Rhode Island Executive Office of Health and Human Services
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Health System Transformation Project Behavioral Health Investment Strategy

Introduction:

The efficient integration of behavioral health (BH) into a complete care model for Medicaid enrollees in the state of Rhode Island is central to the Accountable Entity (AE) Program's goals of driving delivery system accountability to improve quality, member satisfaction, and health outcomes, while reducing total cost of care. Significant barriers exist to coordination of care between BH and physical health (PH) providers. These barriers have prevented full care coordination and have likely had a negative impact on the health of Medicaid beneficiaries in Rhode Island living with mental illness and/or substance use disorder (SUD).

The Rhode Island Executive Office of Health and Human Services (EOHHS) has dedicated $3.5 million from the Health System Transformation Project (HSTP) budget to invest in enhancing coordination between BH (including SUD providers) and primary care. EOHHS engaged in a series of interviews with key stakeholders and subject matter experts including AEs, Managed Care Organizations (MCOs), and BH providers within the state to determine how to best utilize these funds.

Background:

The Medicaid AE Program delivers Medicaid Services through an accountable care model comprised of seven AEs. Sixty percent (60.3%) of Medicaid beneficiaries in Rhode Island are attributed to an AE (as of January 2022).

Nationally, beneficiaries with BH diagnoses account for 20%[1] of the Medicaid population and 48% of Medicaid spending, due to a combination of above-average BH *and* PH service utilization. Increases in BH related hospitalizations and Emergency Department visits in the wake of the COVID-19 pandemic have reemphasized crucial gaps in the provision and coordination of BH care. Rhode Island has not escaped national trends; state overdose deaths have increased by 45%[2] since 2019.

Under the AE Program's Total Cost of Care (TCoC) model, AEs have a significant interest in improving care for members living with a BH condition, to both improve outcomes and avoid spending on services that fail to improve outcomes. Because these members have unmet health needs that may lead to

[1] Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals, KHN https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/
[2] Drug Overdose Data Surveillance Hub, RIDOH https://ridoh-overdose-surveillance-rihealth.hub.arcgis.com/

unhelpful service utilization (e.g., emergency department utilization for conditions that can be prevented or managed through primary care and/or non-hospital BH care), targeting interventions to more efficiently and effectively provide them with the needed care can have a significant impact on spending and outcomes. EOHHS understands that, in response to the incentives implicit in the TCoC model and explicit in the AE program's quality and outcome measures, AEs have sought to implement strategies to better serve members with BH needs. Unfortunately, there remain significant barriers to the type of AE collaboration with BH providers that could reduce the inefficiencies that exist within the system.

To mitigate these barriers, EOHHS is making a one-time $3.5 million investment to facilitate care provision and coordination to AE members with BH diagnoses. Due to the nature of this nonrecurring investment, EOHHS focused on one-time investments without significant maintenance costs. For that reason, EOHHS did not consider rate increases.

Interviews & Findings:

EOHHS conducted a series of interviews between September 2021 and February 2022 to identify areas for investment. EOHHS interviewed all seven AEs and both of RI Medicaid's MCOs that currently have contracts with AEs. Most AEs included their internal leads for BH care as well as their key external partners for the provision of BH care in these interviews. EOHHS also spoke with other BH providers, as well as with the individuals responsible for BH discharge and care coordination at the acute-care, community, and psychiatric hospitals in Providence County.

The overall goal of the interviews was to understand the main obstacles to providing high quality care to patients with BH diagnoses. EOHHS asked interview participants about obstacles to the provision of care to their BH patients, with a particular focus on SUD and pediatric populations. EOHHS also asked about information sharing between providers and challenges faced in coordinating care transitions after patients are discharged from inpatient facilities. During this process EOHHS identified several recurring themes:

1) *Workforce Shortages*
   The main concern voiced by most AEs was that the demand for BH services in the state – especially among AE members – is greater than the supply of qualified providers. The AEs expressed that this concern has existed for many years, but the COVID-19 pandemic has exacerbated the issue. Dedicated staff to perform care coordination are in short supply due to widespread staffing shortages. BH and PH providers *both* report that they are unable to reach each other because there is no one picking up the phone on the other side.

2) *Housing Access*
   The highest-cost patients with BH diagnoses are often homeless or housing insecure. These populations face many barriers to high quality care and as a result often have trouble maintaining care regimens (e.g. medication compliance or attending regular appointments). Outreach to this population for the purposes of care coordination is extremely difficult as they lack reliable addresses and they often do not have access to a phone. Once a homeless patient is discharged from a facility, the ability of other providers – such as AEs or Community Mental Health Centers (CMHCs) who may be responsible for follow up appointments – to contact the patient is limited. Many stakeholders expressed the importance of warm hand-offs and

relationship building prior to discharge to facilitate optimal transitions and reliable care coordination with this population.

