# ABHW

## Association for Behavioral Health and Wellness

*Advancing benefits and services in mental health, substance use and behavior change.*

November 14, 2014

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Ron Wyden
Chairman
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
2322A Rayburn House Office Building
Washington, DC 20515

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairmen and Ranking Members:

Thank you for your interest in the role that private sector managed care plans play in the Medicaid program. As the voice for companies that manage behavioral health and wellness services, the Association for Behavioral Health and Wellness (ABHW) would like to take this opportunity to illuminate best practices for delivering high quality care in an effective and efficient manner, from a behavioral health perspective.

ABHW member companies provide specialty services to treat mental health, substance use, and other behaviors that impact health and wellness to approximately 125 million people in both the public and private sectors. ABHW and its member companies use their behavioral health expertise to improve health care outcomes for individuals and families across the health care spectrum.

Behavioral health should have a prominent place in your examination of the role that private sector managed care plans play in Medicaid. 35% of Medicaid beneficiaries have a chronic mental health or substance use disorder, and 60% percent of those individuals also have other chronic physical conditions and report fair or poor health status. In 2009 average annual spending per capita was 2.5 times higher for Medicaid enrollees with a mental illness than for individuals who did not have a mental illness.

Despite these statistics, many states still have very limited behavioral health benefits in their Medicaid plans, and we are supportive of aligning the benefit to more closely mirror the array of benefits on the medical/surgical side.

Below, please find ABHW's responses to the nine areas in which you request the identification, evaluation, and highlighting of best practices in Medicaid managed care:

1. **Responsible Medicaid rate-setting processes that take into account different types of Medicaid managed care plans, including industry standards for assessing actuarial soundness.**

ABHW members would like to explore alternatives to fee-for-service rate-setting models, allowing providers to focus on outcomes rather than on time spent with a patient. This would be beneficial, as a payment system that rewards performance, rather than quantity of service delivered, would reduce costs and improve care. Additionally, moving to an outcome-based payment model will encourage creative and different ways to reform payment, especially if managed care organizations (MCOs) are granted the flexibility to establish creative outcome-based reimbursement structures with their providers. This would require promoting and establishing provider performance measures within the MCOs to support pay-for-performance. At least one of our member companies is beginning to reach out to providers and engage in pay-for-performance pilots across the country.

National standards around at-risk populations are just entering managed care. This equates to more government regulation and less flexibility within the state, but having only one set of rules allows for some standardization across states and beneficial guidance around rates. ABHW members support one standard of global payments and national consistency around rate cohorts.

2. **Development of comprehensive provider networks that meet the full range of patient needs, including strategies for recruiting and retaining primary and specialty care providers.**

ABHW member companies see a great need for more licensed providers in behavioral health and recommend looking beyond traditional providers to create comprehensive networks. Medicaid requires a different, broader network than commercial. For example, as Medicaid is now mandating coverage for Autism Spectrum Disorders, we need more licensed providers for Applied Behavioral Analysis (ABA). For example, funding training for psychiatrists in medical school as a way to incentivize and increase the provider pool.

One way to help expand the provider network, decrease the burden on the existing behavioral health workforce, improve outcomes for beneficiaries, and assist in integrating care is establishing and promoting certification programs to train Peer Support Services (PSS) providers. Peer support is designed on the principles of consumer choice and the active involvement of persons in their recovery process; peers also help reduce hospitalizations and other emergency interventions. ABHW recently conducted a survey of our companies, and the resulting report showed that specialty behavioral health organizations view PSS as a valuable component of a comprehensive approach to wellness. ABHW members have seen that PSS are an effective component of behavioral health treatment and have a positive impact on consumers, purchasers, and payers. In one example,

an ABHW member designed a program to facilitate access to primary medical care, behavioral health treatment, and support services. The program used a patient-centered medical home with peer specialists driving enrollees to appointments, assisting with housing applications, and teaching life-coping skills. In approximately three years, the data reflecting the use of services revealed a 10-percent reduction in inpatient services within six months of enrollment. The program also showed a 35.9-percent decrease in inpatient costs and a 36-percent decrease in medical spending. The value and beneficial opportunity presented by PSS programs is clear, and Medicaid managed care should do what it can to support the offering of PSS.

The services peers provide are imperative for allowing individuals with complex needs to live in their communities. Community-based wraparound services such as supported employment, housing, and transportation have been proven to help people recover and keep patients out of unnecessary inpatient hospital stays. They also keep the goal of recovery at the forefront by helping to maximize function and quality of life. Medicaid waivers have helped to allow for the provision of wraparound services.

