Toolkit of Promising Practices for Financing Integrated Care in the California Safety Net

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I. Warning

Read Before Proceeding!

The authors of this toolkit have spent the last year reviewing the literature on financing integrated care and collecting stories about how primary care, mental health and substance use treatment organizations have worked together to provide more holistic care in California.

By all rights, every project should have failed. We have identified ten major funding obstacles and chronicled countless stories about cultural differences, political hurdles, turf battles, personality clashes, and more.

But, in spite of these obstacles, most of the projects in California have succeeded!

How is this possible?

We have discovered that all successful integration efforts have two things in common:

1) The senior leadership of the primary care system and the behavioral health system have made a strong commitment to ensuring the success of the project – whatever it takes.

2) Each project has had a dedicated champion who possesses a combination of optimism, tenacity, attention to detail, and a belief that the project can make a difference in the lives of those being served.

Federal and private grants and MHSA funds have also played an enormous role in filling the funding gaps that exist in the current environment.

If you feel overwhelmed or discouraged as you read about the complexity of the current systems and obstacles, jump forward or back to one or two of the success stories described in this toolkit and remember that succeeding at integrated care is happening every day in communities throughout the country, made possible by people just like you.
II. Quick Guide

This toolkit has been designed to be read from beginning to end or as selected reading like a reference book. You will also note we have attempted to be concise with our language so the reader can get down to business without having to wade through extraneous verbiage.

III: Background

Start here if you want to ground yourself in the context for integrated care or are interested in a brief history lesson about the public safety net system.

IV: Follow the Money

Read this section if you want additional funding information about one or more parts of California’s public primary care, mental health, and substance use systems, including definitions for a number of acronyms that litter the landscape. Be prepared; wading through this section is not for the faint of heart.

V: Barriers

The Top Ten Barriers section digs into why it’s so difficult for organizations to get paid for integrated care in the current funding environment—and what you can do about it!

VI: Opening the Toolkit

Opening the Toolkit offers an eight-step workplan for designing an integrated care program. Note that it’s useful for both those new to integrated care and those who already have programs up and running.

VII: How You Will Get Paid Tomorrow

How You Will Get Paid Tomorrow explores new payment models for primary care that are already being used in other parts of the country and offers some tips on how to prepare for this new funding environment.

VIII: Final Thoughts

Final Thoughts is our attempt to provide some inspirational guidance as you prepare for your upcoming or continuing foray into the world of integrated care. We end this short section with the advice, Good luck, have fun, and remember that succeeding at integrated care is happening every day in communities throughout the country, made possible by people just like you.
III. Background

Why Integrated Care

Many Americans experience healthcare as fragmented, uncoordinated, complex, costly, and confusing. For persons with mental health and/or substance use disorders, the problems are greater as patients attempt to navigate the separate medical, mental health, and substance use disorder (MH/SUD) treatment silos. The result is that Americans with serious mental illnesses, on the average, die at age 53, substantially earlier than those in their peer group without a mental illness. The healthcare costs for individuals with mild, moderate, serious, and severe MH/SUD is greater due to untreated health conditions that become chronic health conditions resulting in frequent use of emergency and high cost inpatient care.\(^1\)

There is a better way. Research suggests that doing a better job of addressing the healthcare needs of persons with serious mental health and substance use disorders as well as the MH/SUD treatment needs of the entire population is critical to achieving what is known as the Three-Part Aim:

- Better health of the population
- Better care for individuals
- Reduced costs (through improvement, not rationing)

Healthcare reform, beyond insurance coverage expansion, is focused on investing more of the healthcare dollar in better primary care systems (known as Patient-Centered Medical Homes) to achieve this Three-Part Aim. For persons with MH/SUD, medical homes are beginning to be customized with primary care clinics embedding MH/SUD clinicians and MH/SUD clinics embedding primary care providers. This approach - known as bidirectional care - is being tested and studied by the federal government, states, and local communities.

The early results are promising. The Substance Abuse and Mental Health Services Administration (SAMHSA) describes these efforts in the following way.

- Behavioral health is part of health
- Prevention works
- Treatment is effective
- People recover

“Reconnecting the head to the body” changes clinical workflows, provider relationships, patient experience, and most important, clinical outcomes for persons with mental health and substance use disorders -
all for the better. Although this toolkit is about financing integrated care, many references will be made to the clinical practice of integrated care so that financing strategies support clinical care, not the other way around.

Why this Toolkit

Because integrated care is a relatively new concept, many of the existing financing mechanisms are based on a fragmented delivery system model. Health, mental health, and substance use providers in California and throughout the country who are practicing integrated care continually experience barriers to getting paid for their work. Indeed, we have identified our “top ten list” of such barriers in Section V.

The purpose of this toolkit is to help primary care clinics, mental health centers, and substance use treatment facilities identify and overcome (to the extent currently possible) existing barriers (Sections V and VI).

Section VII takes us into the near future when we have moved from fee for service payment models (paying for volume) to alternative models (paying for value) and describes emerging payment models and how provider organizations can prepare to succeed in this new healthcare payment ecosystem.

A Short History - The Tale of Two Siblings

Taking a walk down memory lane to explore how the community health and community mental health systems evolved in the United States provides a foundation for understanding the problems we have to overcome in order to get paid for integrated care today.

Health Centers: In the early 1960s, the Community Health Center movement began with the Migrant Health Act of 1962 and the Economic Opportunity Act of 1964. These Acts created a system of primary care clinics funded and managed by the federal government. During the 1970s, Section 330 of the Public Health Services Act added additional scope and funding for centers. The table on the following page adds additional detail to the Health Center history lesson.\(^2\)
1960s  Migrant Health Act of 1962 for farm workers/families  
**Economic Opportunity Act of 1964 funds CHCs**

1970s  **Section 330 of the Public Health Services Act**  
- Community Health Center Program – Section 330(e)  
- Migrant Health Center Program – Section 330(g)  
  National Health Service Corps begins

1980s  **Health Care for the Homeless Program – Section 330(h)**  
  **Health Center Cost-Based Payments for Medicare & Medicaid**

1990s  **Free Federal Tort Protection (Malpractice Insurance)**  
  **Public Housing Primary Care Program – Section 330(i)**

2000s  **Prospective Payment System replaces Cost-Based Model**  
  **States Required to Cover Difference between Rates & PPS**  
  **Expansion of Funding and Capacity, adding BH Services**

Today there are over 8,500 Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) sites, with clinics in every state. These centers are overseen by the Federal Health Resources and Services Administration’s Bureau of Primary Care Services.

**Community Mental Health Centers:** The 1963 Community Mental Health Centers Construction Act (PL 88-164) and its subsequent amendments created the public mental health system. The original legislation provided federal grant funding to community-based organizations and required grantees to provide five core elements of service: outpatient, inpatient, consultation/education, partial hospitalization, and emergency/crisis intervention. This system also grew in the 1970s, as the deinstitutionalization movement moved people from large state mental hospitals to the community and children with serious emotional disturbances began to be treated by the public system.
De-federalization: President Reagan’s Omnibus Budget Reconciliation Act of 1981 (PL 97-35) consolidated federal mental health funding into block grants to be administered by the state mental health agencies, cutting funding by 21%. This bill also spun community health centers off to the states, but in a little known chapter in history, a “poison pen” amendment was added to the bill that made the community health center de-federalization optional for states and clarified that more money would be available if the states chose not to accept the block grants. This resulted in the re-federalization of community health centers in 1982, continued support in Congress and the Executive Branch, and an upward trajectory of funding that continues to this day – in stark contrast with community mental health center funding that has stayed flat as a percentage of gross domestic product (GDP).

During the last thirty years, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has played an important role in supporting the public mental health and substance use disorder systems through SAMHSA’s Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT). This structure has supported research and practice in each area (mental health and substance use) but these “silos of excellence” are part of the trifurcation of the safety net—primary care, mental health, and substance use. The consequence of this evolutionary process is that, until recently, there has been very little coordination between systems, with disparate funding models that do not support integrated care.

Important Note: Throughout this Toolkit the term “Health Center” is used to denote community-based and patient-directed organizations that serve populations with limited access to health care and are funded by the federal government as Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs) or have obtained designation as an FQHC Look-Alike. This Toolkit is Health Center-centric on the primary care side of the integration process because most public projects involve partnerships between Health Centers and public mental health and/or substance use providers.

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1 In 2009, SAMHSA and HRSA began a ground-breaking Primary Care and Behavioral Health Grant program to support the integration of primary care, mental health, and substance use treatment services. In 2010, these two federal agencies contracted with the National Council for Community Behavioral Healthcare to begin the SAMHSA-HRSA Center for Integrated Health Solutions to promote “the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings.” For more information about the Center for Integrated Health Solutions go to: http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions
California’s Funding Streams for Health, Mental Health and Substance Use Services

California currently spends $41.3 billion for Medi-Cal and indigent healthcare and an additional $5.5 billion on mental health and substance use disorder treatment. The graph below provides additional detail and highlights key figures.8

California Health, Mental Health and Alcohol & Drug Funding
2008 Estimates ($=Millions)

<table>
<thead>
<tr>
<th>Health: 88%</th>
<th>Mental Health: 11%</th>
<th>Alcohol &amp; Drug: 1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal: 90%</td>
<td>Non-Medi-Cal: 10%</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal Enrollees: 7.0 million (61%)</td>
<td>Indigent, Uninsured &lt; 200% FPL: 4.5 million (39%)</td>
<td></td>
</tr>
</tbody>
</table>

The fact that only 10% of total funding is used for indigent, non-Medi-Cal persons, but this group represents 39% of those served underscores one of several challenges for California’s health and behavioral healthcare system. Another red flag is that that only 1% of total spending is allocated to substance use disorder treatment (alcohol & drug).
As national healthcare reform begins to be fully implemented in January 2014, over two million indigent and uninsured Californians will obtain Medi-Cal coverage with a benefit package that includes mental health and substance use disorder treatment services at parity with their healthcare benefit. 100% of the expansion population’s Medi-Cal costs will be covered by the federal government for two years, declining to 90% by 2019. These changes create significant opportunities and challenges for California as these newly covered individuals begin to use their health, mental health, and substance use benefits.

