

MeHAF Integrated Care Initiative

INTEGRATED CARE MOVING FORWARD

Issue Brief

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Integrated Care Moving Forward

Introduction

In 2006, the Maine Health Access Foundation (MeHAF) launched its *Integration Initiative* - a twelve-year, over \$14 million initiative that focuses on promoting patient-centered care by improving coordination and seamless care delivery between behavioral health and primary care providers. Since 2007, MeHAF's grants and programming have supported 42 grant projects involving over 150 collaborative partnering organizations committed to implementing integrated behavioral health and primary care in over 100 Maine practice sites¹. The *Initiative* has three major components: 1) clinical implementation (funding to providers to develop and implement integrated care approaches), 2) policy (identification of barriers to integrated care and work toward their dissolution), and 3) system development (funding to enhance state-wide infrastructure to promote integration).

John Snow, Inc. (JSI) contracted with MeHAF from 2007 through 2013 to conduct an evaluation of the clinical implementation component of the *Integration Initiative*. As the clinical implementation grants have concluded, MeHAF requested a final deliverable on this contract to develop a brief about how integration continues to move forward in the State of Maine. To this end, JSI conducted interviews of seven key informants, all leaders of organizations or initiatives that are at the forefront of health reform in Maine, about their perspectives on how integrated care has informed their work, how their organizations/projects are addressing integration, and what they see as the future of integrated services. Additionally, JSI reviewed publicly-available documents and websites relevant to this inquiry (see attachment for source list). Summary descriptions of each interview are presented first and are followed by an analysis of three cross-cutting findings from the interviews, other secondary material reviews, and knowledge and findings from the clinical implementation evaluation.

It is clear that the dialogue and knowledge about integrated care has shifted significantly from 2006 when MeHAF began its work in this area through the end of 2013, from behavioral health integration being a somewhat novel concept with uncertain benefits to one that is widely embraced and considered an important approach for providing quality services and possibly controlling costs. While several successful approaches to integrate services were implemented, still unclear is the "optimal" model of integrated care or whether there actually can be a single optimal approach. This is in part due to the diversity of provider practices and patient populations as well as the constantly shifting services system as a response to health reform initiatives.

While integrated care makes intuitive sense, there exists the perception that the "business case" has not yet been made and the metrics are not yet available to develop this case. It was clear that all key informants had thought deeply about it, indicating how integrated care is entwined and inseparable from the larger health reform discussions and activities occurring. It is this larger context of health reform that will determine ultimately how and in what fashion integrated care will move forward in Maine.

¹ <http://mehaf.org/priorities/promote-patient-centered-care> - accessed on 02/24/2014.

Organizational/Project Summaries

Maine Quality Counts

Maine Quality Counts (QC) is an independent healthcare collaborative committed to improving health and healthcare for the people of Maine by leading, collaborating, and aligning improvement efforts. Physical and behavioral health integration is one of its strategic priorities as a means of providing high quality care². QC received a systems transformation grant from MeHAF to develop behavioral health metrics, work that the Maine Health Management Coalition is using as the basis for its work on public reporting in this area.

A most important step forward for integrated care was QC's work in identifying integration as one of ten core expectations of the patient-centered medical home (PCMH). In partnership with Dirigo Health Agency's Maine Quality Forum and the Maine Health Management Coalition, QC leads the multi-payer Maine Patient Centered Medical Home Pilot. QC provides technical assistance to sites on practice transformation required to become a PCMH. Initially, there were 25 organizations working toward PCMH accreditation, with 50 additional sites added in 2013. PCMH sites in the pilot receive a per member per month (PMPM) payment to cover additional responsibilities, such as care coordination, essential to becoming a PCMH. Although largely adopting the NCQA standards for PCMH, QC adopted other state-specific competencies, one of which was integrated care. Maine at the time was the only state, or one of only a few states, implementing PCMH that had integrated care as a core expectation.

In 2013, Maine was one of eight states to receive funding from the Centers for Medicare and Medicaid Services (CMS) to add Medicare to its multi-payer PCMH pilot (called the CMS Multi-Payer Advanced Primary Care Practice (MAPCP) program). This, in essence, "re-set" the clock, enabling the 75 organizations involved in the PCMH pilot to be ensured PMPM funding through 2014. The MAPCP program did not have any specific expectations or requirements for behavioral health, but in QC conversations with CMS, officials seem pleased to have it included.

Within the PCMH practices, there is substantial variation as to the implementation of integrated behavioral health. All practices are asked to complete the Integrated Care Site Self Assessment (SSA), developed by MeHAF. The SSA identifies 18 key characteristics of patient-centered, integrated care. Practices rate themselves on each of the 18 items using a 10-point qualitative scale ranging from "the characteristic of integration does not exist at the practice site" to "the characteristic of integration occurs consistently at both the team and system levels." PCMH pilot sites choose a characteristic of integration from the assessment to incorporate into their workplans. Thus, given the requirement, all pilot sites have done something related to integrated care, but there is a wide range of which practice and organizational characteristics they have addressed. However, this requirement instilled the idea of integrated care as essential to the features of a PCMH and to identify strategies for moving toward integrated care. QC provides the technical assistance to implement the various strategies.

