

SUSTAINING AND EXPANDING
INTEGRATED CARE
IN MONTANA



**POLICY, FINANCING AND PROVIDER
CAPACITY RECOMMENDATIONS**

SUBMITTED BY

NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

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COMMONLY USED ACRONYMS

ACRONYM	MEANING
APM	Alternative payment model
CBHPSS	Certified Behavioral Health Peer Support Specialists
CCBHC	Certified Community Behavioral Health Clinics
CCM	Complex Care Management
CPC+	Comprehensive Primary Care Plus
CMHC	Community mental health center
CMS	Centers for Medicare and Medicaid Services (CMS)
DSRIP	Delivery System Reform Incentive Payment
FQHC	Federally Qualified Health Center
HBAI	Health Behavior Assessment and Intervention
IDN	Integrated delivery network
LAC	Licensed addiction counselor
LCSW	Licensed clinical social worker
LCPC	Licensed clinical professional counselors
MHCF	Montana Healthcare Foundation
MSW	Master of Social Work
PACT	Program of Assertive Community Treatment
PCMH	Patient-centered medical home
PMPM	Per member per month
PPS	Prospective payment system
RHC	Rural health clinic
SBIRT	Screening, Brief Intervention and Referral to Treatment
SMI	Serious mental illness
SUD	Substance use disorder
TCM	Targeted case management

BACKGROUND

Over the past five years, integrated primary care has expanded all across Montana. Federally qualified health centers (FQHCs), rural health clinics (RHCs) and primary care clinics at hospitals with prospective payment system (PPS) financing have integrated behavioral health into primary care settings, Tribal Health and Urban Indian Centers. The development of these strong practices has been strengthened by continuing and recent policy change and innovation, including:

1. 2019 Medicaid eligibility expansion continuation.
2. The opening of Collaborative Care codes in Medicaid in the Summer of 2019.
3. Comprehensive Primary Care Plus (CPC+) continuing in PPS hospitals.



Since 2016, the National Council for Behavioral Health (National Council) has worked closely with the Montana Healthcare Foundation (MHCF) and other key stakeholders to improve the quality of integrated health services across Montana and access to these services. While most integrated practices have been able to develop sustainable basic finance models, full implementation of integrated care with a robust plan for care coordination would be aided by the following recommendations.

Because of Montana's unique structure, identifying national examples to support the proposed policy and financing changes is challenging. Montana is one of only 11 states that do not have Medicaid managed care and, of those 11, Montana is one of six that has expanded Medicaid. Furthermore, there are variations across these six states in the way Medicaid is funded. Some of the most striking examples of integration across the country are either specific provider organizations that have developed successful and sustainable practice models or state-level innovations led by managed care companies. Thus, many of the examples included in this document represent an attempt to identify principles and practices that have succeeded in other places and can be translated into the Montana context. Vermont is an exception because its state-led innovation takes place without Medicaid managed care.

This report identifies challenges and recommendations in two primary areas, the behavioral health workforce and finance and policy levers, both of which can help improve the current integrated primary care landscape in Montana. While the focus of this paper is on the integrated primary care setting, several recommendations for the specialty behavioral health system are included because of the close connection between physical and behavioral health. These recommendations were informed by subject matter experts and examples in the field that can be applied to or adapted for Montana.

FINANCE AND POLICY CHALLENGES AND RECOMMENDATIONS

THE NEED FOR ENHANCED CARE COORDINATION

Integrated primary care was originally conceptualized to meet the needs of people with mild to moderate behavioral health challenges who most often present in primary care. People with serious mental illness (SMI) and/or substance use disorders (SUD) ideally receive integrated care with the support of the community behavioral health system. In Montana, there are many communities with few or no specialty behavioral health services to support these populations. Individuals with these more serious and complex illnesses require different and more intense approaches to both care coordination and treatment than are currently supported by the existing finance models.

Care coordination and care management have emerged as major areas of concern in health care generally and specifically in integrated care. As the system moves to target specific patient-centered outcomes and increases its awareness and focus on the impact of social determinants of health, the importance of care coordination increases. In this context, care coordination is seen as:



The deliberate organization of patient care activities between two or more participants involved in patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.”¹

The care coordinator in this context functions as part of the health care team, but in reality, more often serves as the hub of the team. The care coordinator ensures care recommendations are implemented and assures prompt follow-up after hospitalization and emergency room visits. The care coordinator also has a high focus on engagement and eliminating barriers to care, whether perceived (stigma, bias etc.) or tangible (copays, transportation, etc.) and supporting this role is key to robust integrated care.

While sometimes perceived as similar services, targeted case management (TCM) and care coordination have different implementation considerations and benefits. Historically, TCM has been an open billing code that staff can use to receive reimbursement without ties to meeting quality metrics and without clear coding tied to the specific TCM activity. Care coordination, on the other hand, is generally associated with value-based payment models and tied to quality criteria and outcomes.

