

# *Behavioral Health/Primary Care Integration*

## ***Environmental Assessment Tool State Level Policy and Financing***

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**National Council for  
Community Behavioral Healthcare**

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This assessment tool has been prepared under the auspices of the National Council for Community Behavioral Healthcare. It is a work in progress, reflecting the participation of NCCBH staff, NCCBH consultants and external reviewers. Comments are welcomed and should be directed to the NCCBH offices at Suite 320, 12300 Twinbrook Parkway, Rockville, MD 20852 or [www.nccbh.org](http://www.nccbh.org).

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# NCCBH Resources

## Behavioral Health/Primary Care Integration

### Environmental Assessment Tool

### State Level Policy and Financing

#### Introduction

This Assessment Tool is intended to assist state level agencies and provider associations in a review of their state level policy and financing environment and the extent to which it supports effective collaboration among behavioral health and primary care providers, especially regarding the Medicaid and “safety net” populations.

Integration has been defined in many ways. There can be **financial, structural** and/or **clinical practice integration**. Integration that is financial (benefit packages, “carve-ins”, shared risk pools or other incentives) or structural (services delivered under the umbrella of the same organization, BH specialty services co-located with primary care services) does not necessarily assure clinical integration. However, clinical integration is difficult to achieve without financing mechanisms and structures or infrastructure that support the collaborative effort. **Clinical integration—what is experienced by the consumer in relationship to the providers—is the goal.**

There has been considerable discussion about whether BH should be “carved-in” or “carved-out” when states or other purchasers make purchasing decisions. This tool assumes that each of these methods is neutral in impact on clinical integration—what is important is how services are financed and managed by the plan—the “devil is in the details” holds true. There are carve-out models that have supported clinical integration efforts, and carve-in models that have had the effect of reducing overall levels of BH spending and services. This state level assessment tool tries to dig deeper into state policy and financing issues in order to put together a picture of the multiple forces that affect successful clinical integration.

Clinical integration of behavioral health and primary care services starts with a description of the populations to be served. Our Four Quadrant Model builds on the 1998 consensus document for mental health (MH) and substance abuse/addiction (SA) service integration, as initially conceived by state mental health and substance abuse directors (NASHMHPD/NASADAD) and further articulated by Ken Minkoff and his colleagues. Their model for a Comprehensive, Continuous, Integrated System of Care (CCISC) describes differing levels of MH and SA integration and clinician competencies based on the four-quadrant model, divided into severity for each disorder:

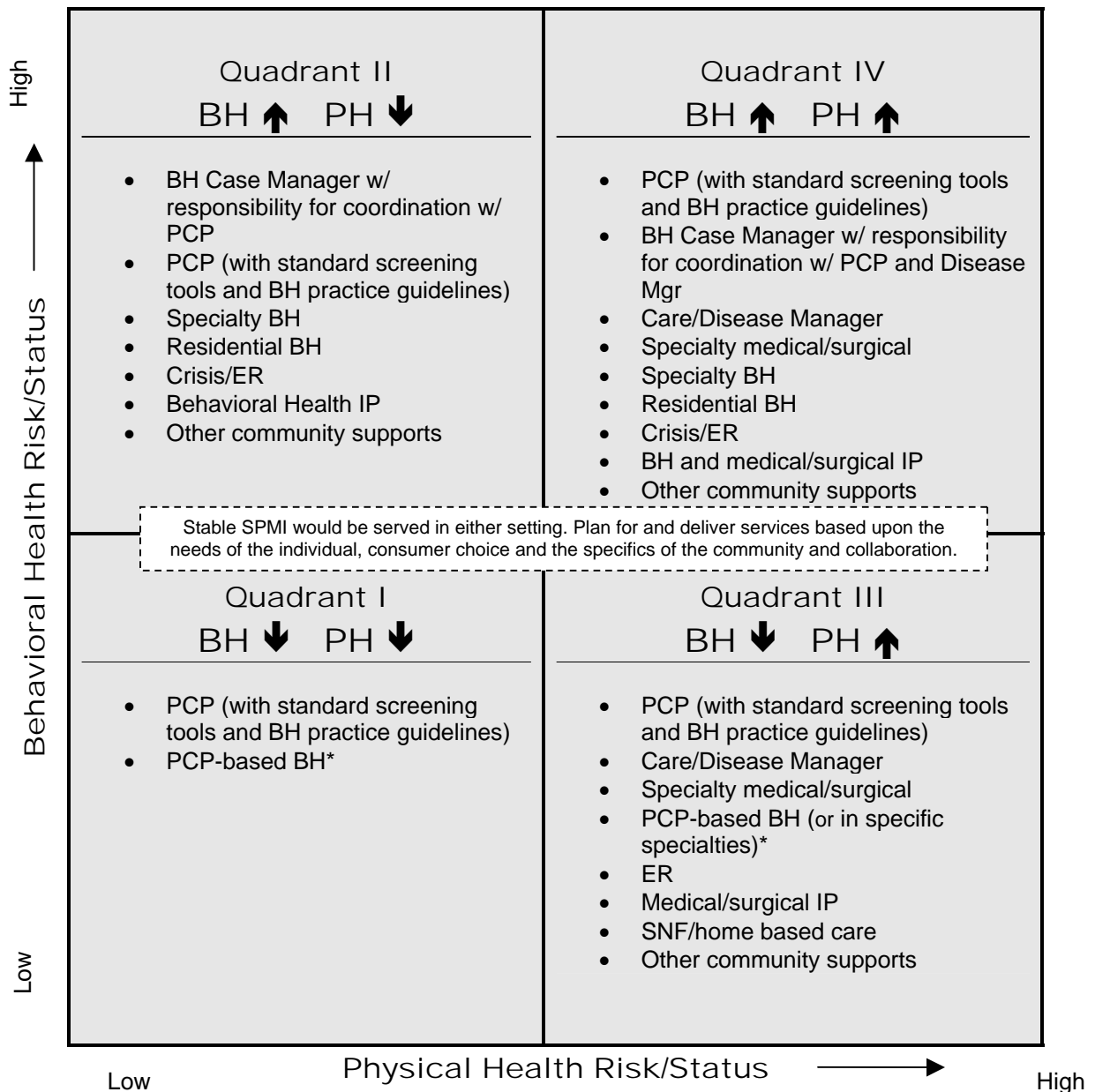
- **Quadrant I:** Low MH-low SA, served in primary care
- **Quadrant II:** High MH-low SA, served in the MH system by staff who have SA competency
- **Quadrant III:** Low MH-high SA, served in the SA system by staff who have MH competency
- **Quadrant IV:** High MH-high SA, served by a fully integrated MH/SA program