As Medi-Cal expansion occurs between 2014 and 2019, we estimate that 400,000 Medi-Cal enrollees with substance dependence or abuse NOT currently receiving care will have access to a drug and alcohol treatment benefit. The following table provides detail on this estimate.10

**California Substance Dependence or Abuse Gap Analysis**

| Current Medi-Cal Enrollees, All Ages | 7,033,568 |
| Current Medi-Cal Enrollees, 12+ Years Old | 4,237,325 |
| Estimated Coverage Expansion, 2014-2019 | +2,000,000 |
| Projected Medi-Cal Enrollees Ages 12+ by 2019 | 6,237,325 |
| Prevalence of Substance Dependence or Abuse | 9.3% |
| Projected Medi-Cal SUD Demand after 2014 | 580,071 |
| ADP FY2009 Persons Admitted to Care | 181,720 |
| Potential Medi-Cal SUD Treatment Gap | 398,351 |

Similar gaps will exist for Medi-Cal enrollees with mental health disorders. The following table illustrates the gap for California residents with a mental health disorder that have Medi-Cal or are indigent (under 133% of federal poverty) and uninsured.11

**California Mental Health Gap Analysis FY2007**

<table>
<thead>
<tr>
<th></th>
<th>Need</th>
<th>Served</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medi-Cal</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild/Moderate</td>
<td>1,019,308</td>
<td>81,983</td>
<td>937,325</td>
</tr>
<tr>
<td>Serious/Severe</td>
<td>735,272</td>
<td>341,594</td>
<td>393,678</td>
</tr>
<tr>
<td>Total</td>
<td>1,754,580</td>
<td>423,577</td>
<td>1,331,003</td>
</tr>
<tr>
<td><strong>Uninsured &lt;133% Poverty</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild/Moderate</td>
<td>652,058</td>
<td>45,433</td>
<td>606,625</td>
</tr>
<tr>
<td>Serious/Severe</td>
<td>483,659</td>
<td>189,304</td>
<td>294,355</td>
</tr>
<tr>
<td>Total</td>
<td>1,135,717</td>
<td>234,737</td>
<td>900,980</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>2,890,297</td>
<td>658,314</td>
<td>2,231,983</td>
</tr>
</tbody>
</table>

Note the large gap for Medi-Cal enrollees with a mild or moderate disorder (937,000 people), many of whom do not currently meet medical necessity criteria and are thus not eligible for Medi-Cal specialty mental health services. This will change when the federal Medicaid parity regulations are issued. Also note the large unmet need for uninsured persons under 133% of federal poverty (900,000 people).
The Importance of Bidirectional Care

In 2009, the National Council for Community Behavioral Healthcare released a report, *Behavioral Health/Primary Care Integration and The Person-Centered Healthcare Home*, which addresses the gap between current Medical Home designs and the needs of persons with mental health and substance use disorders. This report presents a blueprint for how primary care and MH/SU provider organizations can come into alignment with the nation’s emerging healthcare reform strategies. The report “emphasizes the need for a bidirectional approach, addressing the integration of primary care services in behavioral health settings as well as the need for behavioral health services in primary care settings.”

The report’s Four Quadrant Model has received national recognition as a framework for organizing care based on the different needs of population subsets. Each quadrant considers the behavioral health and physical health risk and complexity of the population and suggests the healthcare home model that may be more appropriate.

<table>
<thead>
<tr>
<th>Quadrant II</th>
<th>Quadrant IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Population:</strong> Moderate to high behavioral health and low to moderate physical health complexity/risk.</td>
<td><strong>The Population:</strong> Moderate to high behavioral health and moderate to high physical health complexity/risk.</td>
</tr>
<tr>
<td><strong>The Model:</strong> Person Centered Healthcare Home: primary care capacity in a behavioral health setting, including medical nurse practitioner/primary care physician, wellness programming, screening for health status concerns, and stepped care to a full-scope healthcare home. Access to the array of specialty behavioral health services designed to support recovery.</td>
<td><strong>The Model:</strong> Person Centered Healthcare Home: primary care capacity in a behavioral health setting, including medical nurse practitioner/primary care physician, nurse care manager, wellness programming, screening/tracking for health status concerns, and stepped care to a full-scope healthcare home. Access to the array of specialty behavioral health.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant I</th>
<th>Quadrant III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Population:</strong> Low to moderate behavioral health and low to moderate physical health complexity/risk.</td>
<td><strong>The Population:</strong> Low to moderate behavioral health and moderate to high physical health complexity/risk.</td>
</tr>
<tr>
<td><strong>The Model:</strong> Person Centered Healthcare Home: a primary care team that includes a behavioral health consultant/care manager, psychiatric consultant, screening for behavioral health concerns, and stepped care.</td>
<td><strong>The Model:</strong> Person Centered Healthcare Home: a primary care team that includes a behavioral health consultant/care manager, psychiatric consultant, screening for behavioral health concerns, stepped care, and access to specialty medical/surgical consultation and care management.</td>
</tr>
</tbody>
</table>

As the Four Quadrant Model illustrates, persons with low to moderate behavioral health complexity and risk (Quadrants I and III) would receive their behavioral healthcare in the Primary Care setting. Persons with moderate to high complexity and risk (Quadrants II and IV) would receive their behavioral healthcare in specialty behavioral health centers.
and be offered the option to receive their healthcare in those settings as well. The following diagram illustrates this bidirectional care concept.

Since the 2009 paper was published, hundreds of bidirectional integration projects have unfolded across the country, a number of which have been funded through the SAMHSA/HRSA Primary and Behavioral Health Care Integration Grant program. Many of these projects, including several in California, are bringing together Health Centers and MH/SU provider organizations to put the theory of bidirectional integration into practice.

Additional information on bidirectional integration can be found at the following SAMHSA, National Council, Washington, and Colorado websites:

http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions
http://integratedcare-nw.org/map.html
http://www.cbhc.org/integration/map/
IV. Follow the Money
How We Get Paid Today for Disintegrated Care

California’s funding for health, mental health, and substance use disorder treatment has evolved into a complex mix of funding streams and rule sets over the last several decades. The following diagram organizes these funding streams to align with the new Medi-Cal 1115 waiver that has been designed as a “Bridge to 2014,” when healthcare reform is implemented.

The rows are organized by Medi-Cal eligibility and color-coded by service type: health, mental health, and alcohol and drug. The columns describe the populations. Priority Populations include complex high cost patients, most of who are served in unmanaged fee for service healthcare arrangements. Non-Priority Populations represent healthier, lower cost enrollees. (A discussion of the acronyms follows.)

<table>
<thead>
<tr>
<th>Priority Populations</th>
<th>Non-Priority Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPD</td>
<td>TANF</td>
</tr>
<tr>
<td>Dual Eligibles</td>
<td>Mostly Managed Care</td>
</tr>
<tr>
<td>SMI</td>
<td>Mostly FFS</td>
</tr>
<tr>
<td>CCS Youth</td>
<td>Mostly FFS</td>
</tr>
<tr>
<td>Medi-Cal Health Services ($40 Billion)</td>
<td>Mostly Fee For Service</td>
</tr>
<tr>
<td>Medi-Cal Mental Health Services ($2.3 Billion)</td>
<td>Co. MH Plans (Primarily Fee for Services with either County or State Match)</td>
</tr>
<tr>
<td>Drug Medi-Cal ($204 Million)</td>
<td>State/County Managed Fee for Service (State makes the Match)</td>
</tr>
<tr>
<td>Non-Medi-Cal MISP, CMSP Health Services</td>
<td>Locally or Regionally Managed (CMSP $255 Million; MISP unknown $)</td>
</tr>
<tr>
<td>MHSA Mental Health Services</td>
<td>Locally Managed ($1.2 Billion)</td>
</tr>
<tr>
<td>Non-Medi-Cal Mental Health Services</td>
<td>Locally Managed and Long Term Care ($1.4 Billion)</td>
</tr>
<tr>
<td>Non-Medi-Cal ADP Federal, State, Local</td>
<td>State and Locally Managed ($388 Million)</td>
</tr>
</tbody>
</table>
Unsorting the Acronym Alphabet Soup

The following key explains the acronyms and terms listed above.

**Priority Populations.**

- **SPD** is the acronym for Seniors and Persons with Disabilities, the population with greater than average health and behavioral health complexity often requiring high cost care.
- **Dual Eligibles** are persons with Medi-Cal and Medicare coverage.
- **SMI** is the acronym for Serious Mental Illness used for individuals with conditions such as schizophrenia, bipolar disorder, and major depression.
- **CCS Youth** stands for California Children’s Services, a program that currently serves children with complex health conditions.

**Non-Priority Populations** are either already in managed care or are lower cost individuals.

- **TANF** stands for Temporary Assistance for Needy Families, the federal welfare program.
- **Healthy Families** is a federal/state partnership providing low cost insurance for children and teens who do not qualify for Medi-Cal.