While there are several mechanisms to support care coordination, including CPC+, complex care management (CCM), Passport to Health and patient-centered medical homes (PCMHs), there is no direct reimbursement mechanism for care coordination services connected to primary care. While targeted case management services still exist in some communities, they are not easily accessible to primary care patients who are not connected with community mental health centers (CMHCs). Addressing social determinants of health and other engagement and access issues through care coordination is a critical component of high performing integrated primary care practices and in decreasing emergency room use and hospitalizations for physical and behavioral health issues.

¹ Agency for Healthcare Research and Quality. (2014, October). Care Coordination, Quality Improvement. Retrieved from <https://www.ahrq.gov/downloads/pub/evidence/pdf/caregap/caregap.pdf>

STATE FINANCE AND POLICY RECOMMENDATIONS



To address challenges and maximize existing opportunities to increase adoption of integrated primary care practices statewide, there are several key actions the state can take. These include greater use of policy and finance levers available through Medicaid state plan amendments and other mechanisms and by changing current state reimbursement policies. While the recommendations provided here outline specific actions the state can take, the example provided by Vermont is instructive in terms of the power of creating an overarching vision (The Blueprint for Health), then using a strategic planning process to move change over time throughout the health care system.

1. Leverage Medicaid Options To Provide Team-Based Care With Strong Care Coordination For People With Chronic Conditions In Primary Care.

There are several mechanisms through Medicaid that could be used to provide population-based, integrated and team-based care for people with multiple chronic conditions (see Vermont Case Study on page 6). These options can be used independently or together to expand these services, such as Medicaid Health Home State Plan, enhancing payment to PCMHs, participating in Primary Care First and leveraging existing Accountable Care Organizations through Medicare and increasing support for the Medicaid population and developing Certified Community Behavioral Health Clinics (CCBHCs) in Montana through a section 1115 Medicaid waiver or a state plan amendment.

With a Medicaid Health Home section 2703 State Plan Option, Montana can establish health homes that provide comprehensive care coordination for individuals with chronic conditions. Health homes based in primary care practices can be a versatile option for integrating behavioral health care into the primary care practice. Behavioral health conditions commonly seen in primary care, such as depression, anxiety or alcohol use disorders are included as eligible conditions. Health home staff covered by per member per month (PMPM) payments can include a requirement for behavioral health consultant staffing and performance measures addressing behavioral health conditions seen in primary care.

As of August 2019, 21 states and the District of Columbia have established a health home state plan amendment resulting in 36 different models nationwide.² To be eligible for health home services, Medicaid beneficiaries must meet state-defined criteria of: two chronic conditions or one chronic condition and risk for a second. Chronic conditions include mental health conditions, SUDs, asthma, diabetes, overweight and heart disease, but states can propose other conditions to incorporate into their health home models. States can also tailor the core health home services; however, they must provide at least six core services, including:

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care and follow-up
5. Individual and family support
6. Referral to community and social services

States receive enhanced federal funding (90% federal match) for the first eight quarters of implementation of the model. Health Home models provide an opportunity to employ peers, nurse care managers and community health workers within behavioral health providers, FQHCs, RHCs and PPS hospitals as part of the reimbursement model to support care coordination for people with SMI and other chronic conditions.³ Health home models require a strong team-based care approach and an ability to track and report data and manage the alternative payment arrangement. This would present a challenge for solo or small group primary care providers unless they have access to these support services.

Primary care practices seeking to integrate behavioral health services would also benefit from access to Health Behavior Assessment and Intervention (HBAI) billing codes that allow behavioral health staff in primary practices to build for behavioral interventions focusing on addressing the behavioral aspects of chronic medical conditions. Behavioral health aspects of chronic medical conditions include lifestyle changes required to follow complicated medical regimens, medication adherence, smoking cessation, weight reduction and others.



CASE EXAMPLE: VERMONT BLUEPRINT FOR HEALTH

The Vermont Blueprint for Health provides the guiding and organizing framework for a continuously evolving and expanding approach to health care in Vermont. Within this framework, Vermont has used multiple Medicaid levers to integrate care, provide local approaches to care and provide care coordination services. The Blueprint programs include PCMHs, Community Health Teams, a hub-and-spoke system for opioid use disorder treatment, the Women's Health Initiative, Support and Services at Home and Self-management and Healthier Living Workshops. The Blueprint utilizes population data and analytics to inform policymakers, communities and practices and provides learning labs for providers and communities.⁴

² Centers for Medicare and Medicaid Services. (2019, August). Medicaid Health Homes: An Overview. Retrieved from <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf>

³ Centers for Medicare and Medicaid Services. (2019). Health Home Information Resource Center. Retrieved from <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/index.html>

