Medicaid 2.0
Issue Brief:
Behavioral Health Integration

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Background

Overview

The expansion of Medicaid has infused the adult behavioral system with new money and services allowing the State to increase rates and expand the scope of services, particularly for Substance Use Disorder (SUD). However, for the most part, these services remain outside the Medicaid managed care delivery system which provides all other health care services for beneficiaries. Behavioral health services are provided largely through a network of hospitals and community providers. SUD services are managed by an Interim Managing Entity (IME) that provides oversight and coordination of SUD services.

Reimbursement for most of these services is being converted from contract based reimbursement to fee-for-service system and is scheduled to go into effect July 2017. In July 2016, the State increased reimbursement by $127M to improve access and better align reimbursement for behavioral health services. However, despite these additional funds, timely access to some behavioral services continues to present a challenge. In 2014 the Medicaid program began covering telehealth services for mental health treatment but limited the use of these services to traditional mental health delivery sites.

Integration of Physical and Behavioral Health Services

The integration of physical and behavioral health is a major objective in the State's waiver renewal. At the clinical level, behavioral health and physical care are integrated for those with serious mental illness (SMI) through the State's Behavioral Health Home model which the State is proposing to expand statewide. For the non-SMI population --both children and adults-- the integration of behavioral health and primary care is emerging, but progress is challenged by inconsistencies in state licensing requirements, lack of available clinicians and sustainable financing. For the integration of physical health within SUD, the Medicaid waiver renewal calls for the development of an SUD continuum under which state SUD and Medicaid program funding will be consolidated.

At the payment level, the MCOs are only responsible for physical health for the majority of Medicaid beneficiaries. (MCOs are at risk for behavioral health for the Medicaid long-term care and developmentally disabled populations.) In addition, the State's licensing framework and regulations limit the co-location of behavioral health and physical health services which consequently limits reimbursement as providers can only bill for licensed services. More recently the state has granted case by case waivers of its licensing regulations to facilitate co-location but the State has not put forth a comprehensive co-location strategy.

Autism

Access to autism diagnostic and treatment services for children is limited for several reasons. There is little dissemination and use of proper assessment tools to detect autism in early childhood at the primary care level. Detection is critical as there is a small window (up to 6 years of age) where early intervention can improve the long-term quality of life for the child and lower their need for long-term treatment and care in adulthood.

Once diagnosed, there is a shortage of physicians and nurse practitioners who are certified to diagnose and develop a plan for caring for the child. This shortage may be due, in part, to the lack of reimbursement to physicians to support the additional resources they need to care for this population. Coordination of autism services between schools and providers crucial, but there continue to be breakdowns that result in children not receiving the full scope of these services. Lastly, the lack of funding for support services for the families to assist them in addressing the child's needs hinders clinical progress.

Problem Statement

- Behavioral health and physical health services are fragmented at the clinical and payment levels. The regulatory structure and reimbursement for integrated services is limiting innovation.
- The benefits of integrating physical and behavioral health cannot be fully realized without improving access to behavioral health services.
- Autism services are not reaching all eligible children – especially younger children missing the opportunity to identify and treat services when the impact of therapy is greatest

Goals

- Develop sustainable long-term strategies to integrate behavioral health and physical health care at the clinical, payment and regulatory level for both the SMI and non SMI population
- Develop strategies to improve access including the expanded use of telehealth and practice extenders
- Broaden evaluation services to identify all children with Autism for early diagnosis

Strategy Options (informed by other states)

Payment Integrations

- Carve all BH services into MCOs at full risk
- Carve all BH services into MCOs without risk
- Require MCOs to take all the providers and use states rates but remain at risk for the total cost of care

Clinical and Regulatory Integration:

- Require all primary care practices to employ licensed clinical social workers with incentive payments to the practice
- Consolidate the licensing functions under one state agency

Autism Services

- Request federal approval to cover support services for the family of children with autism

Research Links

Crain's Detroit Business: Michigan Debates Integrating Physical, Mental Health Systems. May 15, 2016. http://www.crainsdetroit.com/article/20160515/NEWS/160519934/michigan-debates-integrating-physical-mental-health-systems

DMAHS: Transition to Fee for Service. March 2016. http://www.state.nj.us/humanservices/dmhas/information/stakeholder/Rate_Setting_Transition_Overview.pdf

*MassHealth: Delivery System Restructuring: Additional Details. April 14, 2016. http://www.njhcqi.org/wp-content/uploads/2016/04/MassHealth-Delivery-System-Restructurig.pdf

New Jersey DMAHS: NJ FamilyCare 1115 Comprehensive Waiver Demonstration Application for Renewal. June 10, 2016. http://www.nj.gov/humanservices/dmahs/home/NJ_Comprehensive_Waiver_Renewal_for_public_comment.pdf

New Jersey DMAHS: NJ FamilyCare Report 2015. August 2016. http://www.state.nj.us/humanservices/dmahs/news/NJ_FamilyCare_2015_Annual_Report.pdf

NY Department of Health: Health and Recovery Plan (HARP) Subpopulation. April 19, 2016. http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/2016-04-19_harp_rpt.pdf

RAND Health: Financing Integrated Care for Adults with Serious Mental Illness in Community Health Centers. June 2015. https://www.rand.org/content/dam/rand/pubs/working_papers/WR1000/WR1084/RAND_WR1084.pdf

Roots: Meeting the Challenge: Behavioral Health Integration in Primary Care. 2016. http://jhf.org/admin/uploads/roots-behavioral-health-2016.pdf

*RWJ Partners' Project ECHO Introduction. September 2016. http://www.njhcqi.org/wp-content/uploads/2016/09/Project-ECHO_RWJF-Partners.pdf

Seton Hall: Integrating Behavioral and Physical Health Care in New Jersey. June 2016. https://issuu.com/seton-hall-law-school/docs/behavioral-physical-health-care-in-?e=19054437/36892034

Seton Hall: Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Barriers and Opportunities in New Jersey. March 31, 2016.
https://issuu.com/seton-hall-law-school/docs/integration-of-behavioral-and-physi?e=19054437/34560793

*TBD Solutions: Beyond Appearances: Behavioral Health Financing Models and the Point of Care. February 2016.
http://www.njhcqi.org/wp-content/uploads/2016/04/BeyondAppearances_BH_Funding_PointsOfCare_Feb2016-final.pdf

*The NJHCQI website is being updated. Documents saved on the NJHCQI website may have different links once the new site launches.