**Other Acronyms and Terms**

- **FFS** is Fee for Service, which is a per-visit or per-day payment method.
- **Co. MH Plans** are the county-run Medicaid Mental Health Plans responsible for managing this program.
- **MISP** is the acronym for the Medically Indigent Services Program, which is defined below.
- **CMSP** is the acronym for the County Medical Services Program, which is defined below.
- **ADP** is the term for the California Department of Alcohol and Drug Programs.

The following pages provide additional information for each box in the diagram on the previous page.
There are two major Medi-Cal health services funding streams that cover the different populations in the figure on the preceding page - fee for service and managed care. The following diagram quantifies how many people are in each subpopulation-funding stream.13

Providers who serve the 3.2 million enrollees in fee for service Medi-Cal have contracts with the California Department of Health Care Services (DHCS), bill the state directly for care on a per service basis and are paid based on the Medi-Cal fee schedule. The exceptions are Federally Qualified Health Centers (FQHCs), FQHC lookalikes and Rural Health Centers (RHCs) that are paid a pre-negotiated per visit payment based on federal statute and regulation known as the Prospective Payment Systems (PPS).

The 3.8 million enrollees in Medi-Cal managed care have their health services managed by County or private health plans that are hired by DHCS, receiving capitation dollars - a fixed per member per month
payment for each Medi-Cal enrollee - in return for taking on the responsibility for providing all required services for the Medi-Cal enrollees that have signed up with the health plan. Each health plan builds a provider network of primary care practices, specialists, hospitals, and other providers of covered services and supports.

Most of these provider organizations are also paid fee for service by the health plans, using the per visit model or the PPS system. Health plans have the flexibility to set their own reimbursement rates and do not need to follow the state’s Medi-Cal fee schedule. There are also a few instances where Medi-Cal health plans subcapitate provider groups such as primary care practices, paying a fixed per member per month payment to provide a predefined set of services.

The intent of the 2010 California 1115 Medi-Cal waiver is to systematically move all Medi-Cal enrollees into managed care by 2014 so that all enrollees, including the expansion population, will be served by organized systems of care.

**Medi-Cal Mental Health Services**

| Medi-Cal Mental Health Services ($2.3 Billion) | Co. MH Plans (Primarily Fee for Services with either County or State Match) |

Medi-Cal mental health services are organized through 57 County mental health plans; with Sutter and Yuba combined into a single plan. The plans use local funds, including Realignment Funding dollars from sales tax revenue and vehicle license fees, to draw down federal matching funds to pay for the Medi-Cal adult mental health budget. The state provides the match for children’s services organized through the EPSDT program and a small amount of money is organized through a capitated stream from the state.

Most Medi-Cal mental health services are reimbursed based on Certified Public Expenditures (CPEs) incurred by each plan. A plan incurs the CPE, either by paying a contract provider based on interim/provisional rates or, for services provided by county operated providers, by their own county costs which are approximated by interim/provisional rates. The interim/provisional rates are then used to generate claims for reimbursement to the State Medi-Cal program and the State reimburses the plan for the 50% federal share for adult services and approximately 90% for children’s EPSDT services. (Note: Assembly Bill 118 and Senate Bill 89 have changed the structure of Realignment Funding to shift additional funds and responsibility down to the Counties.)

Providers in this system are paid in a few ways. County-provided services are generally funded through fixed annual budgets that are based on estimates of revenues that will be generated through Medi-Cal
billings. Other organizations are paid either fee for service or on a 1/12th payment model where an annual budget, based on estimated fee for service revenues, is paid out in monthly increments.

All Medi-Cal mental health services are subject to a cost reporting/cost settlement process where the final federal matching dollar amounts are computed based on the actual certified public expenditures incurred or a Schedule of Maximum Allowable (SMA), whichever is lower. In some cases this settlement process results in a retroactive adjustment to payments that have been made to non-County providers. In other cases the original payment is considered final. Are you confused yet?

**Drug Medi-Cal Services**

<table>
<thead>
<tr>
<th>Drug Medi-Cal (204 Million)</th>
</tr>
</thead>
</table>

Currently, California has a very limited substance use benefit for Medi-Cal enrollees. It is anticipated that a significant expansion of the benefit package will be necessary when the Federal Medicaid Parity Regulations are released and all of California’s Medi-Cal enrollees have a parity-based substance use benefit.

Currently, most Drug Medi-Cal services are paid directly from the state to the provider organization with the state making the federal match. Rates are generally very low, as illustrated by the following table.

**Approved Drug Medi-Cal Rates For Fiscal Year 2008-09**

<table>
<thead>
<tr>
<th>Service</th>
<th>Unit</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcotic Treatment Program - Methadone</td>
<td>Daily</td>
<td>$12.44</td>
</tr>
<tr>
<td>Narcotic Treatment Program - Individual Counseling</td>
<td>10 Minutes</td>
<td>$15.00</td>
</tr>
<tr>
<td>Narcotic Treatment Program - Group Counseling</td>
<td>10 Minutes</td>
<td>$3.49</td>
</tr>
<tr>
<td>Outpatient Drug Free Individual Counseling</td>
<td>Visit</td>
<td>$74.99</td>
</tr>
<tr>
<td>Outpatient Drug Free Group Counseling</td>
<td>Visit</td>
<td>$31.45</td>
</tr>
</tbody>
</table>

**Uninsured/Indigent Health Services**

<table>
<thead>
<tr>
<th>Non-Medi-Cal MISP, CMSP Health Services</th>
</tr>
</thead>
</table>

In the early 1990s, California state funding was realigned, shifting resources and responsibilities to the counties to support social services, indigent health services, and mental health. The California Welfare and Institutions Code Section 17000 designates counties as health care providers of last resort for indigent residents. Each California County Board of Supervisors has discretion to determine who is eligible, how much to spend, what services to cover, and how indigent healthcare will
be delivered.

Larger counties have developed Medically Indigent Services Programs (MISP) for inpatient and emergency services. They have also developed some outpatient care for uninsured adults (and children in some counties). Thirty-four smaller counties have banded together to create a single County Medical Services Program (CMSP).

Funding for indigent health comes through Realignment Funding (sales tax revenue and vehicle license fees), federal Disproportionate Share Hospital (DSH) funds, the California Safety Net Care Pool (SNCP) for counties that own hospitals, grants for counties with Federally Qualified Health Centers and/or Rural Health Centers, and local resources in some (but not all) counties to support these services.

**MHSA Mental Health Services**

<table>
<thead>
<tr>
<th>MHSA Mental Health Services</th>
<th>Locally Managed ($1.2 Billion)</th>
</tr>
</thead>
</table>

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA), which was designed with the dual purpose of expanding and transforming California’s county mental health system. The expansion has been funded by imposing an additional one percent tax on individual taxable income in excess of one million dollars.

Generally, MHSA funds are used to fund Medi-Cal type services to the uninsured, and non-Medi-Cal type services (such as housing) to all clients. These funds are also used to fund prevention and early intervention projects and innovative projects, and to develop workforce, information systems and facilities. Note that for persons with Medi-Cal coverage, MHSA funds are also used to cover the local share of Medi-Cal allowed services described in the Medi-Cal Mental Health Services section.

MHSA revenues peaked in FY2009/2010 and are on a downward trend that is projected to continue through FY2012/2013.

**Uninsured/Indigent Mental Health Services**

<table>
<thead>
<tr>
<th>Non-Medi-Cal Mental Health Services</th>
<th>Locally Managed and Long Term Care ($1.4 Billion)</th>
</tr>
</thead>
</table>

The Realignment Funds described in the Uninsured/Indigent Health Services section are also used to pay for Uninsured/Indigent Mental Health Services as well as the match for Medi-Cal Mental Health Services. The following figure lists all of the programs covered with
Realignment Funding and the funding prioritization process.

The complex formula that determines how each account is funded, combined with the increase in Realignment Fund dollars to match Medi-Cal Mental Health, results in a situation where some counties have no money left to fund local mental health programs for indigent persons.

**Uninsured/Indigent Substance Use Services**

Over two-thirds of non-Medi-Cal substance use funding comes from Federal Block Grant dollars and the remainder is primarily from the State General Fund. Very few local dollars are invested in substance use services for non-Medi-Cal persons.

In 2014 it is anticipated that a substantial number of uninsured persons needing substance use services will obtain Medi-Cal, which will be offering mental health and substance user services at parity with the healthcare benefit.
V. The “Top Ten” Barriers to Getting Paid for Integrated Care

As integrated care expands in California, more and more organizations are faced with the question: How do we get paid for behavioral health services provided in primary care and primary care services provided in behavioral health?

During the Spring of 2011, a series of CiMH-sponsored regional integration forums were held that brought together dozens of organizations from across the state. The stories told during the forums reflected wisdom and expertise that appears throughout this toolkit and we heartily thank the participants for the work they are doing.

To dig deeper into the barriers confronting integrated care, we contacted several of these local experts and asked if they would take the time to participate in short interviews related to their experiences. Many of their stories appear below, but as is so often the case when conducting these types of interviews, each person offered enough information to be worthy of separate toolkits derived from their respective projects.

Interviewees included:
- Nancy M. Callahan, PhD, IDEA Consulting
- Clayton Chau, MD, PhD, Orange County Health Care Agency
- Mike Geiss, Geiss Consulting
- Brenda Goldstein, Psychosocial Services Director, LifeLong Medical Care
- Michael Heggarty, Director, Nevada County Behavioral Health
- Kathy Montero, Deputy Director of Behavioral Health, Glenn County
- Elizabeth Morrison, LCSW, MAC, Golden Valley Health Centers
- Martha Paine, Director, General Fund Financial Services, Santa Clara County
- Louise Rogers, Deputy Chief, San Mateo County Health System

We thank each and every one for the time they took to speak about their work, but more importantly, for the work they do each day to serve the people of their communities.
Who, What, Where, When, and How Much

Paradoxically, gaining an understanding of how to get paid begins with an examination of funding barriers, which we’ve organized into the categories of Who, What, Where, When, and How Much.