⁴ State of Vermont. (2020). Blueprint for Health. Retrieved from <https://blueprintforhealth.vermont.gov/about-blueprint>

To expand its payment approach to PCMHs, Vermont provides financial support for the development of required community health teams. This ensures that the expanded payment translates into additional staff to provide the required services. Each of Vermont's Health Services Areas designs its own Community Health Team to meet the needs of the local population.⁵ Community Health Team services may be co-located within practices or centralized in a convenient location. Each team is configured to meet local needs. Community Health Team services include:

- Patient-centered medical home patient population/panel management and outreach.
- Individual care coordination.
- Brief counseling and referral to more intensive mental health care, as needed.
- Substance use disorder treatment support.
- Condition-specific wellness education.⁶

The Community Health Teams provide integrated behavioral health services, care coordination, outreach and engagement and wellness support. They are in part directed by the local community, so to some degree their composition varies from one community to another, but they must provide these core services. Community Health Teams are located in PCMHs, but also have outreach into the local community.

The accountable care organizations in Vermont are funded by all the payers in the state and are responsible not only for primary care and inpatient care management but are also required to contract with CMHCs for care for people with SMI and SUDs.

Vermont's Integrated Communities Care Management Learning Collaborative provides technical assistance to Blueprint for Health providers. The Learning Collaborative uses health service area-level data to engage in rapid cycle quality improvement for care coordination and care management. An Integrated Communities Care Management Toolkit⁷ provides technical assistance resources for:

- Identifying people with complex needs.
- Recruiting people for cross-organization care management.
- Documenting a person's story, goals and care team.
- Reviewing a person's health history.
- Conducting a root cause analysis.
- Convening care team conferences.
- Identifying person's lead care coordinator.
- Developing and implementing a shared care plan.⁸

This comprehensive and evolving approach to care has allowed Vermont to maximize its various reimbursement strategies, engage local communities and work toward improved health for their citizens.

⁵ State of Vermont. (2020). Blueprint Community Health Teams. Retrieved from <https://blueprintforhealth.vermont.gov/about-blueprint/blueprint-community-health-teams>

⁶ Ibid.

⁷ State of Vermont Blueprint for Health. (n.d.). Integrated Communities Care Management. Retrieved from <https://blueprintforhealth.vermont.gov/about-blueprint/integrated-communities-care-management>

⁸ State of Vermont. (2020). Integrated Communities Care Management. Retrieved from <https://blueprintforhealth.vermont.gov/about-blueprint/integrated-communities-care-management#ICCM%20Toolkit>

2. Participate In The Primary Care First Model

Beginning in 2021, providers participating in the CPC+ model will be eligible to participate in the new Primary Care First model. The Primary Care First model builds off of principles and goals of CPC+. Unlike CPC+, Primary Care First is a risk-based model⁹ that will offer the state an opportunity to continue to receive enhanced primary care funding when CPC+ ends in 2021. It is important to note that Primary Care First will not impact existing PCMH activities in the state. The Primary Care First model is an opportunity for providers to move in the direction of value-based care, allowing them more flexibility to provide services that are not currently in the Medicaid plan as part of the PMPM payment.



Primary Care First will use a set of clinical quality and patient experience measures to assess whether practices are meeting established standards to qualify for performance-based adjustments to their revenue. Measures will include a patient experience of care survey, high blood pressure control, diabetes hemoglobin A1c control, colorectal cancer screening and advance care planning. While Primary Care First is a Medicare program, the Centers for Medicare and Medicaid Services (CMS) encourages multi-payer participation, including state Medicaid plans. The multi-payer group in Montana will have additional measures specific to the state.

Because Primary Care First is a risk-based model, the state has an opportunity to strategically incentivize integrated primary care practices to address high emergency department utilization rates and re-hospitalizations among patients. However, it is important to note that provider participation in Primary Care First requires practices to be able to comply with data collection and reporting requirements and successfully understand risk-based contracting. Providers will also be required to participate in the statewide health information exchange (HIE) once that becomes available. Primary care practices will benefit from education and support related to back-office management, workflow design and understanding true costs of care.

Primary Care First also represents an opportunity for the state to consider incentivizing regional partnerships to address these outcome measures. While the opportunity to apply for Delivery System Reform Incentive Payment (DSRIP) participation is not recommended, noting outcomes from this work across the country can provide opportunities for innovation at this critical juncture.¹⁰

New Jersey, New York and Texas included increasing collaboration between hospitals and behavioral health systems among their DSRIP goals. Arizona, New Hampshire and Rhode Island give priority to enhanced services for individuals with SMI and SUDs. Additionally, Massachusetts and Washington have included integrated care for complex conditions, including the purchasing of integrated physical and behavioral health care (Washington) among their goals.¹¹

⁹ Centers for Medicare and Medicaid Services. (2019). Primary Care First Model Options. Retrieved from <https://innovation.cms.gov/initiatives/primary-care-first-model-options/>

¹⁰ Gusmano, M. K. & Thompson, F. J. (2018, September 28). Medicaid Delivery System Reform Incentive Payments: Where Do We Stand? Health Affairs Blog. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20180920.103967/full/>

¹¹ Ibid.



