SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Strategic Collaborations with Payers to Support Integration

May 19, 2016

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Moderators:

Brie Reimann, Deputy Director, CIHS

Rose Felipe, Associate, CIHS

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Today's Purpose

- Recognize key messages needed to establish meaningful relationships with payers.
- Gain practical strategies to meet payers where they are and to leverage relationships to support integrated care initiatives.
- Learn about one behavioral health organization's successful engagement of payers and critical steps to take when engaging payers.

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Today's Speakers

Patrick Gordon, MPA
Associate Vice President
Rocky Mountain Health Plans

Amy Gallagher, Psy.D
Vice President of Whole Health, LLC,
Subsidiary of Mind Springs Health

Jim May, Ph.D
Director of Planning, Development, Research and Evaluation
Richmond Behavioral Health Authority

What best describes your organization's partnership with payers?

a) Not yet contacted payers

b) Planning Stages – initial discussions with different payers

c) Actively involved: Regular meetings with payer/s with mutually agreed upon agenda

d) Full partnership with payers: mutual goals outlined, regular check in on progress, shared data

What do you see as the biggest barrier to engaging payers?

a) Language

b) Sharing Data

c) Establishing the Business Case

d) Identifying goals

e) Other

Rocky Mountain Health Plans and Whole Health, LLC

Patrick Gordon, MPA
RMHP

Amy Gallagher, Psy.D

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Overview

- Rocky Mountain Health Plans, Mind Springs Health, & The Center for Mental Health came together….

- Conceptualization
  - Understanding that behaviors influence health care outcomes
  - Identified “pain points”
  - Focus on the payer plan
  - Use of logic model
  - Shared financial risk
  - Meet goals of the Triple Aim

Overview

- Implementation
  - Researched CHW work in other states
  - Creation of week-long training program, plus shadowing
  - Hired initial workforce (5 CHWs across 4 counties)
  - Continuous program evaluation and evolution
  - Creation of LLC for enhanced communication and care coordination

Whole Health LLC

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Coordination and Communication

- Building a culture of systems integration
  - CHW to patient
  - CHW to primary care practice
  - CHW to WH supervisor
  - Primary care practice to patient
  - Primary care practice to RMHP
  - Primary care practice to WH supervisor
  - RMHP to WH supervisor
  - RMHP to patient

- Communication, coordination, problem solving, evaluation

Outcome Measures

- Initial data collection
  - ER reduction
  - Needs addressed
  - Service utilization (primarily based up CHW
    contact and ER claims utilization)

- Moving forward
  - *Patient Activation Measure* (3x)
  - *Western Slope Needs Assessment* (3x)
  - Service utilization (“deeper dive”)
  - Medical practice report of success
  - Medical practice narrative stories

Outcomes

- Shared financial risk savings
- ER utilization demonstrates downward trends
- Social determinants of health realized and addressed
- Relationships strengthened between primary care and CMHCs



Lessons Learned

- Continued focus on payer's "pain points"
- Creating "BFFs"
  - Buy-in
  - Ongoing communication
  - Contributions from all involved
- "Goodness-of-fit" when hiring
- Rapid-cycle change mentality helpful
- Bio-psycho-social model of conceptualization

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Community Health Workers Report…

- Transportation conversations are amazing
- Being able to model appropriate behavior for pts is so helpful and can discuss it afterward
- ER communicated with CHW about pt concerns
- Pt with 90+ ER visits in 12 months, reduced to 30 and held a job for 6 months
- Coordination-of-care with pharmacy decreased patient anxiety and increased medication compliance

Richmond Behavioral Health Authority

Finding the Common Ground with Payers

RBHA RICHMOND BEHAVIORAL HEALTH AUTHORITY

About Richmond Behavioral Health Authority (RBHA)

- Local authority that provides Mental Health, Intellectual Disability, Substance Use Disorder, Emergency and Prevention services for the City of Richmond, Virginia
- Served approximately 5% (+11,000) of the City's population last year
- We are known in the community and the state historically as an agency that only delivers behavioral health services