Our Behavioral Health/Primary Care integration model assumes this competency-based MH/SA integration concept, as described above, and builds on the MH/SA integration model to describe the populations that Behavioral Health/Primary Care integration must address:

- **Quadrant I:** Low BH-low physical health complexity/risk, served in primary care with BH staff on site; very low/low individuals served by the PCP, with the BH staff serving those with slightly elevated health or BH risk.
- **Quadrant II:** High BH-low physical health complexity/risk, served in a specialty BH system that coordinates with the PCP.

- **Quadrant III:** Low BH-high physical health complexity/risk, served in the primary care/medical specialty system with BH staff on site in primary or medical specialty care, coordinating with all medical care providers including disease managers.
- **Quadrant IV:** High BH-high physical health complexity/risk, served in both the specialty BH and primary care/medical specialty systems; in addition to the BH case manager, there may be a disease manager, in which case the two managers work at a high level of coordination with one another and other members of the team.

## The Four Quadrant Clinical Integration Model



\*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

For a more detailed discussion of the populations, services and financing related to the Four Quadrants, please refer to the NCCBH Behavioral Health/Primary Care Integration Background Paper, available on the NCCBH website: <http://www.nccbh.org>

## Using the Tool

The process for using this tool will be most effective if a work group is convened that includes members of the provider associations (BH, CHC) and leaders from key state agencies (Medicaid, MH, SA, Health/Primary Care, Welfare, Budget, Attorney General).

This state level assessment tool is organized around major payor/policy groupings. Each grouping has a series of major policy areas, with detail regarding choices for implementation. Within each policy area, it is the details that determine whether the environment supports, is neutral, or acts as a barrier to integration.

To score the tool, for each major policy area (the dark shaded rows):

- For each item place a check in the Yes or No box.
- Some items ask you to choose among 1, 2, and/or 3—depending on your state, you may choose 1, answer the items underneath it with Yes or No, then skip 2 and 3. In other states, more than one of the items may be appropriate, so answer all that are applicable. *The choice items are always italicized.*
- Some items have a subsequent question that is answered only if the main question is answered yes. Otherwise, leave it blank.
- If you are not directed to choose, complete every item.

This process is a little like having an eye exam (which is clearer—lens A or lens B—think about how many subtle choices go into arriving at the best correction to achieve clear vision!)

Write down your questions and document where it is hard to choose or there is disagreement—these are areas that will require more study and research as a part of your integration planning process.

