CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome

November 4, 2021 Quarterly IBH Committee meeting

Agenda

Topic *Presenter(s)*	Duration
Welcome *Rena Sheehan, MBA, LICSW & John Todaro, PhD*	5 minutes
HSTP BH Investment *Charlie Estabrook, MPH, Accountable Entity Program Manager, EOHHS*	55 minutes
OHIC's FOCUS ON BEHAVIORAL HEALTH INTEGRATION *Marea Tumber, Principal Policy Associate, OHIC*	30 minutes

HSTP BH Investment

CTC Integrated Behavioral Health Meeting

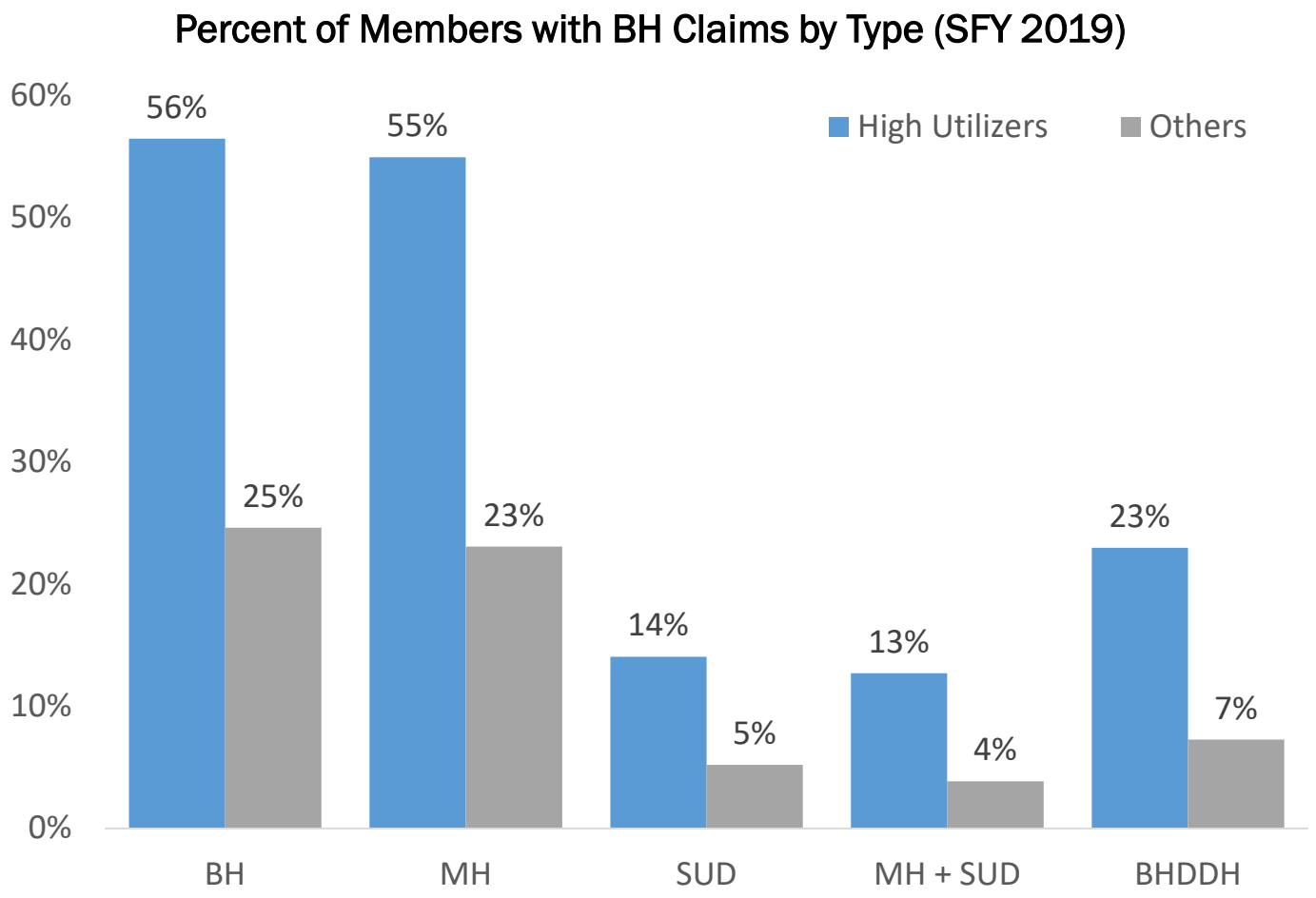
11.4.2021

RHODE ISLAND

HSTP is investing $3.5M in addressing BH in the AE program

- EOHHS has identified and set aside $3.5 million in HSTP funds to invest in improving quality of care among the BH population in the AE program
- This is a **one-time** investment, and therefore cannot be used to increase rates. We will also be trying to avoid investments that will have high maintenance costs.
- The structure of the AE program incentivizes coordination; however, significant barriers to effective coordination limit the effectiveness of incentives.
  - The TCoC model implicitly incentivizes focusing on the highest cost patients, many of whom have BH diagnoses.
  - Quality measures explicitly measure AEs performance at caring for their BH patients and coordinating with BH providers.