3) *Care Transitions*
   Patients who receive inpatient BH services are often discharged from inpatient facilities without adequate care transition plans in place. Often AEs are unaware that a patient was discharged or even hospitalized. AEs are responsible for following up after inpatient hospitalization for BH under the AE Quality Measure Set. They often struggle with performance on this measure as they lack the necessary information – such as accurate contact information – required for follow-up. Once discharged, it becomes harder for AEs to track patients and schedule the necessary follow-up appointments.

4) *BH Data Sharing*
   Due to interpretations of 42 CFR Part 2 and the Rhode Island State Mental Health Law, BH providers are often conservative in sharing information with other providers. As a result, AE providers responsible for the care of attributed members have limited insight into the range of services their patients are receiving.

5) *Attributed but Not Seen Population*
   Some portion of the BH population in each AE falls into the category of "Attributed but Not Seen," meaning that the AE is responsible for the care of patients that are not currently receiving care from any of its providers. Some of these patients are receiving care elsewhere through a combination of Emergency Departments, Urgent Care Centers, CMHCs, and Inpatient Hospitalizations. If the AE has no contact with these patients, they are unable to coordinate their care.

6) *Mid-Acuity Patients*
   Due to the structure of the BH system, patients who do not fall into the category of Integrated Health Home (IHH) or Assertive Community Treatment (ACT) receive fewer resources than those that do, including care coordination. There is a risk that mid-acuity patients' conditions may deteriorate without the appropriate level of care, resulting in them 'stepping up' to a higher level of care rather than achieving the goal of 'stepping down' or stabilizing. While high acuity patients require a higher level of care and care coordination, there is concern that mid-acuity patients are not receiving proportionate focus.

The above interview findings informed the development of the HSTP BH investment strategy. EOHHS developed a series of investment plans to facilitate improvement of the quality of care provided to AE members with BH diagnoses. This brief covers Part 1 of the investment, valued at approximately $1.0 million. EOHHS plans to implement the initiatives highlighted below during state fiscal year (SFY) 2023 and SFY 2024. Part 1 of this plan will be followed by further investments in discharge coordination between inpatient BH facilities and AEs as well as coordination efforts between CMHCs and AEs.

Investment Part 1 - Health Information Technology (HIT)

The provision of quality care for AE members with BH diagnoses program depends on clear communication and strong care coordination between patients, AEs, inpatient facilities, and CMHCs. Significant barriers exist to functional communication and coordination between these groups, which has resulted in many patients not receiving the care and supports that they need.

To improve communication and care coordination between the AEs and Rhode Island's BH providers and inpatient BH facilities, EOHHS is investing in expanding HIT capabilities related to care for BH patients. EOHHS has identified several HIT investments and enhancements that will facilitate more efficient communication between AEs and BH providers that care for AE patients. These investments and enhancements are foundational to creating a more robust system for data sharing and care coordination, which EOHHS will leverage with subsequent investments.

Number	HIT Enhancement Description	Context
1	Flag AE members for BH providers in CurrentCare and/or Care Management Alerts and Dashboards (CMAD)	• The ability of BH providers to identify AE patients and know which AE they belong to is central to the success of all AE/BH care coordination initiatives. • All information that is required to implement a flagging system is currently available; this investment will facilitate the technical work required to add this flag.
2	Overhaul CMAD to include new BH enhancements: opioid overdose risk flag and IHH/ACT flag	• Adding an opioid overdose risk flag and IHH/ACT flags will help AEs and other providers more easily identify high risk and high-cost patients. • Improving discharge planning capabilities by adding these flags for hospitals will create an easier pathway for transitions of care for high-risk patients.
3	Support CMHCs and OTPs in onboarding to the Quality Reporting System (QRS)	• Covering onboarding costs for these providers will increase participation in the QRS and in CurrentCare, which will allow for more comprehensive care coordination.
5	Implement BH consent process and data sharing into CurrentCare	• Implementing technical data segregation of Part 2 and non-Part 2 data will streamline the handling and transfer of patient records. • Embedding a new consent and compliance framework in CurrentCare will allow disclosure of information to entities instead of individual providers.
5	Provide training & technical assistance on CurrentCare consent practices.	• New consent practices – including opt out and the ability to disclose to entities instead of specific providers – will require training