We’ve learned that each of the ten barriers fit the formal definition of a barrier quite nicely “Something immaterial that obstructs or impedes.” In some cases a barrier can be overcome. For others, one of the following two approaches must be used:

- **Grants** – Grants appear to be the universal “go to” solution for virtually any barrier. If the policy environment prevents funding an activity using traditional channels, grant funding is often the easiest way forward. Of course, grants bring with them their own challenges, but they do bypass the challenges involved in bringing about policy changes.

- **Avoidance** – Some barriers just cannot be overcome without a change in law or regulation. As you will see below, the “same day billing” issue has what are effectively two solutions: Do the work and absorb the loss; or don’t do same day visits.

As you may guess, those barriers that simply must be avoided are often best suited to grant funding. In situations where grants are not a workable option, avoidance can provide the way forward. It sounds so simplistic, but it really is vital to identify if an insurmountable barrier is actually a critical barrier, or just something to be admired in the rearview mirror.
Exploring and Overcoming the Barriers

Barrier 1 (WHO, WHAT AND WHERE): Health Center Billing of Mental Health and Substance Use Services

The federal government has very clear rules about Health Centers billing mental health and substance use (MH/SU) services. Generally, a Health Center is only paid for the Services, Sites, and Providers listed in its “Scope of Project.” If mental health and substance use services, providers and places where those providers provide MH/SU services are in the Scope of Project, you have the green light.

If not, the Health Center should consider expanding the Services, Sites, and/or Providers covered by the Health Center. HRSA has issued two important Policy Information Notices, PIN 2008-01 and PIN 2009-02, to provide guidance on this topic; they can be found at the HRSA site: http://bphc.hrsa.gov/policiesregulations/policies/managefinance.html. Health Centers need to follow these guidelines, making sure to obtain prior approval from the Bureau of Primary Health Care.

As part of this process, the Health Center will often ask for a scope and rate change based on the hiring of new behavioral health positions. The Health Center has to be able to front the money for these positions as the scope and rate setting review process takes place. We’ve listed this as a barrier because changing the Scope of Project is a technical and somewhat complex process and approval in California can often take several months.

Barrier 1 Tips

Of the people we spoke with throughout California, no one who had attempted a change in their Scope of Project ran into a dead end. Interviewees also confirmed that the process is complex and lengthy. In fact, several of the organizations we spoke with had deliberately avoided moving in directions that would have clearly required a change of scope for that reason. Additionally, some organizations were hesitant to undertake a change of scope because they were hesitant to undergo the associated review of their rates.

Perhaps the most critical barrier presented by the Scope of Project is that many people who have spent their careers working in behavioral healthcare may have very little familiarity with the concept. Fortunately, this obstacle can be navigated with the help of several potential resources, including Health Center partners or consultants that have significant experience with the issue. Your local Health Center and the California Primary Care Association (CPCA) are two good sources of consulting referrals. CPCA can be reached at www.cpca.org and (916) 440-8170.

Overall, changing a Health Center’s Scope of Project should be viewed as an important strategy, only to be avoided on rare occasions.
Barrier 2 (WHO): Limitations on Who Can Bill for Services

HRSA Policy Information Notice (PIN) 2009-02 defines Health Center providers as “individual health care professionals (including physicians, physician assistants, nurse practitioners, and certified nurse midwives) who deliver services to health center patients on behalf of the health center. Providers assume primary responsibility for assessing the patient and documenting services in the patient’s record. Providers include only those individuals who exercise independent judgment as to the services rendered to the patient during an encounter/visit.”

HRSA regulations limit which behavioral health providers can bill for services to psychiatrists, psychologists, psychiatric nurse practitioners, and licensed clinical social workers “who develop, deliver or supervise comprehensive onsite behavioral health programs, including patient education classes on self-management skills for at risk populations and/or group care clinics provided collaboratively with members of primary care teams.”

Over the years, other types of behavioral health providers have been licensed to practice in most states (e.g., Marriage and Family Therapists [MFTs] and Licensed Professional Counselors [LPCs]). In addition, other states have worked with CMS to add certified peers to the “billable workforce.” While some states have decided that they will reimburse for the services of these other types of behavioral health providers, California has retained the original federal classifications.

The result of this inaction is that Health Centers are only able to bill for a portion of the behavioral health providers that provide services to Californians in the safety net.

Barrier 2 Tips

This barrier is very real for each of the organizations we spoke with. Grants and avoidance (or combinations thereof) were the most frequent options. Every single organization working on integrated care was using some form of grant funding to handle the limitations of who can bill for services. Many of the projects we discussed were using multiple grants to provide the mix of clinicians required to accomplish the work.

As Martha Paine, at Santa Clara Valley Health & Hospital System noted, even when most of a provider’s cost is grant funded, having them do billable work even one day per week can help. Similarly, funding the cost of a provider through multiple grants, even if they require the provider to deliver slightly different services, can be a benefit for clients (and satisfy the requirements of multiple grants).

In the Bay Area, Brenda Goldstein at LifeLong Medical Care has found that being deliberate in hiring is part of the solution. When Licensed Clinical Social Workers (LCSWs) can bill for providing behavioral healthcare
services within a Health Center, be sure that you are only hiring licensed providers for these roles.

If grant funding is available and you are faced with a shortage of LCSWs, Elizabeth Morrison at Golden Valley Health Centers suggests hiring CSWs who are working toward their license, funded through grant dollars, and shift their funding to billable services when they become licensed. This has the added benefit of helping address workforce shortage issues.

While the limitations on who can bill for services present numerous barriers, the ability for Health Centers to bill the services of licensed behavioral health providers is critical to the success of an integration project. Brenda Goldstein at LifeLong Medical Care has found that the relative dearth of psychiatrists at the Health Centers in her area means that being able to offer a psychiatrist is an appealing feature for clients.

Of course, if all else fails, a Health Center may be able to recalculate their Prospective Payment System rate to include unlicensed behavioral health providers and apply for a rate adjustment. One California Health Center attempted this strategy but was denied the inclusion of case managers and social workers in their rate and has been actively appealing this decision with the State of California.

**Question:** What is the Prospective Payment System?

**Answer:** Traditionally, Federally Qualified Health Centers (FQHCs) were reimbursed based on their costs. That changed in 2000, with passage of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA). The BIPA established a prospective payment system for FQHCs. This system, which has been in place since January 2001, replaced the previous cost-based reimbursement system for health centers under Medicaid.

The prospective payment system establishes a per visit payment rate for each FQHC in advance. The 2001 payment rate was based on the average of each FQHC's reasonable costs per visit in FY 1999 and FY 2000. Since FY 2002, payments made under this system have been adjusted annually for inflation using the Medicare Economic Index. Payments also are adjusted when a Health Center requests a rate change or a change in scope of practice.
Barrier 3 (WHAT): Psychiatric Consultation to Primary Care Provider or Care Manager

Psychiatric consultation provided to a primary care practitioner or behavioral health consultant, when the person has not been directly seen by the psychiatrist, is not a billable event in most parts of the United States. Yet, this method of consultation by phone or email is a cost-effective and proven strategy to improve mental health services in primary care, using the limited resources of psychiatry in a way that expands access to appropriate care.

Exceptions are the DIAMOND project – a widespread implementation of the IMPACT model in Minnesota and the Washington State Disability Lifeline integration project that is also based on IMPACT. In both projects, case rates are paid that cover the cost of psychiatric consultation to primary care providers and care managers.

Barrier 3 Tips

Perhaps the most succinct solution for this barrier was offered by Louise Rogers at San Mateo County. Louise pointed out that in California, Medi-Cal mental health rules in fact allow for these types of phone calls and pay by the minute. This solution, however, requires that the consult is coming from someone outside the Health Center. The lesson then is twofold – there is a solution, and the solution is to be careful how fully you have integrated your system. If the consult is coming from someone within the Health Center, it cannot be billed, whereas if it is coming from an outside specialist, even one based in primary care, it can be billed.

On the other hand, Elizabeth Morrison at Golden Valley Health Centers and Michael Heggarty, Director at Nevada County Health & Human Services Agency’s Behavioral Health Department have both chosen to simply absorb the costs of these types of consultations. Nevada County provides a psychiatrist a few hours each week to two of the area Health Centers, allowing the Health Centers to bill for the services, if possible, but otherwise not requiring anything of the Health Centers.

At Golden Valley, while the initial cost of hiring a psychiatrist seemed beyond the realm of possibility, now that the position has been integrated into the practice, it is a critical, though technically money losing, component. While not lucrative in its own right, the psychiatrist at Golden Valley spends approximately 20% of her time working with, and training primary care providers in matters related to behavioral health, with the result that she is viewed as a critical member of the team and there is no thought of doing without the service.

“ ’You do the right thing and the right thing happens’”
Elizabeth Morrison, Golden Valley Health Centers

2 For further information on the IMPACT model and these financing initiatives, please visit: http://impact-uw.org/.
Barrier 4 (WHAT): Lack of Codes for Non Face-to-Face Psychiatric Consultation, Care Management, and SBIRT

There are three sections in the CPT manual relevant to behavioral health services: the Evaluation and Management section (selected codes within the 99201-99340 range); the Psychiatry codes in the Medicine section (90801-90899); and the Health Behavioral Assessment codes in the Medicine section (96150-96155). The Integrated Behavioral Health Project in California has compiled an excellent description of how and when to bill these various codes. This can be found at the following website: [http://www.ibhp.org/index.php?section=pages&cid=141](http://www.ibhp.org/index.php?section=pages&cid=141).