Over Half of High utilizers Have a BH Diagnosis



High Utilization Criteria:

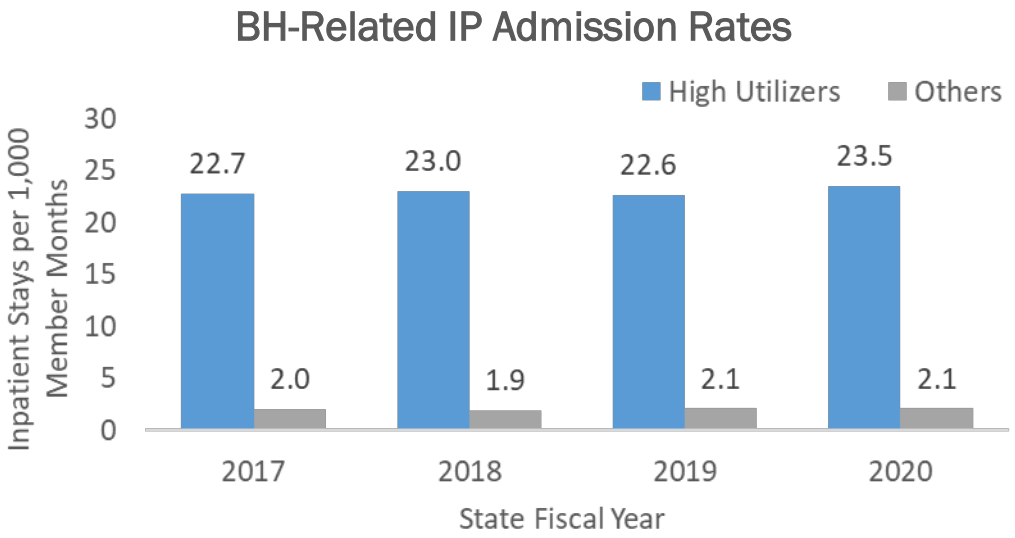
- Total Spend >= $25,000 per year
- **or** 4+ ED Visits per year
- **or** 2+ IP Stays per year

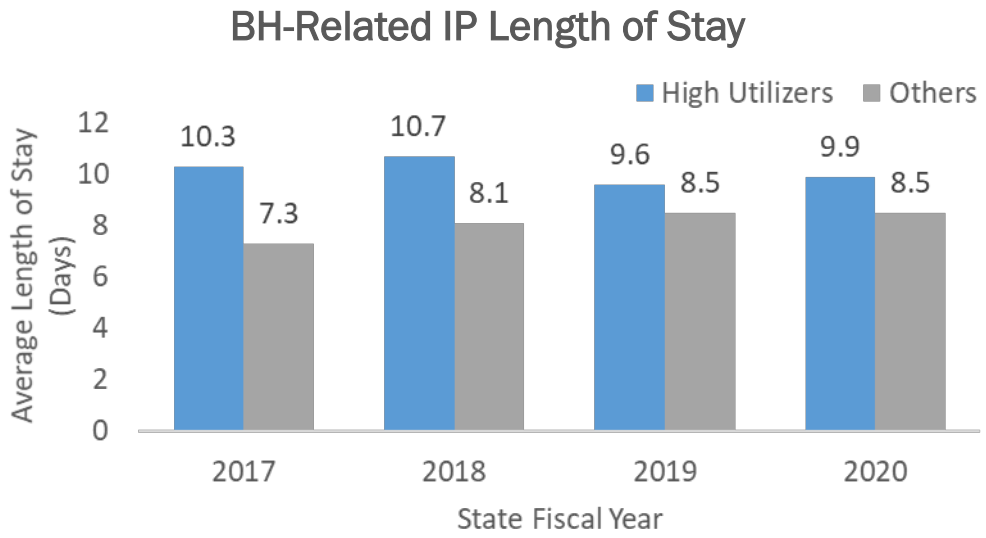
Total Spend includes Medical and Pharmaceutical costs.

Full Medicaid beneficiaries only.