CASE EXAMPLE: NEW HAMPSHIRE DSRIP PROGRAM¹²

While no new DSRIP models have been approved in the past three to four years, principles from New Hampshire's DSRIP model could serve as an example of how Primary Care First might be operationalized in Montana. New Hampshire used the DSRIP program as an opportunity to address chronic underfunding for individuals with behavioral health needs. The program focuses on three pathways: improve care transitions, promote integration of physical and behavioral health and build mental health and SUD treatment capacity. To reach its goals, New Hampshire is developing seven Integrated Delivery Networks (IDNs), regionally-based networks of physical and behavioral health providers and social service organizations. Each IDN will implement three community-driven projects from a pre-defined menu that includes interventions such as care transition teams, expansion of peer support access, capacity, utilization, integrated treatment for co-occurring disorders and enhanced care coordination for high-need populations, among others. New Hampshire will move at least 50% of Medicaid provider payments into alternative payment models under the DSRIP program to ensure sustainability and quality of care.

3. Revamp The Passport To Health And Patient-Centered Medical Home Programs To Support Increased Care Coordination

With the evolution of models of care in Montana, the Passport to Health program now stands outside the value-based, outcome-driven approach that is emerging with CPC+, PCMHs and the tier-based payment system available in them. Moving the Passport to Health program to an approach tied to integrated, team-based care with attention to outcomes would strengthen it and allow a reimbursement structure that could support care management and coordination. This changed structure and rates should be coupled with an expectation for increased attention to team composition and care coordination outcomes (i.e., Vermont Blueprint model). PMPM rates should be developed based on a staffing cost model for a hypothetical model team serving a standard number of patients. The rate is set by the local average cost for each full-time equivalency on the care management team prorated to the model amount of time they spend on care management activities.

Similarly, implementing the option of health homes in PCMHs would fill a significant gap. Health homes are a hotspot model, since you can only enroll people with SMI or two or more chronic conditions. You can also include people with one chronic condition who are at risk for a second chronic condition. Many states have qualified for health home status within PCMHs enrolling people with diabetes alone, since diabetes is a risk factor for other chronic conditions. Furthermore, there is the option of tiered PMPM payments, in which the tiers can be varied by chosen severity or chronicity requirements. Montana can also write their operational definition of the requirements of the six core services, specific staffing levels and types of staff. There is a federally defined set of performance indicators that are required, but states can require additional performance indicators at their discretion.

¹² National Academy for State Health Policy's Value Based Payment Reform Academy Meeting. (2017, July). New Hampshire's DSRIP Waiver Program, Alternative Payment Models and Safety Net Providers. Retrieved from https://nashp.org/wp-content/uploads/2017/11/NH-DSRIP-Waiver-OverviewNASHP_2017.pdf

The Principal Care Management benefit now available in Medicare could be turned on in Medicaid in Montana and would provide an additional payment mechanism for people who had only one condition, but that condition put them at high risk for hospitalization and who require complex care.^{13, 14} This would benefit specialty physical health providers who at this time have no ability to access payment for care management.

If neither of these strategies is chosen, at a minimum, providing education and technical assistance to PCMHs on the use of the current tier system, in particular tier four, would assist in increasing attention to and management of patients with complex chronic conditions.

4. Increase The Reimbursement Rate For Screening, Brief Intervention And Referral To Treatment (SBIRT)

One evidence-based practice in primary care that has demonstrated important outcomes is the implementation of SBIRT. There are several barriers to this implementation: The first, training, is addressed both by the Montana Primary Care Association and the National Council technical assistance process. The second is provider fear that if they identify issues there will not be support to address them. This is addressed by the presence of behavioral health providers in primary care. The final barrier is related to payment. The reimbursement rate for SBIRT is very low; low enough that interventions often are not coded or billed for, so there is little incentive to fully implement this critical practice. Additionally, the reimbursement for screening and brief intervention is limited to licensed individuals and should be allowed for other non-licensed care team members. Given the rate of alcohol use in Montana, incentivizing prevention and early intervention more strongly in primary care would support improved outcomes.

5. Turn On The Health And Behavior Codes In Medicaid For Licensed Clinical Social Workers (LCSW) And Licensed Clinical Professional Counselors (LCPC) Staff In Integrated Care Settings

Medicare limits these codes to licensed psychologists, but most integrated care settings have LCSW and LCPC staff who are limited to serving patients who meet threshold criteria for behavioral health diagnoses. Opening codes to these disciplines would allow for more work with patients who are experiencing challenges with chronic disease management. The current training institutes being developed in Montana could provide the education and certification needed to support and ensure that the services provided are evidence-based health behavior change strategies.