With all that said, there are two problems with existing codes. First, there are no CPT codes for non-face-to-face psychiatric consultation or care management. Getting these created is a big deal, requiring a national initiative organized through the American Medical Association, which maintains the Current Procedural Terminology (CPT) code set through their CPT editorial board.

The second problem is that CPT codes exist but are not “turned on” by a number of payors. For example, there are a number of SBIRT codes (Screening, Brief Intervention and Referral-to-Treatment) including 99211, 99408 and 99409, but in California and most other states, the Medicaid agency has not activated them as billable codes.

A third separate, but related problem, is that Health Centers in California cannot bill for group services, a treatment modality considered to be highly effective for many behavioral health issues.

Barrier 4 Tips

While we identified grants and avoidance at the outset as the two near-universal ways of dealing with barriers, the mechanism Louise Rogers at San Mateo County has used to overcome Barrier 3 is also relevant here – use a behavioral health clinician working for the behavioral health center to provide and bill for services in the Health Center that are allowable charges in the mental health system.

Barrier 5 (WHAT): Barriers to Team-Based Care

Team approaches to providing integrated care has proven to be particularly effective, especially when proven models such as IMPACT are used. A related barrier to consultation and same day billing is that Health Centers receive no additional payment if multiple providers are involved in the delivery of services on the same day, including during the same encounter.
Barrier 5 Tips

As with so many of the other barriers we examined, the lack of additional Health Center payment for multiple providers involved in the delivery of services on the same day can effectively only be addressed through grant funding, incorporating the cost into the Health Center’s Prospective Payment System rates, or using behavioral health clinicians working for the behavioral health center to provide and bill for services in the Health Center.

It bears repeating, though, that some services are so critical to success, that even if they do not inherently cover their own costs, they are still decidedly worth doing. Brenda Goldstein at LifeLong Medical Care identified team-based care and the associated meetings and related activities as being something that was worth simply accepting the costs in recognition of the profound value added for the clients and for the providers’ abilities to effectively do their work. Brenda also noted that there is another barrier within the payment challenge related to team-based care - who are the members of the team? Do you include staff other than the providers? Even if the financing barrier were resolved, additional challenges lurk beneath the surface and will need to be addressed within each organization.

Clayton Chau, MD, PhD, the Associate Medical Director of Integrated Services and Recovery for the Orange County Health Care Agency is just beginning a project founded on team-based care. Through multiple grants and the committed involvement of his county’s managed care plan, Dr. Chau is aiming to deliver services far beyond simple colocation of MH/SU and primary care providers and instead is aiming at truly bidirectional team-based care.

Barrier 6 (WHAT): Mental Health Diagnosis as Primary in Primary Care

In a number of states, Medicaid disallows reimbursement when primary care practitioners submit bills listing only a mental health diagnosis and corresponding treatment.

Barrier 6 Tips

This was one of the barriers where we found a few of the most interesting responses during our interviews. As Louise Rogers at San Mateo County noted, this issue has the potential to disappear entirely in the presence of a county health plan that specifically allows these billings. In that situation, the county plan is billed first and the issue is effectively resolved. While it is well outside the purview of this toolkit to devise and structure county health plans, it is worth noting that such plans offer many potential opportunities.

Brenda Goldstein at LifeLong Medical Care has actually experienced this barrier somewhat differently, finding it difficult to get paid when a client lacks a mental health diagnosis yet is receiving treatment by a behavioral health provider. Brenda traced this issue to clients and providers being cautious about labeling someone with a mental health diagnosis for a whole
host of reasons, including the perception of employment consequences, stigma, and other long term concerns.

**Barrier 7 (WHERE): Inability to Bill for Telephone, Telemedicine, and Email-Based Services**

Other states have created mechanisms for ensuring that providers are paid for some or all of these non-face-to-face services. In California, these services are currently unbillable for integration-related care provided in primary care, mental health, and drug and alcohol.

**Barrier 7 Tips**

Yet again, this barrier appears impervious to all but grant funding and adjustments to the PPS rates. Driving home the importance of these types of care, Mike Geiss, a consultant working with several California counties, identified the critical role electronic access could have in rural areas where providers can be woefully scarce. On the other hand, Brenda Goldstein at LifeLong Medical Care noted it was actually less of an issue in urban areas, as direct access to care can be less burdensome there.

**Barrier 8 (WHERE): Care Provided Outside the Four Walls**

In a number of states it is very difficult to obtain Health Center reimbursement for health and behavioral health services in school-based health centers and other settings outside the four walls of a clinic.

**Barrier 8 Tips**

The more we discussed the issue of school-based mental health care, the clearer it became that the real issue was the challenge of providing any type of field-based services. Generally, providers delivering services within a Health Center located at a school are covered by the Scope of Project, and thus their services are paid for in the same way any service would be. What appears to be far more challenging, is delivering services beyond the “four walls” of a Health Center.

This issue is complicated further by the blend of myth and reality that makes up providers’ perceptions of field-based care. While it can be complicated to navigate how to deliver these types of services, it clearly is possible. At Ravenswood Family Health Center, in San Mateo County, a mobile van is certified as a Health Center. Although the van is not providing behavioral healthcare services, it serves as a shining example of the sort of innovations that are possible, even within the current environment.

The final tip is a repeat from other sections – if the behavioral health clinicians are working for the behavioral health center, it is likely that they will be able to bill for community-based services.
Barrier 9 (WHEN): Same Day Billing Restriction

It was widely believed the “same-day billing restriction” was a federal regulation. It has recently been clarified this is not federal policy. Current California law specifically restricts Health Centers from billing Medi-Cal for both a primary care encounter and a mental health encounter on the same day, although it allows for billing both a primary care encounter and a dental encounter on the same day. The result is to undermine the model of an embedded behavioral health consultant on a primary care team taking a “warm hand-off” from the primary care provider - a technique demonstrated to improve engagement with the behavioral health consultant and primary care-based MH/SU services.

Barrier 9 Tips

Of all the issues we discussed, this one is certainly the most well-known. No one that we spoke with had devised a magical solution that would somehow allow a Health Center to bill Medi-Cal for both a primary care encounter and a mental health encounter on the same day. As with all of these other barriers though, your colleagues are finding ways to work in, on, over, and around this barrier.

Once again, using a behavioral health clinician working for the behavioral health center to provide and bill for services in the Health Center can overcome this barrier. This approach has been used for years by behavioral health organizations in California.

Another approach is to secure grant funding, a strategy being used by many Health Centers providing same day visits. But there is another option, identified by Brenda Goldstein at LifeLong Medical Care – don’t provide same day encounters. While this flies in the face of so much current literature on the need for warm hand-offs, closer integration of behavioral health and primary care, and team-based services, LifeLong avoids same day encounters in part because they are questioning whether warm hand-offs actually result in better rates of follow-up visits. LifeLong hasn’t determined what the real impact of warm hand-offs is for them, but they have determined that in the current environment, they can best meet their clients’ needs by minimizing same day visits.

LifeLong does some warm hand offs (introducing the behavioral health service, and having the client meet the clinician), but they do not do full blown encounters (of twenty minutes or longer) on the same day. They are able to offer some same day services without stretching their resources through the use of psychology and MSW students. For clinics in areas with behavioral health degree programs this is a valuable resource, a workforce development tool, and a way to provide more non-billable services. LifeLong also uses their health educators and other case management staff to help with initial assessments and interventions - considering them to be part of the behavioral health team - and when well trained, these staff...
members can also fill in doing some of the functions that are not billable.

In contrast with LifeLong’s approach, Golden Valley Health Centers has
determined that the cost of same day visits is worth it, even if they aren’t
being paid. Their rationale is simple: about 60% of their clients using
integrated behavioral health services are covered by Medi-Cal (the rest
uninsured) and about 60% of those clients are seen in non-same day visits.
By seeing approximately four billable clients each day, Golden Valley’s
LCSWs have essentially covered their salaries. That said, as the playing
field has shifted and cost allocations have become more sophisticated, the
margin has tightened. Now 5 to 6 billable encounters are necessary each day
for the LCSWs to break even. Even so, Golden Valley makes no effort to
limit same day visits.

**Barrier 10 (HOW MUCH): Poor Reimbursement for HBA Codes**

In California, non-physicians such as advance practice nurses, psychologists,
social workers, and other healthcare providers have been able to use the six
Health and Behavioral Assessment (HBA) codes for services that include
assessment (96150); reassessment (96151); and prevention, treatment or
management of a problem or symptom including individual (96152), group
(96153), family and patient (96154), and family without patient present
(96155). These codes are intended to be used with a medical diagnosis to
cover services provided by a behavioral health clinician related to
management of the medical problem. Unfortunately they have much lower
relative value units (RVUs) than their Evaluation and Management
counterparts. For example, HBA 99150 has an RVU of 0.50 and a nurse
clinician fee of $51.46 for 30 minutes; 99203 Office visit new patient, 30
minutes, has an RVU of 1.34 and a fee of $91.62.

**Barrier 10 Tips**

While not all of the providers we interviewed were intimately familiar with
the delightfully arcane world of billing codes, this barrier really does
encapsulate many of the challenges confronting integrated care. As Louise
Rogers at San Mateo County Behavioral Health and Recovery Services
noted, this is a very important issue that does not get the attention it
deserves, particularly related to different types of services and how they are
valued. We will discuss this issue further in Section VII. How You Will Get
Paid Tomorrow.
Leveraging Who Works Where to Get Paid

You have most likely noticed that strategic employment of behavioral health clinicians – in the Health Center or in the behavioral health center – can make the difference in whether you get paid or not. Although the conventional wisdom is to try and bill through the Health Center to access the PPS rate, there are many instances in which behavioral health clinicians working for the behavioral health center stationed at the Health Center is the best solution.