- **3+ consecutive fiscal years**

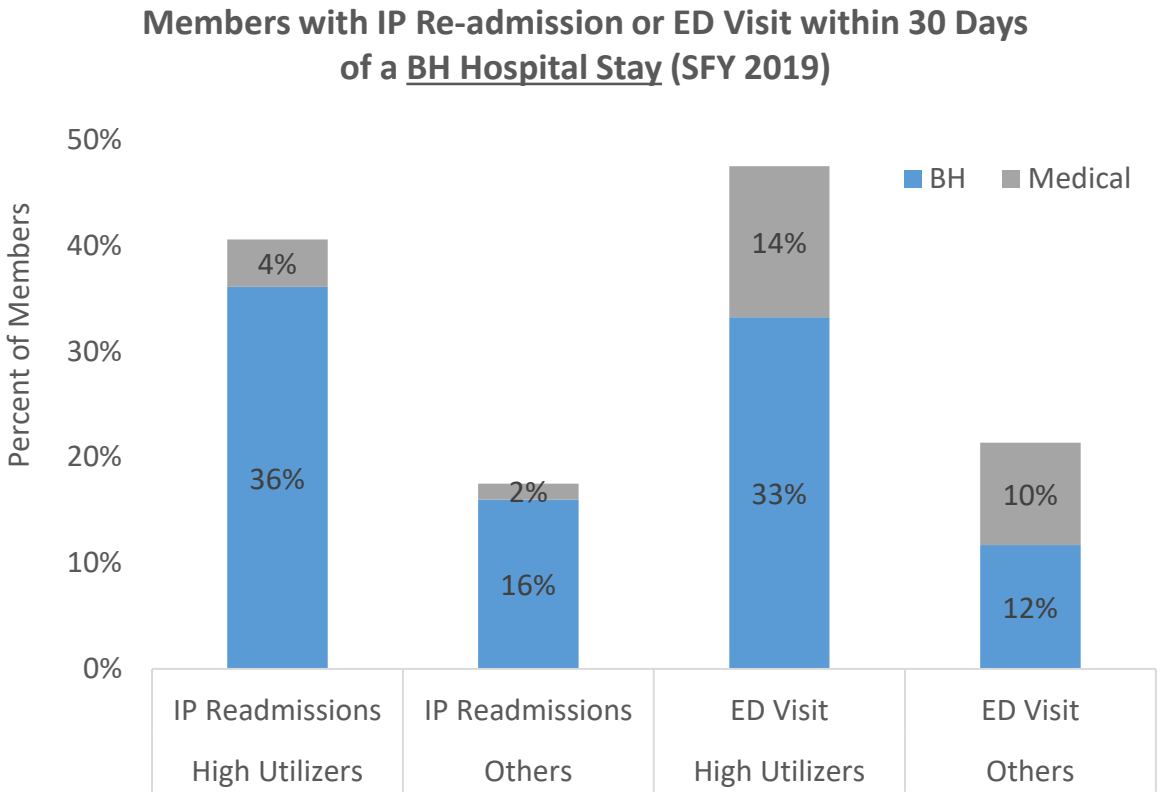
Inpatient Utilization





- High utilizers are admitted to the hospital for BH reasons at a rate 10x higher than the rest of Medicaid.
- When admitted to the hospital with a BH-Related diagnosis, the average length of stay is significantly longer for high-utilizers.

High Utilizers with BH Hospitalizations Have a High Rate of Readmission



- Among high utilizers with a BH-related hospital admission in SFY 2019, 40% were readmitted within 30 days and 47% were seen in the ED within 30 days.

AEs identified common themes in our interviews

Everyone agrees that improving care for patients with BH diagnoses is a priority and presents significant opportunities for population health improvement and cost savings; but structural barriers impede AE's ability to effectively provide care for this population.

- Data sharing & care coordination face significant hurdles
  - Varied and mostly conservative interpretations of 42 CFR Part 2 and the state MH law prevent BH providers from reliably sharing information about patients. Strong desire for AEs to be able to receive hospital/ED alerts and discharge information
  - AEs struggle to communicate with clinical staff within inpatient BH facilities and community mental health settings to support discharge planning and care coordination
- Provider Supply
  - High demand of services and low supply of providers has created a significant bottleneck, exacerbated by non-competitive wages and COVID-19.
  - There is a shortage of both professional/licensed clinicians as well as paraprofessional providers.
  - There is an even more substantial shortage of multi-/bilingual providers
- Delivery system challenges
  - Lack of access to care for mid-acuity populations (those who don't meet eligibility for IHH/ACT)
  - Lack of appropriate residential and step-down services for SUD and other BH
- Housing
  - Barriers to stable housing for homeless/unstably housed population with BH needs

AEs highlighted promising BH interventions

Despite challenges and widespread gaps, AEs have been active in this area and have stood up several programs that have shown success and may provide examples of best practices that can be scaled up.