To facilitate greater adoption of integrated primary care in Montana, there are several workforce strategies available that would help overcome existing challenges. Current behavioral health workforce challenges and recommendations are discussed here.

¹³ O'Connor, K. (2019, December 3). Principal Care Management (PCM) Reimbursement under the 2020 Medicare Physician Fee Schedule. Retrieved from <https://www.nixonlawgroup.com/nlg-blog/2019/12/3/principal-care-management-pcm-reimbursement-under-the-2020-medicare-physician-fee-schedule>

¹⁴ American Society of Clinical Oncology. (n.d.). Principal Care Management Services. Retrieved from <https://practice.asco.org/sites/default/files/drupalfiles/2020-02/PCM2020.pdf>

BEHAVIORAL HEALTH WORKFORCE CHALLENGES AND RECOMMENDATIONS

High performing integrated care practices use team-based care with a strong care coordination function. Highly effective teams are made up of a variety of disciplines with overlapping and distinct functions. Nationally, workforce shortages make the full implementation of team-based care challenging and Montana is no exception to these workforce challenges, specifically in the behavioral health workforce. Because of these shortages, the ability to maximize team functioning through the use of all possible members is critical.

Several billing restrictions have exacerbated existing workforce shortages, including within Medicare and Medicaid. Medicare requirements have an influence because primary care practices cannot afford to have internal barriers to connect to behavioral health providers based on payer requirements. Because Medicare only covers LCSWs and doctorate level psychologists (Ph.D. and Psy.D.), the workforce is limited for behavioral health billing in primary care. Pediatric and perinatal practices are able to use LCPCs as behavioral health providers, but in general, there is an overall shortage of masters-level prepared therapists. This situation is exacerbated by the prohibition on using in-training practitioners in many settings. Hospitals and primary care practices receiving PPS reimbursement and critical access hospitals without an RHC are not able to hire these emerging providers even when appropriate supervision is in place, which exacerbates the workforce shortage. Allowing these in-training providers to function across the primary care spectrum would increase the ability of practices to provide integrated care.

The opening of the collaborative care codes holds promise for helping with this shortage in two ways: first, it expands the potential pool of staff who can bill in collaborative care to include bachelors-level prepared staff and in-training behavioral health practitioners, including Master of Social Work (MSW) graduates working toward licensure. Expanding the behavioral health team in this way will increase access to evidence-based care.

Enhancing the use of two other critical workforce members would complement the work currently being done by integrated teams. Licensed addiction counselors (LACs) and certified behavioral health peer support specialists (CBHPSS) are currently limited in some primary care settings by financing and regulatory barriers. Given the high incidence of substance use-related illnesses in Montana and the limited number and availability of specialty providers providing care in each community, it is critical that LACs are available in primary care to reduce financial costs of providers and disease burden among individuals with SUD. Expanding Medicaid reimbursement for these positions within primary care settings would increase primary care capacity to provide chronic disease management and care coordination to individuals with SUD, co-occurring mental health and SUD and other chronic diseases. The term, “co-occurring disorders” refers to individuals with multiple physical, mental and/or substance use disorders.



While adding LACs to primary care teams is one way to address workforce capacity issues, LACs can currently only receive Medicaid reimbursement when employed by FQHCs, RHCs, Indian Health Services clinics, tribal health or urban Indian clinics. LACs in hospital-owned primary care clinics cannot currently receive reimbursement for services.¹⁵ While it is true that if primary care practices become state approved SUD providers they can bill for LACs, working through this process and maintaining this status creates one more layer of regulation for busy primary care practices. The goal of integrated care is to put providers as close to the site of care as possible, which allowing for reimbursement would achieve.

Similarly, reimbursement for CBHPSS for mental health services and SUD services is limited to mental health centers (for mental health services), state-approved SUD programs (for SUD services), FQHCs, RHCs, Urban Indian Health Centers or IHS Tribal 638.¹⁶ CBHPSSs currently employed by hospital-based primary care clinics and other primary care settings are unable to receive reimbursement. While this is not the only barrier to adoption of peer support in these settings, changes in reimbursement potential would increase the likelihood of adoption of peers. An increase in the use of peer support would be impactful in several ways, including providing additional support for people with SMI and other mental health challenges being served in these settings, diversifying the health care team and providing additional support for care coordination.