The moral of this story? Working together using the partnership model of bidirectional care is almost always the best way to succeed at managing complex cases and getting paid in the current environment.

Interested in More Information on Barriers?

We are aware of four other resources that offer additional information on barriers to integrated care and may be of interest to readers.


Mauch, D, Kautz, C., Smith, S. Reimbursement of Mental Health Services in Primary Care Settings. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. February 2008.


The University of Washington, Department of Psychiatry & Behavioral Sciences IMPACT website sections:
http://impact-uw.org/implementation/billing.html
http://impact-uw.org/tools/
Final Thought – Don’t let your project get derailed by the need for a sink!

It really is critical to think through all of the ways integration will change how you deliver services. By planning ahead, Kathy Montero at the Glenn County Mental Health Department determined that her project (bringing a Physician’s Assistant into the mental health facility one day per week) meant that the PA would need a sink. In the normal course of traditional mental health visits, obviously no sink is required in the room. But when primary care is brought into the mix, many things never on the radar of mental health providers need to be thought through; and vice versa for the challenges Health Centers face.

“Physical set up of services is also a critical issue and one which significantly impacts success of integration and may require some resource investment or change in the clinic set up.”

-Brenda Goldstein, LifeLong Medical Care
VI. Opening the Toolkit
How to Get Paid Today for Integrated Care

Now that we’ve run you through the maze of funding silos and funding barriers, you are prepared for the good stuff - how to get paid for integrated care.

Creating Your Eight - Step Workplan

The workplan includes the following activities.
1. Engage Top Leadership and Identify a Project Champion
2. Organize a Planning Workgroup and Prepare a High Level Project Timeline
3. Design the Clinical Model
4. Identify and Address your Funding Barriers
5. Design a Detailed Implementation Plan
6. Prepare a Detailed Integration Budget
7. Revise your Infrastructure and Obtain Necessary Approvals
8. Go Live; Monitor and Adjust As Needed

Review each step and then complete a second read of this section to determine what you have already put in place and which additional tasks must be completed.
Step 1: Engage Top Leadership and Identify a Project Champion

As mentioned in Section I, there are many obstacles to getting paid for integrating primary care, mental health, and substance use treatment - and yet most communities that have attempted this innovation have succeeded. How is this possible?

All successful integration efforts have two things in common:

1) The senior leadership of the primary care system and the behavioral health system have made a strong commitment to ensuring the success of the project - whatever it takes - and followed through.

2) Each project has had a dedicated champion with a combination of optimism, tenacity, attention to detail, and belief that the project can make a difference in the lives of those being served.

We define leadership engagement to include three attributes:

- **Awareness** of the importance of integration to the health of the population being served.

- **Understanding** the need to bridge different cultures - moving beyond co-location to build personal relationships between primary care, mental health, and substance use treatment providers, all of whom agree to work with new, science-based clinical models that involve a more holistic approach to treating the person.

- **Commitment** to overcoming the obstacles that exist in the current environment - funding challenges, cultural differences, technology, and more - and the determination to stay engaged with the project, helping remove roadblocks until it is fully up and running.
Step 2: Organize a Planning Workgroup and Prepare a High Level Project Timeline

Top leadership and a single champion are important, but not enough to achieve a successful integration project. Healthcare is quickly moving from an individual sport to a team sport. Thus, the importance of a multidisciplinary workgroup involving local primary care, mental health, and substance use integration partners, whose job is to develop, implement, and monitor the eight step workplan.

The first task of this group should be to add detail to the eight step workplan listed in this toolkit, including development of a realistic timeline (Step 5) and budget (Step 6). Much of the cost of implementing the integration plan will be sweat equity from the partners, but there are out-of-pocket costs that must be funded, including hiring a dedicated Integration Coordinator (some consider this a necessity), technical assistance costs, information technology changes, etc.

Note that you can wait until Step 5 to design your detailed implementation plan and timeline; this initial Project Timeline should be at a higher level, identifying the major tasks and estimating the time each will take. The example below shows a high level sample plan that will prevent you from getting bogged down in the details early on.

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<thead>
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<th>Task Name</th>
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<td>Thu 4/19/12</td>
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<td>2 Project Management &amp; Admin Time</td>
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<td>3 Requirements Definition</td>
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<td>5 Kick Off Meeting - All Partners</td>
<td>Mon 8/29/11</td>
<td>Wed 8/31/11</td>
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<td>8 Clinical Design</td>
<td>Wed 8/31/11</td>
<td>Wed 10/5/11</td>
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<td>15 Evaluate Funding Barriers</td>
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<td>19 Develop Budget</td>
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<td>40 Monitor and Adjust</td>
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Step 3: Design the Clinical Model

System redesign should begin with the design of the clinical services that meet the needs of the populations being served, followed by the design of the business model - not the other way around.

For example, a number of integration efforts across the country have worked with the University of Washington AIMS Center to implement the IMPACT collaborative care model. The following diagram illustrates a Washington State public sector version of this approach that utilizes a primary care-based care team consisting of the primary care provider, a behavioral health care coordinator, a consulting psychiatrist and other clinic-based behavioral health providers. These teams have a partnership with specialty behavioral health provider organizations that are able to treat complex cases not able to be managed in primary care. Both groups use evidence-based clinical treatments, clinical tools for systematic outcome tracking, patient registries, stepped care, and treat-to-target approaches. Further information can be found at http://uwaims.org/ and http://uwaims.org/integrationroadmap/principles.html.

**Person Centered Healthcare Home Clinical Design based on IMPACT Model**
- Systematic outcomes tracking (e.g. PHQ-9 for depression, GAD-7 for anxiety)
- Treatment adjustment as needed including stepped care (e.g. up to specialty BH)
  (based on clinical outcomes, evidence-based algorithm; in consultation with team psychiatrist)
- Relapse prevention
Clinical Design Resources

There is a great deal of additional information available on how to design integrated clinical services, including webinars and material from the following organizations, many of which are free.

California Institute for Mental Health (CiMH): http://www.cimh.org

California Primary Care Association (CPCA): http://www.cpca.org

California Integrated Behavioral Health Project (IBHP): http://ibhp.org/

California Mental Health Care Management Program (CalMEND): http://www.calmend.org

SAMHSA-HRSA Center for Integrated Health Solutions: http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions
National Association of Community Health Centers: http://nachc.org

Patient Centered Primary Care Collaborative: http://www.pcpcc.net


Milbank Memorial Fund: http://milbank.org/

Hogg Foundation for Mental Health: http://www.hogg.utexas.edu/

AIMS Center: http://uwaims.org/

Advancing Integrated Mental Health Solutions
Step 4: Identify and Address Your Funding Barriers

Because “All healthcare is local,” a Primary Care, Mental Health, Substance Use ecosystem has evolved in each community in California that has assembled the PC/MH/SU pieces differently, working within the state and federal funding frameworks.

Some things currently can’t be funded by PC, some can’t be funded by MH, and some can’t be funded by SU. A number of these barriers are the result of federal or state law/regulation that would need to be changed before they stop being a barrier. This creates a Serenity Prayer moment:

“Grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference.”

It also pushes a number of issues over into the “how do I get paid tomorrow?” category.

The objective of Step 4 is to draw on the experience of other colleagues in California articulated in Section V, and to develop a set of strategies for either overcoming specific barriers or acknowledging that a barrier is unmovable in your community. This work will likely require its own mini-workplan.

Case in Point: The Walls of Dubrovnik, Croatia were considered to be amongst the great fortification systems of the Middle Ages, as they were never breached by a hostile army. If you are facing similar financing barriers, find a new castle to storm and move on to other ways to finance your integration project.

Stress Testing Your Barrier Busting Plan: One way to determine whether you have removed a sufficient number of barriers so that you don’t go broke is to complete a stress test of your clinical and financial models.
This can be done by sketching out the most frequent clinical workflows in your integration project and noting how each step in the flow will be funded – or not. The following diagram illustrates this process.

Who is Receiving the Service?

Who is Providing the Service?

What is the Service?

Where is the Service being Provided?

Does the patient have Medi-Cal, Medicare, and/or Private Insurance? If NO, an alternative funding source is needed (and you can ignore the other questions).

Does the funding stream in your clinical design (PC, MH, SU) allows this provider type to bill for care? If NO, change the design or find an alternative funding source.

Does the funding stream in your clinical design (PC, MH, SU) pays for this type of service? If NO, change the design or find an alternative funding source.

Does the funding stream in your clinical design (PC, MH, SU) pay for this location? If NO, change the design or find an alternative funding source.
Step 5: Design a Detailed Implementation Plan

Completing steps 2 through 4 provides enough information to allow you to craft a detailed implementation plan that identifies all tasks needed to bring your integration design online. Many successful projects organize their implementation into multiple phases, as opposed to a “big bang” approach that attempts to bring the entire integration plan online at once.

There are two major approaches to phasing the integration effort. Under the first approach, attention is placed on embedding robust behavioral health capacity in a single medical clinic or primary care capacity in a behavioral health clinic. Using behavioral health in primary care as an example, multiple primary care providers in a clinic implement the new clinical model with their behavioral health team members, working together to refine the process. Once the bugs are worked out, adjustments are made to the implementation model and a second clinic project is begun.