- Several AEs spoke about the benefit of having contractual relationships with BH providers that allow for embedded care coordinators and/or liaisons. These contractual relationships have also resulted in rapid turnaround on referrals.
- A secure texting program for asynchronous communication has been successful with monitoring lower acuity BH patients
- One AE has embedded psychiatric services in pediatric primary care and triages lower acuity patients BH needs to primary care providers. They have seen significant success with this model and are looking to expand to adult populations.
- A designated provider-to-provider triage system has shown some promise in its ability to reduce unnecessary ED utilization among patients with BH needs
- AEs have developed a number of programs and partnerships to provide stable housing through Crossroads and hotel vouchers. The impact of these interventions remains unclear.

4 strategies have emerged as options to address BH challenges

We have identified preliminary areas of focus for the BH investment, as well as other available funds, to address gaps in data sharing and care coordination as well as workforce shortages.

1. Clarifying the language and aligning interpretations of 42 CFR Part 2 and the state MH law would have a significant impact on patient care and care coordination.
2. Develop a HCTI-style program that creates an embedded position within BH inpatient facilities to coordinate care and discharges between AEs and BH providers.
3. Leverage HSTP/DLT funds to implement larger programs targeted towards acute workforce needs rather than smaller scale one-off training programs
4. Long term alignment of incentives for CMHCs, hospitals, and AEs

Questions

- Any comments or questions regarding our initial findings form our AE interviews?

- Are there any individuals or groups you think we should reach out to?

- Are there any other areas where we could spend this money that you think we should be exploring?

OHIC's FOCUS ON BEHAVIORAL HEALTH INTEGRATION

NOVEMBER 4, 2021

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

AFFORDABILITY STANDARDS AND INTEGRATED BH

- In 2019, OHIC established the Integrated Behavioral Health (IBH) Work Group to identify potential solutions to several administrative barriers to patient access to integrated care.
- The final report proposed a set of recommendations to the health insurance commissioner that addressed:
  - Reducing co-payments at qualifying IBH practices*
  - Expanding health and behavior assessment and intervention code coverage policies
  - Eliminating out-of-pocket costs for preventive BH screenings
- Based on the recommendations from this work group, OHIC incorporated several IBH requirements in its revised Affordability Standards promulgated in June 2020.

AFFORDABILITY STANDARDS AND INTEGRATED BH

A "Qualifying IBH Primary Care Practice" is a PCMH that:

- a. Is recognized by a national accreditation body (such as NCQA) as an IBH practice; or
- b. Currently participating in, or participated in and successfully completed, an IBH program under the oversight of CTC-RI; or
- c. Completes a qualifying BH integration self-assessment tool and develops an action plan for improving its level of integration*

* Practices may use options (b) and/or (c) for up to a total of 3 years

AFFORDABILITY STANDARDS AND INTEGRATED BH

- The Affordability Standards include payer reporting requirements on IBH efforts, including:
  - Confirming compliance with the Affordability Standards IBH requirements
  - Delineating additional strategies to facilitate and support access to IBH services
  - Providing an update on their progress on the primary care APM requirement

FUTURE BH EFFORTS: NEXT GENERATION AFFORDABILITY STANDARDS AND BH SPENDING

- OHIC has had primary care spending requirements as part of the Affordability Standards since 2011.
- The Affordability Standards require insurers to dedicate at least 10.7% of annual medical spend to support and strengthen the capacity of a primary care practices.
- OHIC is exploring the idea of instituting similar type of spending requirement for BH.
- EOHHS and OHIC are currently performing a BH spending analysis, which will examine less-intensive vs. more-intensive services, how they correlate to outcomes, and then benchmarking RI data against other states.
- This analysis will help inform where BH spending is most needed to lower costs and improve quality.

FUTURE BH EFFORTS: NEXT GENERATION AFFORDABILITY STANDARDS AND BH SPENDING

- OHIC aims to build on the success of its recent accomplishments in the federal State Flexibility to Stabilize the Market Grant completed in 2020.
- The federal State Flexibility Cycle II Grant will help OHIC to enhance its ability to effectively regulate commercial health insurance markets.
- The award is for approximately $660,000 over two years.
- Projects include:
  - Upgrading to a consumer–centered website that is educational and easily accessible
  - Enhancements to OHIC's UR data portal to assist in identifying trends and/or and discriminatory practices for investigation, including through market conduct examinations
  - Hiring of a staff person and expert legal consultant assistance to improve access to BH services and ensure BH parity

Friendly Reminder

- No meeting in December
- Thursday, **January 13, 2021,** Quarterly IBH Meeting – Pediatric IBH Learning Collaborative
- Thursday, **February 10, 2021** Quarterly IBH Committee Meeting

Happy holidays