ACC Phase 3
Integrated Care Benefit

Concept Proposal

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Problem Statement

- The Dept is committed to advancing the integration of member care for physical health (PH) and behavioral health (BH) to provide whole-person care in ACC Phase 3.

- The Dept would like to see distinct care considerations for members with higher acuity conditions (SMI/SUD)

Proposal

HCPF is looking to design a distinct Integrated Care Benefit (ICB) that considers the current reimbursement structures of key PH and BH providers (i.e. FQHCs, CMHCs, PCPs, etc.). This new benefit will fold in the current Short-Term Behavioral Health (STBH) benefit.

Options Considered

- 2703 Health homes for SUD
- 2703 Health homes for both SMI/SUD
- ACC Phase 2 merged PH and BH under the RAEs
- The state's participation with the State Innovation Model (SIM)
- The implementation of the 6 Short Term Behavioral Health (STBH) benefit
- 1302 grant pilot funding to promote PH and BH integration
- Specific care considerations for high acuity conditions, serious mental illness/substance use disorder (SMI/SUD)

Proposed Approach for ICB

The ICB will start with a mechanism to identify PH settings who are operating as IC providers

1) Behavioral Health Entities (BHEs) would stand up a PH clinic onsite/embedded in their practice (as done in SIM).

- Address the specific care needs of the SUD/SMI populations where BHE is the primary provider connected to members.
- Consider the scope of BH services on member attribution here, which would give us the outcome of a health home.
- We could design distinct metrics/outcomes for PMPM or incentives related to members with high-acuity BH conditions

2) There are multiple models of integration when adding behavioral health services to medical settings. Distinct BH services would be added/billed in this setting and require a licensed BH practitioner who is enrolled with Medicaid be employed or contracted by the IC location.

Proposed Approach for ICB

Policy Parameters:

1. The ICB is intended for early intervention, pre-diagnosis, lower acuity, and maintenance level encounters.
2. There would be no limit to contacts per year. The number of contacts with a member would be determined by the member, the Integrated Practitioner, the condition being treated, and the business model of the IC setting.
3. The Integrated Practitioner (medical staff or BH staff) would only see patients established at the host agency (i.e. PH clinic/setting or BHE).
4. MAT services should be encouraged and incentivized in practices where it is appropriate.

Proposed Approach for ICB

Payment Components

1. The Integrated Practitioner would bill codes for each encounter. RECOMMEND SUNSETTING THE STBH BENEFIT FOR PCMPS. Replace with a full bundle of codes designed for Integrated Care Models.
   a) Adding a distinct line of business (BH) to a PH setting requires more than a PMPM or APM financial investment. This needs a distinct set of codes and a clear, identifiable billing pathway.
   b) Using billable codes directly links payment to a service provided that is trackable and has a direct financial impact to the location for those services. PMPMs alone risk being absorbed by unrelated business expenses.
2. IC Providers would participate in a PMPM for additional resources, which is linked to established care metrics.
3. HCPF would design data, metric, and outcome measures for these providers [before the benefit is created in order to determine ROI and value, etc.] and in both contexts: PCMP with BH or within BH.
4. HCPF would offer incentives (BHIP?) for the RAEs to recruit/contract with a certain percentage of IC practices.

Decisions

1. Since these services will be provided in physical health settings, the medical services will be billed FFS [current process]. Would it be better (for cost, care, administrative burden, etc.) to allow the ICB codes to also be billed FFS? If we wanted the distinct BH encounters billed under the Cap, RAEs could be required to automatically include the ICB codes in the IC contracts. If we wanted some services covered under each (FFS/CAP) we could develop a "staircase" for this benefit to identify what and when a service is billed to each.
2. How to address providers who have a cost-based reimbursement structure (i.e. FQHCs - already have a staffing and billing model for both their PH/BH encounters)

Questions?

Thank you!

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