A second approach is to pilot small integration efforts in multiple clinics. This might involve embedding a primary care clinician one day per week in three or four behavioral health clinics to serve the consumers in those clinics. All healthcare is local and the champions of the integration effort should determine which approach will be most effective in their particular environment.

The workplan should detail the rollout approach and the specific steps needed to bring the phases online. The plan should list specific tasks, when each task will occur, who is the lead for each task, which team members will implement the task, and what additional resources are needed. This includes identification of specific clinical tasks and workflows. An excellent example can be found at the following AIMS Center link: http://uwaims.org/integrationroadmap/principles.html.

The following Gantt Chart provides an illustration of a Microsoft Project-based integration implementation plan.
<table>
<thead>
<tr>
<th>Task Name</th>
<th>Duration</th>
<th>Start</th>
<th>Finish</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q1</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration Implementation Plan</td>
<td>209.53 days</td>
<td>Fri 7/1/11</td>
<td>Thu 4/19/12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Management &amp; Admin Time</td>
<td>15 days</td>
<td>Fri 7/1/11</td>
<td>Thu 7/21/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Requirement Definition</td>
<td>30 days</td>
<td>Mon 7/18/11</td>
<td>Fri 8/26/11</td>
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<tr>
<td>Information Gathering - All Partners</td>
<td>30 days</td>
<td>Mon 7/18/11</td>
<td>Fri 8/26/11</td>
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<td>Kick Off Meeting - All Partners</td>
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<td>Wed 8/31/11</td>
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<tr>
<td>Kick Off Meeting - All Partners</td>
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<td>Tue 8/30/11</td>
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<td>Wed 8/31/11</td>
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<tr>
<td>Compile Research on Models</td>
<td>5.15 days</td>
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<td>Wed 9/7/11</td>
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<tr>
<td>Study Existing Workflows</td>
<td>5.15 days</td>
<td>Wed 9/7/11</td>
<td>Thu 9/15/11</td>
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<td>Gather, Review, Define Potential Problem</td>
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<td>Wed 9/21/11</td>
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<td>Decide Clinical Model</td>
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<td>Wed 9/2/11</td>
<td>Thu 9/22/11</td>
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<tr>
<td>Develop &quot;to be&quot; workflows</td>
<td>5.17 days</td>
<td>Thu 9/22/11</td>
<td>Thu 9/29/11</td>
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<tr>
<td>Revise Job Descriptions</td>
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<td>Evaluate Funding Barriers</td>
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<td>Mon 10/17/11</td>
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<tr>
<td>Gather, Review, Define Barriers</td>
<td>2.02 days</td>
<td>Wed 10/5/11</td>
<td>Fri 10/7/11</td>
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<tr>
<td>Determine which Barriers Cannot be Moved</td>
<td>2 days</td>
<td>Fri 10/7/11</td>
<td>Tue 10/11/11</td>
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<tr>
<td>Develop &quot;Barrier Busting&quot; Strategies</td>
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<td>Mon 10/17/11</td>
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<td>Tue 10/25/11</td>
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<tr>
<td>Develop Budget</td>
<td>6 days</td>
<td>Mon 10/17/11</td>
<td>Tue 10/25/11</td>
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<td>Wed 11/2/11</td>
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<td>Revise Patient Registry</td>
<td>24 days</td>
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<td>Thu 10/6/11</td>
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<td>Develop Interface between EMRs</td>
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<td>Thu 9/29/11</td>
<td>Mon 10/17/11</td>
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<td>Develop Quick Check Procedure Toolbox</td>
<td>3 days</td>
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<td>Thu 10/20/11</td>
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<td>2 days</td>
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<td>Mon 12/12/11</td>
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<tr>
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<td>3.03 days</td>
<td>Thu 10/27/11</td>
<td>Tue 11/1/11</td>
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<td>participating in the first round of</td>
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<tr>
<td>Run the pilot for two weeks, providing</td>
<td>10 days</td>
<td>Tue 11/1/11</td>
<td>Tue 11/15/11</td>
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<td>real-time support as needed</td>
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<tr>
<td>Compile the results of the plots and</td>
<td>3 days</td>
<td>Tue 11/15/11</td>
<td>Fri 11/18/11</td>
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<tr>
<td>hold a group debrief with the pilot</td>
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<tr>
<td>Revise the design as needed</td>
<td>3 days</td>
<td>Fri 11/18/11</td>
<td>Wed 11/23/11</td>
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<tr>
<td>Run round 2 of the plot</td>
<td>10 days</td>
<td>Wed 11/23/11</td>
<td>Wed 12/7/11</td>
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<tr>
<td>Debrief and finalize design</td>
<td>3 days</td>
<td>Wed 12/7/11</td>
<td>Mon 12/11/11</td>
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<td>Pilot Site 2</td>
<td>18.01 days</td>
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<td>Thu 1/5/12</td>
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<tr>
<td>Train the clinicians that will be</td>
<td>3.46 days</td>
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<td>Thu 12/15/11</td>
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<td>pilots</td>
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<tr>
<td>Run the pilot for two weeks, providing</td>
<td>11.55 days</td>
<td>Thu 12/15/11</td>
<td>Mon 1/2/12</td>
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<tr>
<td>Make needed Corrections</td>
<td>3 days</td>
<td>Mon 1/2/12</td>
<td>Thu 1/5/12</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Project Evaluation</td>
<td>30 days</td>
<td>Thu 1/6/12</td>
<td>Thu 2/16/12</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Monitor and Adjust</td>
<td>45 days</td>
<td>Thu 2/16/12</td>
<td>Thu 4/19/12</td>
<td></td>
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</tbody>
</table>
Step 6: Prepare a Detailed Integration Budget

Programs across California have been very creative in developing integration budgets that braid and blend funding from Mental Health Medi-Cal, Drug Medi-Cal, the Health Center Prospective Payment System, MHSA funds, Medi-Cal and indigent health dollars, federal and private grants, and other sources. Until new payment models are rolled out, this type of creativity is essential to supporting integrated care.

The objective of this step is to develop a budget for the clinical model, sorting what will be funded by primary care, mental health, and substance use. The following tasks should be part of the budget development process:

<table>
<thead>
<tr>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Project how many people will be served in the integrated care program</td>
</tr>
<tr>
<td>2. Estimate services volumes based on the estimated level of need of the population who will be served (visits per person, per year)</td>
</tr>
<tr>
<td>3. Identify staffing levels, by position and location, needed to serve the population</td>
</tr>
<tr>
<td>4. Calculate the fully-loaded staffing costs</td>
</tr>
<tr>
<td>5. Estimate the startup costs, ongoing technical assistance expenses, and other items outside the normal budget</td>
</tr>
<tr>
<td>6. Map service volumes to payor source (e.g. Health Center PPS encounters, SD-MC visits, Drug Medi-Cal visits) and project the per-visit revenue</td>
</tr>
<tr>
<td>7. Compare revenues and expenses before additional funding; determine the level of grant support and MHSA funding to fill the gaps</td>
</tr>
<tr>
<td>8. If the project isn’t affordable, make any needed clinical design changes to balance the budget</td>
</tr>
</tbody>
</table>

The following diagram provides a high level illustration of this approach for a two-component project that has embedded behavioral health clinicians in a primary care clinic and primary care providers in a mental health center.
The authors of this toolkit have developed an Excel-based budgeting tool for the 2011 1115 Waiver Coverage Expansion initiative that can also be used to support an integration budgeting process. Contact CiMH to obtain a copy of this tool (916-556-3480 or [www.cimh.org](http://www.cimh.org)).
Step 7: Revise your Infrastructure and Obtain Necessary Approvals

Supporting the clinical design and getting paid for this work will likely require addressing numerous details and related approval processes. Issues to tackle include:

- Does the Health Center require a change in Scope of Project due to changes in services, providers and places where those providers provide services?
- Who will own the charts and how will documentation be shared?
- Will a shared patient registry be implemented that tracks key demographic, utilization, and clinical information?
- What shared outcome tools and measures will be used?
- Will there need to be changes in forms and data collection elements?
- Are we currently capturing the appropriate data in the primary care clinic and behavioral health center to properly bill and be paid for services?
- What are the implications for the electronic health record systems in use and health information exchange interfaces?
- Will existing productivity standards work in the new model? Are workflow changes needed to support the new model of care and ensure financial viability?

Many of the issues embedded in the questions above relate to a single, simple sounding objective: That all clients/patients have one problem list, one medication list, and one care plan that is shared by all providers including behavioral health providers.

This objective, in most cases, requires a significant change in business processes and workflows. Business process redesign will often be necessary, along with the revision of business workflows, data capture forms, and staff and supervisory responsibilities. This is the devil in the details step that will bite you if neglected or under-resourced.

This step also involves receiving necessary approvals for any changes in the Health Center’s Scope of Practice, MHSA Plan, budgets or hiring approvals from the Board of Supervisors, etc.
Step 8: Go Live; Monitor and Adjust, As Needed

“Going live” with an integration project can range from embedding a single behavioral health clinician in a primary care clinic with psychiatric backup to opening a new clinic built from the ground up, with a full array of primary care and behavioral health services.

One common denominator is that the go live process is one step in a long journey to bring holistic care to the population being served. In all cases, there is a need to monitor progress and be on the lookout for unintended consequences or other issues that require modification.

Most healthcare organizations follow the Plan, Do, Study, Act (PDSA) quality improvement approach as a way to structure this continuous change process. This has evolved in recent years into the Rapid Cycle Improvement method of quality improvement, as illustrated by the following diagram.

Related to the implementation approaches discussed in Step 5, a change process (the integration of primary care and behavioral health) is designed (Plan), tested on a small scale (Do), data is collected and evaluated (Study), identified course corrections are made (Act), and the change process is expanded.