Within the existing integrated primary care practices in Montana, people with SMI can be treated for their physical health illnesses if they can access integrated care, but this population presents unique challenges with care coordination. They are more likely to live in poverty and their cognitive challenges may make accessing existing services difficult. Traditionally, the community mental health system has assisted this population with care coordination services provided by case managers. Because of limited funding and geographical barriers, these services are difficult to access across the state. This presents a challenge for primary care practices in need of care coordination services. Three remedies for this are proposed: 1) supporting bidirectional integration – meaning developing primary care clinics within the large CMHCs in Montana; 2) developing a Medicaid section 2703 state plan amendment or 1115 waiver for a Health Home or similar service that is team-based, which can provide strong care coordination across the health spectrum, including with primary care, and is accountable for outcomes in the same way primary care providers are; and 3) moving in the direction of developing CCBHCs.

¹⁵ Montana Department of Public Health and Human Services (DPHHS). Montana Healthcare Programs Notice, Licensed Addiction Counselors. (2017, October 26). Retrieved from <https://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2017/provnoticeLAC10262017.pdf>

¹⁶ Montana DPHHS. (2019, October 1). Addictive and Mental Disorders Division Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health. Retrieved from <https://dphhs.mt.gov/amdd>

WORKFORCE RECOMMENDATIONS

1. Provide A Reimbursement Mechanism For Licensed Addiction Counselors Within Hospital-Based Clinics And Primary Care Settings And/Or Simplify The Process For Primary Care Clinics To Become “State Approved” Providers

State policies and regulations should be amended to allow for reimbursement of LACs in other primary care settings, including hospital-based primary care clinics, without requiring these settings to take on the additional burden of becoming state approved addiction providers. The goal of having this workforce available across primary care is not to replicate the specialty addiction treatment system, but to provide care for those who are exhibiting at risk substance use and/or to engage people in the process of care so that eventually they will move to specialty substance use care when it is appropriate. In addition to expanding the settings in which LACs can seek reimbursement, the services they are able to be reimbursed for should be expanded. Currently, LACs in FQHCs and RHCs can only receive reimbursement for the following billing codes in Montana:

- H0001 – Assessment/Evaluation
- H0004 – Individual Therapy
- H2035 – Group Therapy

In 2018, 13 states extended LACs as a covered provider under a PPS or alternative payment model (APM) encounter in their Medicaid programs.¹⁷ Additionally, states have expanded reimbursement opportunities for LACs to include the following billing codes:¹⁸

- Diagnostic services: 90791, H0001, H0031
- Individual therapy: 90837, 08034, H0004, H2019, H0022, H2035, H5010
- Family/couples therapy: 90847, 96154, H0004, H2019, H2035, T1006
- Group therapy: 90853, 96153, H0004, H0005, H2019, H2035, H5020
- Crisis intervention: 90839, H2011

Reimbursement rates for addiction counselors under Medicaid range significantly due to variations related to education and training requirements for licensure (see Table 1).

TABLE 1. MEDICAID REIMBURSEMENT RATES FOR ADDICTION COUNSELORS¹⁹

	Assessment	Individual therapy (1 hour)	Family/couples therapy (1 hour)	Group therapy per client (1 hour)	Crisis intervention (1 hour)
Range (low-high) in dollars	\$17 - \$189	\$27 - \$126	\$43 - \$110	\$6 - \$58	\$69 - \$200

¹⁷ National Association of Community Health Centers. (2018, August). Behavioral Health in Primary Care. Retrieved from <http://www.nachc.org/wp-content/uploads/2019/03/BH-Fact-Sheet-3.20.19.pdf>

¹⁸ Beck, A. J., Page, C., Buche, J., Rittman, D., & Gaiser, M. (2018, September). Scopes of Practice and Reimbursement Patterns of Addiction Counselors, Community Health Workers, and Peer Recovery Specialists in the Behavioral Health Workforce. University of Michigan Behavioral Health Workforce Center. Retrieved from <http://www.behavioralhealthworkforce.org/wp-content/uploads/2019/06/Y3-FA3-PI-SOP-Full-Report-Updated-6.5.19.pdf>

¹⁹ Ibid.

By expanding the number of services LACs can bill for, LACs can help fill gaps in current workforce capacity shortage areas and contribute to a more comprehensive system of care for patients with behavioral health needs. To assure sustainable implementation by providers, the rate needs to be set a level that adequately covers the actual cost of care. In order to calculate the rate effective and appropriate for Montana, we recommend conducting a salary survey for LACs currently in Montana, then adding the average fringe and indirect partial costs found in primary care practices and assume 70% productivity. Montana could further incentivize integration by limiting reimbursement for LACs to practices that also provide either primary care or CMHC services at the same location.

2. Expand Peer Support Services Within Primary Care Settings

CBHPSSs are incredibly valuable members of integrated primary care teams. While the basic training for CBHPSS does not prepare them to function in primary care, there are additional evidence-based trainings that can be used to develop the additional skills necessary to function effectively as a member of the primary care team. As an example, Michigan trains peers in the Stanford Chronic Disease model and they co-lead groups.²⁰

The Whole Health Action Management (WHAM) training prepares CBHPSS to support self-management in people living with chronic health conditions. It is currently being studied using a randomized control trial design by Judith Cook at the University of Illinois. While this research has not yet been published, the results demonstrate the effectiveness of CBHPSS in supporting chronic disease management in people with (or without) SMI.

