Commission on Improving the Status of Children in Indiana

Recommendation to the Commission

Party Submitting Recommendation: CISC MH & SA 3.1 subcommittee: Integration (Carrie Cadwell and Jenifer Vohs, Co-Chairs)

Date of Submission: 2/6/2020

Type of Action Requested:

☐Legislation ☐Policy ☒Resolution of Support or Endorsement ☐Public Promotion

☐Other:_____

Which of the Commission's Strategic Priorities does this Recommendation help advance:

☐Child Health and Safety ☐Juvenile Justice and Cross-system Youth

☒Mental Health and Substance Abuse ☐Educational Outcomes

Summary of Recommendation:

Attached you will find the summary document of recommended initiatives. Items listed under "Critical Integration Infrastructure Recommendations" are considered first priority whereas "Important for Future Exploration" are secondary considerations. It is also recommended that our committee serve as available experts to FSSA as the agency completes work on an integrated care redesign.

Background of Recommendation:

What is the need or problem?

Our current health system for youth is fragmented. Families must move across different healthcare providers for medical care and behavioral health/substance use care. Current mechanisms for supporting care coordination/care management across healthcare infrastructures are not uniform and thus it occurs only in pockets. Families/parents are left to serve as the main care coordinator for their children. Families/parents do the best they can with what they have within their current socioeconomic status, understanding, and abilities but healthcare providers can and want to do better. Research on integration points to improved patient outcomes, engagement, satisfaction and provider satisfaction. To move from fragmented care to more integrated care (whether single site delivery or integrated service delivery across entities) will require a gap analysis.

What are the factors that limit the full realization of integration?

The Integration subcommittee was charged with examining this across healthcare infrastructures with a specific focus on Indiana Medicaid/HIP.

An important contextual factor to keep in mind is that some reports point to general population statistics indicating that 1 in 6 U.S. children aged 2–8 years (17.4%) had a diagnosed mental, behavioral, or developmental disorder https://www.cdc.gov/childrensmentalhealth/data.html . A JAMA Pediatrics report published in 2019 (data examined from 2016) placed Indiana quartile rankings as follows: youth mental health disorder prevalence within 20-27% range and youth not receiving treatment for those disorders at 46-53% range. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2724377 . Prevalence rates for youth with Medicaid coverage have often been reported as higher than the general population rates. Prevalence rates for children with special healthcare needs also follows that increased prevalence https://www.kff.org/medicaid/fact-sheet/ten-things-to-know-about-medicaids-role-for-children-with-behavioral-health-needs/ . Integration presents a robust approach to addressing this challenge with evidence of positive outcomes compared to usual care https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/behavioral-health-primary-care-integration . While this data only provides a snapshot it gives the Commission a starting point from which to understand the "Why" of integrated care.

What is the current response to the problem by the State of Indiana?

Beginning in 2012, state agencies including FSSA, DMHA, ISDH undertook (alongside Indiana providers and healthcare infrastructures) the development of statewide strategic plan which culminated in the Indiana Primary Care and Behavioral Health Initiative (IPCBHI). The goals and objectives of that plan can be found at https://www.in.gov/fssa/dmha/2898.htm . The result of this work was certified Integrated Care Entities (ICE) serving youth, families, adults. A current list of these ICE sites can be found at https://www.in.gov/fssa/dmha/2901.htm . These sites were TANF-grant funded through December 31, 2019. A goal of the committee that worked to develop ICE sites was not only to set up the infrastructure but to develop a payment methodology that could sustain ICE sites. The aim was to achieve an ICE designation on the Indiana Medicaid Provider enrollment type and specialty matrix. This did not come to fruition, but ICE sites can be viewed as the forerunner to supporting a health home model. However, ICE sites represent only a single site integration approach and thus still there remains the need for discussion as to how integration is supported across delivery systems and within varying healthcare infrastructures. Ultimately, the convening of the CISC 3.1 Integration subcommittee can be seen as that next step in the State's efforts. This current committee brought together individuals who have served on the IPCBHI initiative committees for many years, ICE site representation, and varying healthcare infrastructures and geographic terrain.

What is the recommender proposing, and how will it help solve the problem?

We propose a myriad of recommendations as the State pursues a plan toward integrated care (attached). We also propose to assist FSSA, as needed, as integrated care policy and funding decisions are made.

What data, research or other information did the recommender consult to formulate this proposal?

The committee membership represents subject matter experts in integration, healthcare infrastructure, healthcare policy, and CHW/CRS training initiatives. Further subject matter experts from Indiana Medicaid and the Division of Mental Health & Addictions was key to this committee initiative. Information and lessons learned from the Integrated

Care Entity (ICE) initiative were incorporated into this review. Subject Matter Expert review and input over a 6 month period (June 2019 through November 2019) was undertaken.

If a legislative request, cite the current relevant code and specify what change is being recommended.

Click or tap here to enter text.

If a policy request, cite the current relevant policy and specify what change is being recommended.

Click or tap here to enter text.

If the recommendation involves an endorsement or public promotion of a specific initiative or statement, attach the document of which you are seeking the Commission's support/endorsement/promotion.

The Commission is not being asked to endorse any specific item on the attachment "CISC Integrated Care 3.1: Subcommittee Recommendations" but rather to bring awareness to best practices for integrated care.