This method is relevant to Step 8 because of the importance of ongoing monitoring and adjustment of the design as integration is expanded to new sites and settings.
VII. How You Will Get Paid Tomorrow
New Healthcare Reform Payment Models

How to Fix the Healthcare System

The U.S. healthcare system has lower quality and higher costs when compared with other industrialized nations. The following two graphs illustrate this double-problem: We have both the highest rate of preventable deaths and the highest per capita health costs.

**Preventable Deaths* per 100,000 Population**
in 2002-2003 (19 Industrialized Nations, Commonwealth Fund)
* by conditions such as diabetes, epilepsy, stroke, influenza, ulcers, pneumonia, infant mortality and appendicitis

**Per Capita Health Expenditures, 2007 (US $)**
18 Industrialized Nations, OECD Health Data, 2010
Note: US Spending is 52% above Norway and 88% above Canada
The “fix” is very much related to Bob Woodward’s quote of Deep Throat during the Watergate era: “Follow the money.” This is because **most of the money in the U.S. healthcare system begins flowing after you get sick, primarily to inpatient and institutional services such as hospitals and nursing homes.** The diagram below illustrates the current resource allocation next to a picture of how we need to change the allocation of healthcare resources in this country.

**Prevention activities** must be funded and widely deployed, **primary care budgets** in the United States must be doubled, and **mental health and substance use disorder assessment & treatment** for all must become the standard of care in order to decrease demand in the specialty and acute care system. This is also known as “flipping the resource allocation triangle.”

**New Payment Models**

New payment models are one of the key strategies for flipping the triangle and achieving the triple aim of better health for the population, better care for individuals, and reduced costs. This change in healthcare financing is very relevant for individuals and organizations working on integrated care.

**Primary Care/Medical Home/Health Home Payment Models:** A number of pilots across the country are working with a new three-layer payment model to address the underfunding of primary care.

Currently, most primary care clinics in the United States are paid fee for service based on the submission of claim forms that contain CPT and HCPCS codes. The reimbursement rates are quite low, even for commercial health plans and many primary care practices must become part of larger group practices containing specialists in order to survive, with the
specialists, in many cases, subsidizing their primary care colleagues. Health Centers are paid a flat rate per encounter that comes closer to covering true costs, but often does not support the full costs of a robust care team that is needed to meet the full range of services and supports provided by a primary care clinic that has achieved NCQA Patient Centered Medical Home certification.\(^3\)

This structural underfunding of primary care has created a generation of young doctors who have chosen higher paying specialties over primary care. The following diagram illustrates “Phase 1” of changing this trajectory.

Under this new model, primary care providers - physicians, nurse practitioners, and physician assistants – continue to be paid fee for service for visits, but at higher rates in order to support more competitive salaries.

A second layer consists of a per-patient, per-month case rate for all patients assigned to the primary care practice. This funding supports hiring a care team made up of nurse care managers, health coaches, social workers, and other staff necessary to creating a robust health home. Funding is based on the acuity levels of the patients in each practice, with greater funding for patient panels that have higher acuity.

The goal of this new funding is to achieve better health for the patients in the practice, better care for individual patients, and reduced total healthcare expenditures for those patients. Currently, physicians and healthcare organizations delivering this type of care have seen healthcare costs 20% lower than the U.S. average. We could save $640 billion per year if the entire healthcare system operated in this manner.\(^19\)

This brings us to the bonus layer. If a primary care practice participating in this model is able to achieve these types of savings, they will be able to participate in a shared savings pool, receiving a bonus check that could be as much as 20% to 30% of their annual budget.\(^20\)

In most cases, clinics must be certified by NCQA as Patient Centered

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Medical Homes in order to be eligible for this funding model.

**Phase 2 Health Home Funding Models:** A number of health economists and health policy experts believe that we need to move entirely away from fee for service to achieve the triple aim. Under what some are considering the Phase 2 health home funding model, primary care clinics would no longer bill for encounters. Instead the case rate and fee for service layers are combined into a single, risk-adjusted payment to cover the costs of the practice and the bonus layer remains in place.

Currently, a new medical home approach known as Direct Primary Care already uses this payment model, with or without the bonus layer. For example, Qliance enrolls members in Washington State who pay a fixed monthly fee to be served by a dedicated primary care physician with a panel of 850 patients. The primary care physician provides 85-90% of the services needed by those patients. Qliance is in the process of discussing this model with the Washington State Health Care Authority, the entity that manages the state-funded populations including Medicaid enrollees.

**Infrastructure Requirement to Succeed in the New Healthcare Payment Ecosystem**

To succeed under these new payment models, organizations working on integrated care should set their sights on the following objectives.

- Primary Care Clinics should work to obtain NCQA Certification as a Patient Centered Medical Home
- Behavioral Health Providers should prepare to obtain NCQA Certification as a Health Home Neighbor, if or when that certification process is available (see below)
- Both types of organizations should develop the necessary infrastructure to be able to manage under case rate and bonus arrangements.

**NCQA PCMH Certification:** NCQA has developed a comprehensive Patient-Centered Medical Home Recognition Manual that provides a wealth of information needed to obtain certification. This is available at [http://www.pcmdny.org/index.cfm?organization_id=128&section_id=2047&page_id=8777](http://www.pcmdny.org/index.cfm?organization_id=128&section_id=2047&page_id=8777).

The manual includes a self-assessment that covers the six certification areas:

- PCMH 1: Enhance Access & Continuity
- PCMH 2: Identify & Manage Patient Populations
- PCMH 3: Plan & Manage Care
- PCMH 4: Provide Self-Care Support & Community Resources
- PCMH 5: Track & Coordinate Care
- PCMH 6: Measure & Improve Performance

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**Health Neighbor Designation:** In 2010 the American College of Physicians released an important paper, “The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices.” This paper articulates the characteristics special practices must possess in order to be “good neighbors” to medical homes/health homes. This includes the following competencies:

- Communication, coordination, and integration
- Timely consultations and referrals
- Timely, effective exchange of clinical data
- Effective participation in co-management situations
- Patient-centered care, enhanced care access, and high levels of care quality and safety
- Supporting the health home practice’s work

They have also called for NCQA to create a certification process for Health Neighbors. The paper can be obtained at the following website: [http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf).

**Case Rate and Bonus Infrastructure Development:** Organizations that wish to participate in the new payment models will need to possess information technology that allows the organization to manage case rate and bonus models. In addition to Patient Registries and Electronic Health Records that support clinical practice and outcomes measure, the organization must have a four-component practice management system, which is illustrated in the following diagram.
The Financial Accounting System collects direct service and overhead department revenues and expenses. The Patient Accounting System compiles service and diagnosis data. The Cost Allocation System collects data from both systems and assigns a cost to every recorded service. The Information Reporting System allows staff to examine cost and outcome data in numerous ways including:

- Costs and outcomes for individual patients
- Costs and outcomes by provider
- Costs and outcomes by health condition
- Costs and outcomes by clinic or specialty
- Costs and outcomes by demographic group

Plus a combination of any of the above criteria.
VIII: Final Thoughts

Every organization embarking on the journey to integrating primary care, mental health, and substance use treatment should know that you are not only preparing for the future, you are the future!

It’s also important to remember the current obstacles to being paid for integrated services are significant, but in spite of these obstacles, most of the projects in California have succeeded!

Knowing the barriers in advance, and building an eight-step integration implementation plan can ease (but not eliminate) the pain that exists in the current financing ecosystem.

Organizations also must prepare for a new healthcare ecosystem where payors have moved away from paying for volume to paying for value. Beginning your integration efforts now is one of the best strategies for preparing for a future where the head is reconnected to the body and holistic care is the standard.

Good luck, have fun, and remember that succeeding at integrated care is happening every day in communities throughout the country, made possible by people just like you.
End Notes

1 The Business Case for Bidirectional Integrated Care Mental Health and Substance Use Services in Primary Care Settings and Primary Care Services in Specialty Mental Health and Substance Use Settings, California Institute for Mental Health, June 2009.


3 The Health Services Resource Administration Data Warehouse: http://datawarehouse.hrsa.gov. The map and site count was prepared July 5, 2011.

4 Information compiled from the Maine Rural Health Research Center, Edmund S. Muskie School of Public Service University of Southern Maine. http://muskie.usm.maine.edu/ihp/ruralhealth/.

5 Ibid.

6 Community Health Center history based on a February 2011 interview with David A. V. Reynolds, Senator Bernie Sanders’ Senior Policy Advisor for Health.

7 Mental health funding level source: Richard G. Frank and Sherry A. Glied. Better But Not Well: Mental Health Policy in the United States since 1950.

8 2008 data compiled from the California Department of Health Care Services (DHCS), the California Department of Mental Health (DMH), and the California Department of Alcohol and Drug Programs (ADP).

9 Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. Kaiser Commission on Medicaid and the Uninsured. May 2010.


13 Sources: DHCS Research and Analytical Studies Section March 2009 Medi-Cal Beneficiaries Report (total enrollees by aid code); correlated with DHCS 1115 Waiver planning data on the estimated number of enrollees in managed care: 24% of the SPD population and 65% of the remaining enrollees.

14 http://www.thefreedictionary.com/barrier

15 http://bphc.hrsa.gov/policiesregulations/policies/pin200902general.html


18 Mauch, D, Kautz, C., Smith, S. Reimbursement of Mental Health Services in Primary Care Settings. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. February 2008.


21 Source: Qliance website: http://www.qliance.com/ and interviews with Norm Wu, President and CEO.
CiMH works to promote wellness and positive mental health and substance use disorder outcomes through improvements in California’s health systems.