The Recent Health Care Environment in Virginia

- Virginia is a non-Medicaid Expansion state (for now)
- Virginia has defaulted into the healthcare.gov exchange rather than creating its own
- Policy makers in VA have been (and still are) developing a managed care model for indigent care that doesn't involve Medicaid expansion (no, no, no, not going there…..)
- Resources vary wildly between rural and urban areas
- Potential for institutionalization of CCBHCs in VA in next year or two

Stepwise Path to RICH Recovery at RBHA

- Primary Care clinic began as a small, state grant-funded, 1-day per week clinic serving about 80 of our adult MH population; later expanded to two, half-days per week;
- Model involved contracting with an outside FQHC to deliver primary medical services (6 hrs. of one NP), on-site at RBHA, using their EHR;
- July 2013: **RBHA awarded $1.6 million, 4-year grant from SAMHSA**
  - Designed to **expand** RBHA's on-site **primary medical care clinic for persons with behavioral health disorders**
  - Became a full-time clinic staffed by RBHA physicians, nurse practitioners, nurses, care coordinator, and peers

Payer & Payer-Related Challenges

- **Internal** challenges:
  - RBHA's EHR not designed/ready to execute primary medical billing; many changes required;
  - Needed multiple staff to become credentialed with multiple payers, for new RBHA services;
  - No organizational experience with primary medical services billing or coding;
  - There still is no way to bill/pay for services for medically indigent people who have neither health insurance nor other means to pay for services;

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Payer & Payer-Related Challenges

- **External** challenges:
  - Payers didn't know RBHA as a primary care service provider;
  - Needed to expand perception of RBHA as a *behavioral health services* provider to include RBHA as an integrated care service provider that provides primary *and* behavioral health care;
  - With no prior history, we were challenged to demonstrate improved outcomes, particularly with an EHR that was originally designed only for behavioral health services;
  - Large percentage (around 40%) of RBHA adult MH population is uninsured (i.e., has no payer); this remains the largest challenge to long-term sustainability planning.

Lessons Learned

- Make sure your EHR can actually bill in a way that Medicaid and private payers can reimburse;
- Make sure you can demonstrate outcomes and cost savings

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5,000 Foot View: Local Partnerships

- A local hospital system has reached out to us regarding care for their high intensity cases (frequent flyer list);
  - People with frequent hospitalizations
  - People with numerous chronic conditions
  - People with SMI and physical health issues
- We are piloting a capitated pilot program with 10 of the most difficult individuals to make RBHA their health home;
- The model is based on the likelihood that we can effectively lower costs and improve care for these individuals – the triple aim of health care reform.

20,000 Foot View: Enhanced Care Coordination in VA

- A statewide effort that embraces the tenets of integrated care for dual-eligible persons (Medicare/Medicaid):
  - Assists consumers with getting to appropriate medical appointments
  - Encourages more communication with physicians
  - Aims to avoid unnecessary use of high cost
  - Reduction in high-risk behaviors
  - Reduction in baseline indicators for chronic conditions
  - Providing disease management education
- RBHA has made sure to be out front on this effort and be a champion for change at the state level

50,000 Foot View: Payer Outreach and Systemic Change

- Shifting from fee-for-service to a population health mindset;
- Advocating for our agency as an integrated care one-stop shop, and not behavioral health alone;
- Corralling individual payers for site visits so they can see how much our program can accomplish (we built it and they came!);
- Advocating for changes that make sense in this new world (i.e., payment for same-day appointments for both behavioral and primary health);
- Be sure that your staff is engaged at all levels with state and federal administrators, if possible

50,000 Foot View: Payer Outreach and Systemic Change

Enhanced Care Coordination – clients with SMI and co-occurring physical health conditions that require a higher level of case management to address physical health conditions.