## Glossary of Acronyms

BH	Behavioral Healthcare (both MH and SA)
CHC	Community Health Center
CMHC	Community Mental Health Center/ Community And Migrant Health Center
CPT	Current Procedural Terminology (Code)
DSM	Diagnostic And Statistical Manual (IV Edition)
FFS	Fee for Service
FFP	Federal Financial Participation
FQHC	Federally Qualified Health Center
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
MH	Mental Health
MBHO	Managed Behavioral Healthcare Organization
MUA	Medically Underserved Area
NAMI	National Alliance For The Mentally Ill
NMHA	National Mental Health Association
PBM	Pharmacy Benefit Manager
PCP	Primary Care Provider/Physician
SA	Substance Abuse
SCHIP	State Children's Health Insurance Program

<i>[Under each major area/shaded row, complete items by placing a check for either Yes or No]</i>	Yes	No
<b>I. State Medicaid/Behavioral Health Plan</b>		
<b>A. The organization and contracting of Medicaid BH [choose 1, 2, and/or 3 and answer the items under that number]</b>		
1. <i>Medicaid BH services are carved out (risk contract or ASO contract) (if yes, answer questions below)</i>		
a. MH only		
b. SA only		
c. Both MH and SA		
1) If yes, same carve out vendor?		
d. Includes financially eligible children and families		
e. Includes elderly, blind, disabled		
f. State level carve out vendor?		
1) If yes, MBHO/centralized authorization process?		
2) If yes, provider payments are (select all that apply):		
FFS		
Case rate		
Grant		
Subcapitation		
g. Regional/county level carve out vendors?		
1) If yes, consistent authorization processes across regions?		
2) If yes, consistent provider payment methods across regions?		
h. Networks are mainly public sector BH providers		
i. Networks include private BH practitioners		
j. Networks include primary care providers such as CHCs and private physicians (e.g., can be reimbursed for office visit w/psychiatric diagnosis)		
2. <i>Medicaid BH services are carved in (if yes, answer questions below)</i>		
a. MH only		
b. SA only		
c. Both MH and SA		
d. Includes financially eligible children and families		
e. Includes elderly, blind, disabled		
f. Mainly specialized Medicaid plans, rather than a mix of commercial and specialized plans		
g. Most plans have hired MBHOs and recarved BH out		
h. Networks are mainly private BH practitioners		
i. Networks include public sector BH providers		
j. Networks include primary care providers such as CHCs and private physicians (e.g., can be reimbursed for office visit		

<b>[Under each major area/shaded row, complete items by placing a check for either Yes or No]</b>	<b>Yes</b>	<b>No</b>
w/psychiatric diagnosis)		
3. <i>Medicaid BH services are paid via FFS billing to the state Medicaid agency (if yes, answer questions below)</i>		
a. Match to FFP made by provider, using state general funds and other sources, rather than at state level		
b. Medicaid BH coding and claims management is separate from physical health claims processing		
c. Medicaid billing codes cover BH case management collaborative work with PCPs		
d. Medicaid billing rules recognize BH services on the same day as PCP services		
e. New CPT codes for BH services in PCP setting have been implemented		
f. Vendors include public sector BH providers		
g. Vendors include private BH practitioners		
h. Vendors include primary care providers such as CHCs and private physicians (e.g., can be reimbursed for office visit w/psychiatric diagnosis)		
<b>B. The design of the Medicaid BH plan [complete all]</b>		
1. State has adopted the Rehabilitation model with an array of covered services, rather than the Clinic model		
2. Aggregated statewide, there is an adequate array and distribution of BH providers to serve the Medicaid population		
<b>C. The Medicaid BH plan funding level</b>		
1. The overall budget level for Medicaid BH is adequate, with reasonable capitation, case rates or FFS rates that reflect the cost of services		
<b>II. State Behavioral Health Program</b>		
<b>A. The structure for administration of State general funds that support BH [complete all]</b>		
1. State level direct to providers		
2. State via Regional/county level to providers or operated by region/county		
<b>B. The principle use of State general fund BH resources [complete all]</b>		
1. Funding is principally applied as Medicaid match and integrated into administration of Medicaid		
2. Funding is specifically available for BH services to uninsured, low income non-Medicaid individuals		

