for managing medical costs within a predetermined medical loss ratio for a defined population.

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Prepared By:
Joel Hornberger

National Association of Community Health Centers®
1400 I Street, NW, Suite 910
Washington, DC 20005
www.nachc.org/states

For more information about this publication, please contact:
Dawn McKinney
Director, State Affairs
dmckinney@nachc.org
202.296.3800

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