Telehealth is another way to remedy the behavioral health workforce shortage, particularly in rural areas, by creating consistent standards across states. Telehealth has been proven to drive important advancements for our patients, expanding access to care, improving health outcomes, reducing the inappropriate use of psychotropic medications in skilled nursing and other settings, and reducing costs. Telepsychiatry has the ability to reach a broader range of behavioral health consumers, including children and adolescents who appreciate the use of technology when communicating with their behavioral health care providers, and patients who reside in areas where there is a shortage of behavioral health providers. It also helps provide access to elderly patients who may have difficulty leaving their homes to travel to an appointment. However, the fact that each state has its own telehealth eligibility standards, combined with confusion around licensure requirements, prevents Medicaid recipients from obtaining the care they need. At least 40 states do provide some form of Medicaid reimbursement for telehealth services.

3. **Methods for evaluating quality of care, including clinical measures, or other metrics for evaluation.**

Just as our members believe broad provider networks should help with wraparound services for patients, ABHW also stresses the importance of looking beyond medical outcomes when evaluating success. A patient who is becoming healthier but is homeless is not a symbol of long-term success. In assessing quality of care, states should monitor all HEDIS measures related to behavioral health diagnoses and services, as many of these measures encourage integrated care.

One ABHW member company has met with Centerstone Agency, a not-for-profit provider of community-based behavioral healthcare, and learned that the agency has a fully developed process for measuring provider performance, satisfaction, and outcomes. Exploring the programs implemented by community-based behavioral healthcare agencies, like Centerstone, to measure provider performance and member satisfaction and outcomes, as well as promoting the agency's process in Medicaid, could help others evaluate quality of care. Additionally, payers and providers need to work together to determine the best way for a payer to measure providers' performance and outcome. Some ABHW member companies are beginning these conversations by meeting with provider associations to collaborate on appropriate measures.

4. **Clinical and other interventions that coordinate care, especially related to the management and treatment of chronic diseases for higher-risk, higher-cost enrollees, and enrollees requiring long-term services and supports.**

ABHW member companies work to coordinate behavioral health care with an individual's medical care and use clinical outcomes to help measure the effectiveness of a patient's treatment. We recognize that treatment of this population is a team effort, necessitating as much integration as possible. A coordinated care team with the right approach and accountability is essential. One integration program is below, and our member companies have many more examples we would be happy to discuss with you.

One program that is working well has an overarching goal of helping members with depression and certain co-morbid medical conditions achieve the highest possible levels of wellness, functioning, and quality of life. It is based on the IMPACT model of evidenced based depression care. The program utilizes key IMPACT components such as systematic use of depression symptom scales, behavior activation, and relapse prevention prior to members ending participation in the disease management program. The program also includes targeted primary care physician technical assistance on stepped care and the IMPACT tenants of treating to goal. The program aims to increase effectiveness of primary care administered depression treatment as evidenced by positive improvements in depression scale scores, decreased emergency department utilization and costs for the targeted population, and decreased inpatient admissions and costs for the targeted population. The program's Coaches work with the member, Integrated Care Team staff, and appropriate providers to develop a self-management plan that reflects the member's preferences and goals. Preliminary data show positive improvements in depression scale scores for members engaged in the program as well as positive results in lower emergency department and medical inpatient costs.

New York State Medicaid is in the process of moving all fee-for-service behavioral health services to specialized integrated managed care plans in 2015. The program design includes two types of plans with specialized behavioral health features. Both are to provide integrated physical and behavioral health services for adults and children with serious mental illness or addiction disorders. The plans will provide all Medicaid state plan services for physical health, behavioral health, pharmacy, long-term care, and health homes.

Electronic health records (EHRs) improve and simplify the exchange of information which makes treating the whole person easier. EHRs help facilitate coordinated care, but the benefits of EHRs are lost if behavioral health providers are behind on EHR implementation. Due to limited resources, fewer than half of behavioral health providers possess fully implemented EHR systems. When Congress passed the HITECH Act in 2009, it left out behavioral health providers. On average, IT spending in behavioral health organizations represents 1.8% of total operation budgets – compared with 3.5% of total operating budgets for general health care services. Because some key licensed behavioral health providers cannot qualify for an incentive payment for EHRs, the uptake in use of EHRs by certain behavioral health providers is diminished.

Overall, the amount of technological sophistication is not the same in behavioral health as it is in physical health. Over 90% of medical/surgical health care claims are electronic, and only 65-70% of behavioral health claims are submitted electronically. Many behavioral health providers are still filling out claims by hand, rather than electronically. Because of varying technology, access to necessary data is not always possible. Lack of the full picture of a patient's health data hinders innovation in treatment. This disparity in use of technology could be

addressed by extending financial incentives for the meaningful use of EHRs to specified mental health and addiction treatment providers and facilities. The Behavioral Health Information Technology Act, S. 1517, and the Behavioral Health Information Technology Coordination Act, S. 1685, would provide for that; and we encourage you to bring one of those pieces of legislation to the Senate floor.