Benefits Of Peer Support In Primary Care ²¹

- Linking people to shared knowledge and experience.
- Providing health education to individuals and communities.
- Giving practical assistance to achieve and sustain complex health behaviors like those of diabetes management.
- Offering emotional and social support.
- Helping people cope with stressors that accompany health problems.
- Helping people access and navigate clinical care and community resources they need.
- Increasing individual and community capacity for understanding health problems and promoting ways to address them.
- Advocating for patients and their communities.
- Building cultural competency of health care providers.
- Improving two-way communication between patients and health care teams.
- Addressing complex multi-morbidities, serving as a bridge between primary care and behavioral health.

²⁰ Michigan Department of Health & Human Services. (2019). PATH (Personal Action Toward Health). Retrieved from https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_21222_53526-259210--00.html

²¹ Fisher, E. B., Hacker, T., McDonough, M., Nielson, M., & Yao Tang, P. (2015). Peer Support in the Patient-Centered Medical Home and Primary Care Conference Report. American Academy of Family Physicians, National Council of La Raza, Patient-Centered Primary Care Collaborative, and Peers for Progress.

CASE EXAMPLES

Several states have established reimbursement models for peers in primary care settings, including within health home and PCMH models. Examples of peer models from other states include:



The Family Care Center at Brown University is a hospital-based academic teaching practice that has embedded peers within its PCMH model to support behavioral health and social needs among patients with diabetes.²²



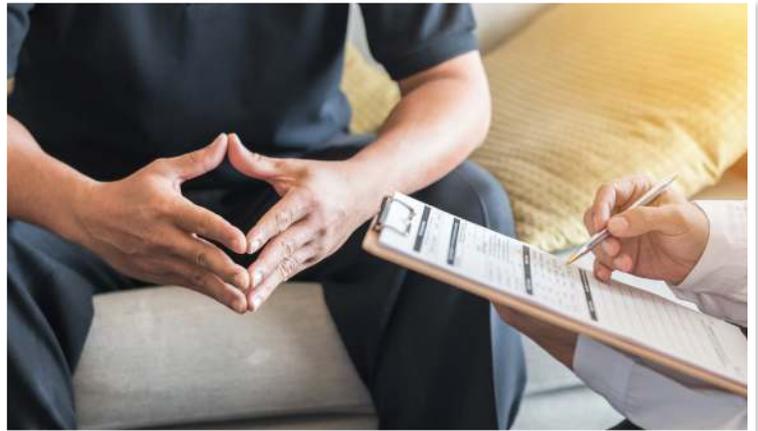
In Pierce County, Texas, OptumHealth integrated reimbursement for peer whole health coaches within Medicaid managed care. The peer services were delivered via a primary care mobile clinic resulting in a 70% reduction in rehospitalization.²³



In Tennessee and Wisconsin, OptumHealth implemented a Peer Bridger program called PeerLink that resulted in significant decreases in the number of average hospital days in both states after enrollment in the program.²⁴

3. Reimburse In-Training Practitioners In PPS Hospitals And Critical Access Hospitals Without An RHC.

One of the major challenges limiting the growth of integrated behavioral health is the lack of reimbursement for in-training practitioners in these settings. Allowing reimbursement of in-training practitioners (with required supervision) unleashes the available workforce to where it's needed most – Montana's rural areas.



²² McDonough, M., Martinez, L., Nash, J., Pistulka, G., & Tang, P. (n.d.). Integrating Peer Support into the Primary Care Team: Public and Private Models of Integration. Retrieved from <https://www.pcpcc.org/sites/default/files/Peer%20Support.pdf>

²³ Bergeson, S., Forquer, S., & Ashenden, P. (2011). Peer Delivered Services in Managed Care. OptumHealth webinar presented via the National Council for Behavioral Health.

²⁴ Ibid.

RECOMMENDATIONS FOR SPECIALTY BEHAVIORAL HEALTH SYSTEM TO ENHANCE PARTNERSHIP, SUPPORT AND OUTCOMES

1. Develop Free-Standing Peer Support Teams Within Specialty Behavioral Health Organizations

When Pennsylvania brought peer support into their Medicaid plan, they created two options: embedded peer support specialists who function within behavioral health organizations or free-standing peer support teams that can take referrals from anywhere across the health care system and/or community. These free-standing teams have the added benefit of creating and holding onto their own “peer culture” and being responsive across the community. They would still potentially be reimbursed as FFS with general fund dollars to support some of their non-reimbursable costs. This would open up peer support to functioning alongside primary care and make their use more likely in those organizations developing integrated services for pregnant and postpartum women through the current Meadowlark Initiative in Montana.