CISC Integrated Care 3.1

Subcommittee Recommendations

Critical Integration Infrastructure Recommendations

1. Support for the health home model of care for youth impacted by Serious Emotional Disturbance (and adults with Serious Mental Illness). This exploration should take place with robust stakeholder engagement and consideration of lessons learned from state Integrated Care Entity (ICE) sites.
2. Building a consistent Care Coordination/Care Management foundation applicable to all Indiana Medicaid and Health Indiana Plan (HIP) plans. This includes:
    a. Expansion of coverage to include the Collaborative care codes already accepted by Medicare and some private insurers but not currently reimbursed by Medicaid/HIP.
    b. Consider Care Management code across health care infrastructures and their unique reimbursement systems for Medicaid/HIP that allows for community-based, mobile approach. This should include expansion of reimbursable Community Health Worker services to their full scope of training.
    c. Healthcare infrastructure differences that were discussed by the subcommittee include: Community Mental Health Centers, Federally Qualified Health Centers, Rural Health Centers, General Medical/Hospital Practice
3. Examination of the lack of use of the approved State Plan Amendment for Federally Qualified Health Center Behavioral Health Advanced Payment Methodology and barriers to adoption.
4. Education to providers and healthcare entities on current, available financial support for integration.
5. Expanding the use of all Health Behavior codes and specific code 96127 to behavioral health settings AND expansion of “who” (scope) can claim for these service codes.
6. Warm hand-offs between agencies. Allow the mental health or substance use diagnosis by a Primary Care provider to create immediate access to behavioral health/substance use provider care versus delaying care due to requirements for lengthy biopsychosocial evaluations at 1st contact. Comprehensive assessment can

take place within a 60-day window but should not stop immediate care needs from being met based either Physician diagnoses or brief, initial evaluation.

7. Removal of requirement for psychiatrist or HSPP psychologist for contracting and submission of behavioral health claims for midlevel providers practicing in integrated setting and allow for primary care physicians with specific behavioral health training.
8. Strongly recommended assessment of key social determinants of health across healthcare infrastructures. State level exploration of Managed Care Medicaid "in lieu of" service options connected to impacting social determinants of health.
9. Training "behaviorally enhanced medical providers and medically enhanced behavioral providers" (Alexander Blount)

a. Revision of graduate level, nursing, physician curriculums to support integration.
b. ECHO integration training for existing professionals
c. Support training for standardized screening, with public domain tools, for physical health, behavioral health, and substance use.
d. Focus on "skilling-up" paraprofessional workforce. To include: (a) Community Health Worker curriculum embedded in Associate and Bachelor level Human Services degrees and (b) Additional technical certificates through community colleges for health coaching and care management

10. Review of relevant Indiana Administrative code for each health infrastructure. Often Indiana Administrative Code is dated and may not support integration or creates barriers.
11. Data mapping where integration is occurring. To include current Integrated Care Entity (ICE sites) and survey across healthcare infrastructures about where integration is happening based on SAMHSA's levels of integration.

Important for Future Exploration

1. Create consistent definition of care plans across healthcare infrastructures and provider types.
2. Consider relevancy and possible revisions for Transitional Care Management and Chronic Care Management codes to be more relevant in integrated care.
3. Reimbursement needs for Federally Qualified Health Centers to facility group interventions.

4. Availability of Wellness codes for behavioral health providers to use. Currently, primary care providers are marginally supported for wellness but no such avenue exists for behavioral health.
5. Exploration of essential roles and responsibilities in integration for the following professions: Registered Nurse, Licensed Practical Nurse, Medical Assistants, Physician Assistants, and Pharmacists.
6. Addressing technology barriers: HIE interface limitations, EHR limitations and variability in functionality between infrastructures, and registry limitations.
7. Need for central data repository versus multiple individual systems depending on payor. Further, creating Consistency in Quality Metric expectations while minimizing the reporting burden. Start with the question: What can we reasonably make progress on in terms of total number of high-value metrics?
8. Financial support on both ends for interdisciplinary team meetings and care coordination (versus one end of the collaboration being billable while the other providers time being unsupported).
9. Financial support for Physician and Psychologist consultation across healthcare infrastructures

Contextual factors for consideration

1. The focus of the subcommittee was to highlight suggestions relevant to Indiana Medicaid and Health Indiana Plan. Consideration to gaps that exist for Hoosiers that have commercial insurance including high deductible plans should be discussed. For those eligible an awareness campaign focusing on Healthy Indiana Plan as a secondary insurance may be helpful.
2. Integration efforts in the state need to be mindful of misalignment between what Indiana Medicaid allows for versus Medicare. Misalignment can create challenges in access and treatment provision specifically for Dual Eligible populations.
3. One model of integration will not work for all healthcare infrastructures and flexibility in model implementation is needed dependent on geographic location and resource availability.

History and Purpose of the Integration subcommittee

The Integration workgroup is a subcommittee (3.1) of the CISC Mental Health & Substance Use Committee. The purpose set forth for the Mental Health & Substance Use Committee is to support creative and effective methods of improving assessment, access to treatment, and wrap-around resources for vulnerable youth and households in need of mental health and substance abuse services. The Integration subcommittee is charged with identifying solutions for barriers to integration in the State of Indiana along with identifying financial frameworks for integration viability and improved health outcomes. While CISC is focused on youth, the subcommittee considered that for youth one must take a larger system view.

Integration Subcommittee Members

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