<i>[Under each major area/shaded row, complete items by placing a check for either Yes or No]</i>	Yes	No
<b>C. Intergovernmental coordination [complete all]</b>		
1. The MH and SA programs are combined		
2. There is productive collaboration among MH and separate, key agencies such as SA, Medicaid, Health, Welfare		
3. MH and SA programs are managed with consistent rules and processes		
<b>D. Program administration requirements [complete all]</b>		
1. Encounter data is collected for state funded BH programs		
a. If yes, data dictionary/encounter coding includes codes for brief services in non BH settings		
2. Documentation (clinical records) requirements for service planning and review allow for variation in the amount of documentation required for those seen briefly for lower level services versus SPMI/SED consumers		
3. Administrative paperwork requirements allow for variation in the amount of documentation required for those seen briefly for lower level services versus SPMI/SED consumers		
<b>E. Local funding to support BH safety net services</b>		
1. County BH programs and/or community based providers receive local funds to provide BH safety net services for low income individuals not otherwise covered by Medicaid, SCHIP, or private insurance		
<b>F. State level association of BH provider organizations [complete all]</b>		
1. There is a state level association of BH provider organizations (if yes, answer questions below)		
a. The association has a strategic plan or system vision that is actively promoted		
b. The association has a strong political presence		
c. The association has a strong collaboration with NAMI, NMHA and other advocacy organizations		
d. The association has a strong collaboration with the CHC/Primary Care Association		
<b>III. State Medicaid Health Plan</b>		
<b>A. The organization and contracting of Medicaid healthcare services (non-BH) [choose 1 or 2, complete 3 and 4]</b>		
1. Medicaid program for healthcare services is organized in a managed care model (if yes, answer questions below)		
a. Includes financially eligible children and		

<b>[Under each major area/shaded row, complete items by placing a check for either Yes or No]</b>	<b>Yes</b>	<b>No</b>
families		
b. Includes elderly, blind, disabled		
c. Mainly specialized Medicaid plans, rather than a mix of commercial and specialized plans		
2. <i>Medicaid program for healthcare services is mainly a FFS system</i>		
3. Aggregated statewide, there is an adequate supply of primary care providers to serve Medicaid enrollees		
4. There are disease management programs being implemented by the Medicaid agency or plans		
<b>B. The structure for managing the pharmacy benefit [choose 1, 2, 3, and/or 4]</b>		
1. <i>The pharmacy benefit is integrated and managed by the Medicaid plans (if yes, answer questions below)</i>		
a. Includes financially eligible children and families		
b. Includes elderly, blind, disabled		
2. <i>The pharmacy benefit is split between the Medicaid plans and the BH system</i>		
3. <i>The pharmacy benefit is managed by the Medicaid agency</i>		
4. <i>The pharmacy benefit is managed statewide by a PBM</i>		
<b>C. The Medicaid program funding level for healthcare services (non-BH) [complete all]</b>		
1. The overall budget level for Medicaid coverage is adequate, with reasonable capitation or FFS rates that reflect the cost of services		
2. The Medicaid prospective/supplemental payment system for FQHCs has been implemented for all eligible FQHCs		
<b>IV. Other Healthcare Initiatives</b>		
<b>A. The SCHIP program structure [complete all]</b>		
1. The SCHIP program is operated as an extension of the Medicaid plan		
2. The SCHIP benefit package includes BH services		
<b>B. Other state/county initiatives to provide insurance coverage for those not insured by Medicaid, SCHIP, or private insurance [choose 1 or 2, complete 3]</b>		
1. <i>The Medicaid program is used to cover expanded eligibility for low income individuals not otherwise Medicaid eligible, including low income single adults</i>		
2. <i>A separately administered plan is offered to low income individuals</i>		
3. If yes to either, the benefit package		

<b>[Under each major area/shaded row, complete items by placing a check for either Yes or No]</b>	<b>Yes</b>	<b>No</b>
includes BH services		
<b>C. State/local funding to support personal healthcare/primary care safety net services [complete all]</b>		
1. Health departments receive state/local funds to provide personal healthcare/primary care safety net services for low income individuals not otherwise covered by Medicaid, SCHIP, or private insurance		
2. Community health centers (CHCs) receive state/local funds to provide personal healthcare/primary care safety net services for low income individuals not otherwise covered by Medicaid, SCHIP, or private insurance		
3. There are designated MUAs and HPSAs that do not have safety net providers		
<b>D. State level association of CHC provider organizations</b>		
1. There is a state level association of CHC provider organizations (if yes, answer questions below)		
a. The association has a strategic plan or system vision that is actively promoted		
b. A state level plan prioritizing safety net expansion has been submitted to HRSA		
c. The association has a strong political presence		
d. The association has a strong collaboration with health care advocacy organizations		
e. The association has a strong collaboration with the BH providers association		
<b>E. The status of parity legislation</b>		
1. Parity legislation has been passed and implemented (if yes, answer questions below)		
a. Includes all major DSM diagnoses		
b. Includes all age groups		
c. Includes substance abuse		
<b>F. Other system aspects [complete all]</b>		
1. Scope of practice laws provide for a wide array of independent practitioners for both BH and primary care services		
2. New CPT codes for BH services in PCP setting have been implemented by private sector plans		
3. There are disease management programs being implemented by private sector plans and major provider groups		
4. Aggregated statewide, there is an adequate supply of primary care providers for individuals who have health insurance		