2. Develop Health Homes In Specialty Behavioral Health

Through the State Youth Implementation Treatment (SYT) grant, Montana did a preliminary experiment several years ago with a behavioral health home. The model used in this grant varied from the requirements of a full health home because it did not require all six core services or the development of team-based care. The target population was also one of the most challenging – transition age youth with SUD. Youth are often not engaged in primary care so engaging them was difficult. This challenging experiment should not limit the possibility of using a model that has been successful in many states with meeting the needs of people with SMI and co-occurring serious physical health conditions and could supplement the work being done in integrated care.

As noted earlier in the report, health homes can be developed in multiple settings. In specialty behavioral health, they provide the opportunity for development of a team that focuses on the whole health of the person, including their physical health needs. In this way, the health home becomes an important partner to primary care, primary care provides medical care and the health home addresses the other issues that impact the ability to meet outcomes. Health homes for chronic conditions are very nicely suited as an initial step in learning care management care coordination. Health homes provide an opportunity for specialty behavioral health organization to collect data, use it to manage a group of people and report on it. This allows the organization to build a data infrastructure and the costs of this infrastructure can be built into the PMPM payment if the state chooses.

In addition the opportunity to build a team, to learn to provide an array of services based on need and to manage a PMPM payment are important building blocks for moving to CCBHCs. The current move toward a tiered Program of Assertive Community Treatment (PACT) system is a first step in this development process.

CASE EXAMPLE: CCBHCs

The Excellence in Mental Health Act demonstration established a federal definition and criteria for CCBHCs, which provide a comprehensive range of SUD and mental health services to vulnerable individuals. In return, CCBHCs receive a Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. CCBHCs must provide nine types of services, with an emphasis on provision of both substance use and mental health care, 24-hour crisis care, evidence-based practices and care coordination.

Data show that the CCBHC model has been effective at decreasing patient wait times, increasing access to integrated care and increasing staff positions.²⁵ Survey data from November 2018 showed that CCBHCs have hired an estimated 3,009 new staff, an average of 46 new staff per CCBHC.²⁶ Patient caseloads have risen by an average of 25% and 68% of clinics have seen a decrease in patient wait times for services. All the CCBHCs surveyed reported being able to increase access to new SUD treatment services or expand their scope of services.²⁷

Montana has begun the movement toward CCBHCs with the implementation of their PACT tier system. This approach will allow providers to focus more on outcomes, adjust their back office functions to an alternative payment arrangement and strengthen the approach to team based care. While the rural and frontier nature of Montana provides some challenges to implementation of CCBHCs, other states that have similar rural and frontier areas have had success with this approach. A flexible approach using regional CCBHCs with strong telemedicine and telehealth approaches could support this next logical step in development.

Several states are using Medicaid Section 1115 waivers and state plan amendments to support CCBHCs. The Texas Adult Mental Health Waiver Amendment to its Transformation Waiver uses the CCBHC framework, STAR+PLUS managed care program and a new 1115 waiver pool to improve care coordination and quality using value-based payments. This amendment has three primary mechanisms: 1) tailoring the existing Texas STAR+PLUS program to increase emphasis on CCBHCs to achieve three outcomes, 2) increasing access to care for SMI populations and 3) establishing an integrated care waiver pool by maximizing local and federal funding through the 1115 waiver. The amendment will also provide a mechanism to continue the funding gains provided to community mental health centers through an 1115 waiver when DSRIP ends in October 2021.²⁸ Similarly, Minnesota has incorporated support for CCBHCs within its Medicaid 1115 waiver application submitted in August 2019.²⁹ Oklahoma, Missouri and Nevada are also pursuing CCBHCs through Medicaid state plan amendments once the CCBHC demonstration ends and New York is pursuing a Medicaid 1915(b) waiver to continue CCBHC activities beyond the demonstration period.³⁰

²⁵ National Council for Behavioral Health. (2019, August). Data Highlights: Certified Community Behavioral Health Clinics.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Texas Council of Community Centers. (2018, October). Adult Mental Health Waiver Amendment to 1115 Transformation Waiver (AMH 1115 Waiver Amendment).

²⁹ Centers for Medicare and Medicaid Services Expenditure Authority. (2019). Minnesota Substance Use Disorder System Reform. Retrieved from <https://www.medicare.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82216>

³⁰ Mandros, A. (2019). What is the Future of the CCBHC? Open Minds. Retrieved from <https://www.openminds.com/market-intelligence/executive-briefings/what-is-the-future-of-the-ccbhc/>

CONCLUSION



The recommendations presented here are intended to support the continued development of strong integrated care practices. The unique and varied characteristics of Montana communities require multiple approaches that are consistent in their commitment to being data-driven, population-based and delivered by a team of providers working together toward the outcome of improved health and wellbeing for the citizens of Montana.

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