Another challenge that stands in the way of using existing data sources more effectively to coordinate care relates to privacy constraints in 42 CFR Part 2 (Part 2). Part 2 protects client-identifying information that would reveal a client as an alcohol or drug client, either directly or indirectly. Part 2 was created after Congress recognized that the stigma associated with substance use disorders and the fear of prosecution deterred people from entering treatment. While a laudable goal, these special protections create barriers to integration, such as: inhibiting electronic exchange of health information between a patient's providers, reducing the effectiveness of clinical reports to physicians, and delaying data transmission to providers. Some individuals with substance use disorders will often go to different providers so that they can obtain multiple prescriptions for medications to which they are addicted; without access to a patient's record, this behavior is hard to detect and treat. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently requested feedback on this issue, and our recommendation is to align Part 2 with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule in order to allow transmission of Part 2 data without written authorization for treatment, payment, and operations purposes. We strongly encourage you to work with SAMHSA and the Department of Health and Human Services (HHS) to amend Part 2 so that individuals with substance use disorders can receive the same coordinated care as everyone else.

5. **Effective policies or programs to communicate with and provide services to vulnerable populations, such as enrollees with disabilities, those who speak English as a second language, those who live in rural or medically underserved areas, etc.**

Broadening capabilities of current providers is one way to deliver services to vulnerable populations. For example, requiring Mental Health First Aid training for rural primary care physicians and expanding telehealth services improves access and communication. And, as stated above, peer support is imperative for reaching these populations.

One example of an effective approach for those who speak English as a second language is the Promotoras model. In this case, lay members in the Hispanic/Latino community who receive specialized training to provide basic health education in the community serve as liaisons between their community, health professionals, and human and social service organizations. Promotoras act as advocates, educators, mentors, and translators for patients.

Urgent care sites for behavioral health needs is another way to reach patients in rural and medically underserved areas. School-based care and partnering with religious organizations have been effective ways to communicate with vulnerable populations as well. Significant attention to cultural background is needed to deliver care to these populations; having people in customer service departments that speak multiple languages also helps address communication issues.

6. **Collecting, using, and reporting complete, accurate, and reliable encounter data.**

While working to extend health information technology assistance eligibility to certain behavioral health providers, Congress must also address the issue of interoperability, another significant barrier to the accessibility of health care data. When EHR systems do not talk to each other, and different providers are gathering data in different forms, it is very difficult to share essential patient information. There is no consistent approach or standard, and this contributes to fragmentation. If providers are not using the same standards or data sets, everyone will come to different conclusions about a patient's care because they lack full information. Furthermore, not all states have caught up with e-health, and some states have varied requirements. This has precluded some providers and facilities from using e-health, thereby hindering them from technological advance and proper integration. We suggest setting standards regarding the appropriate use of data in order to ensure accessibility for different purposes.

7. **Effective strategies to enhance program integrity and prevent improper payments, including the use of data and analytics, information security protocols, billing standards, and drug abuse prevention and diversion strategies.**

Effective ways to enhance program integrity and prevent improper payments include educating providers on proper billing procedures and monitoring provider performance. Identifying long lengths of treatment episodes, the number of members who present to emergency departments while under a provider's care, and level of patient satisfaction can be useful. Our member companies examine billing that seems inappropriate, but oversight of states' Medicaid billing also needs to be done.

Our member organizations strongly support increasing program integrity and reducing instances of fraud and abuse, and we encourage your committees to direct CMS to review the current program integrity restrictions and regulations in light of newly developed integrated care models, such as accountable care organizations (ACOs) and health homes. Several restrictions (such as same-day billing, bundled care, and self-referral), while appropriate in fee-for-service programs, are creating barriers for states, health plans, and practices to create and be reimbursed for fully integrated bio-psycho-social care.

8. **Accountable management culture and processes, including developing a workforce capable of responding to enrollee needs, implementing effective and responsive grievance procedures, and providing enrollees with access to relevant information about services and programs.**
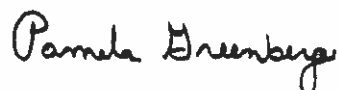
Again, cultural competency is crucial. Spending time to understand the culture of the patients and recognizing the importance of culture must be addressed openly.

9. **Constructive means of engaging and collaborating with states or other partners, including communications, legal, organizational, or other strategies.**

One suggestion is to encourage CMS to continue to provide information to states when they are utilizing managed care to deliver Medicaid services. This would encompass guidance on which services to cover, which codes to use for billing, HIPPA for Medicaid, which type of EHR to use, and best practices.
Effective partnering, outreach, and communication – from family members to the state to the advocacy community – is valuable. It is necessary to engage people and gather input from the community at large in order to have a program that fits patients' needs.

Thank you again for requesting feedback on these important topics. We appreciate the opportunity to share our input and look forward to continuing to assist you in better understanding the role that private managed care plans play in the Medicaid program. If you have any questions, please contact Rebecca Murow Klein at (202) 449-7658 or klein@abhw.org.

Sincerely,

Pamela Greenberg

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