- Payer A – Dual eligible
- Payer B – Dual eligible
- Payer C – Dual eligible
- Payer D – Medicaid only

50,000 Foot View: Payer Outreach and Systemic Change

Bridge Program – RBHA and non-RBHA clients who are seen at hospital discharge by RBHA staff for review of discharge plan, assessment and warm-handoff to service providers:

- Payer E – capitated payment agreement
- Payer B
- Payer A

50,000 Foot View: Payer Outreach and Systemic Change

Payer A Incentive Program aiming to measure efficiency and quality indicators based on claims data for members receiving services from RBHA. Indicators include:

- ER utilization;
- Inpatient 30-day readmission rates;
- 7-day follow up visits post-psychiatric inpatient discharge;
- Follow-up care for children prescribed ADHD meds in initiation phase;
- Adherence to antidepressant medication; and
- Diabetic screenings.
- *There is a financial incentive for meeting targets*

Takeaways

- This is a challenge with *multiple* solutions, not one
- Our experience has been that being data driven and able to demonstrate success (i.e., health outcomes, cost savings, reduced hospitalizations) is key to getting buy-in from payers at any level
- Being without Medicaid expansion is a hurdle, but not a roadblock
- Make your case to payers early, often, and repeatedly
- There may be systemic changes you must advocate for to make this feasible

Contact Us!

Richmond Behavioral Health Authority

www.rbha.org

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For More Information & Resources

Visit www.integration.samhsa.gov or
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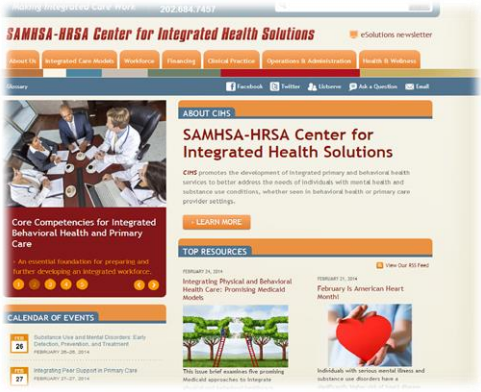

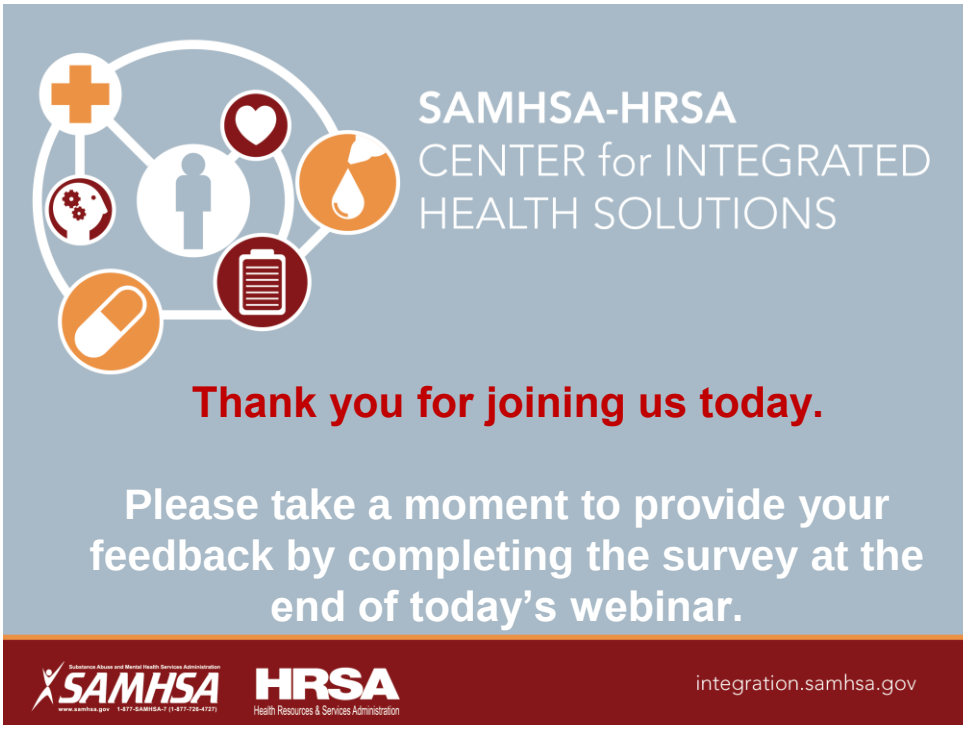
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