² <http://www.mainequalitycounts.org/page/895/who-we-are> - accessed on 02/24/2014.

Additionally, QC worked with the MaineCare Health Homes pilot project (with 80 practices participating) to align behavioral health homes with the PCMH pilot. Through funding from the State Innovation Model (SIM) grant, QC will provide technical assistance to the Part A Health Homes for practice transformation and will conduct a learning collaborative for the Part B Behavioral Health Homes. (The Health Home Initiative is described at a later point in this brief.) Expectations around the requirements for Health Homes are federally prescribed, and although integrated care is consistent with these expectations, it is not explicitly included. In Maine, however, similar to the PCMH pilot, integration specifically is part of the core expectations of the Health Homes.

Quality Counts continues to advocate at a state level as well as nationally for behavioral health integration. QC has tried to influence NCQA to include behavioral health integration as part of its standards for medical homes. NCQA's 2008 and 2011 standards for PCMH included very little on behavioral health integration, and to address this QC put forward recommendations to include behavioral health integration as a standard as part of NCQA's 2014 public comment period. QC does not expect that NCQA will change its core expectations around PCMH, but there is the potential that integration could be more explicitly included within the existing core expectations.

The PMPM funding has been a real support to practices as they build PCMH and Health Homes. A critical question going forward is whether this type of funding will continue to be available. It is unclear whether the PMPM funding for case management will be sustained post-pilot stage. A reduction or elimination of the PMPM payment could adversely affect the ability of PCMH's and Health Homes to sustain their varied integrated models. (The Health Homes Initiative is discussed in more detail below.)

HealthInfoNet

HealthInfoNet (HIN) is Maine's Health Information Exchange. It went live in 2008, and it serves as a central repository for real-time access to patient records for participating providers. In late 2013, all acute care hospitals in Maine, 392 ambulatory practices, 15 FQHCs, 12 behavioral health organizations, and a handful of other provider types had a signed data agreement with HIN. The vast majority were contributing data to HIN. The remaining minority were in "view" mode, meaning that they were not contributing data but were able to view records of their patients from all care sources to better coordinate care. This benefit serves to encourage providers to begin submitting their own data to the system. Data from HIN remains the "property" of the health provider.

It has been much tougher to bring behavioral health providers onto the system. Through 2011, Maine statutes related to consent for release of mental health records were a barrier to bringing mental health records into HIN. HIN and other key partners worked as part of a coalition to change this law. The coalition was eventually successful, and now patients can "opt in" to release their information. Given the sensitivity of the data, it must reside in a separate system on HIN, similar to records of patients living with HIV, where analogous consent and privacy procedure issues prevail. The opt in can work in two ways: 1) a patient can opt in for all providers; thus, their mental health records become part of the patients' clinical profile on HIN (assuming the mental health provider is a HIN participating provider); or 2) opt in at point of care, meaning that a provider can secure consent from a patient at a point in time and can access a patient's full record at this point in time. The mental health portion of the record becomes hidden again after this episode of care. As an additional security, HIN's Chief Operating Officer must review and sign off on all point of care requests.

Substance abuse providers (which often are part of the same organizations as mental health providers) are subject to Federal law 42CFR, which governs the release of substance abuse data and places

considerable restrictions on sharing substance abuse data. As a Federal law, these regulations are much more difficult to change. HIN has worked with the Substance Abuse and Mental Health Services Administration (SAMHSA) on a pilot to inform revision of 42CFR and has made some good progress, but the law still stands.

Other barriers also exist that have slowed behavioral health provider involvement in the HIN. Fewer behavioral health providers have electronic health records (EHRs) from which patient information is drawn into HIN. When they do have EHRs, the organizations often have less experience using them or inadequate electronic interface capacity. There are also nuanced issues that need to be resolved, such as how to handle records of patients with mental health and substance abuse co-morbidity; potentially different consent rules for patients with mental health conditions in primary care settings; and the policies governing the sharing of documentation from mental health-licensed workers in primary care settings.

Through funding from the SIM grant, HIN will provide incentives to a select number of behavioral health organizations to enhance their EHR capacity, especially related to using EHRs for quality improvement (referred to as behavioral health meaningful use). There are approximately 65 behavioral health organizations in the state, and, given the resources available, HIN is anticipating that it will be able to fund approximately 20 through this mechanism.

Accountable Care Organizations (Eastern Maine Healthcare Systems, MaineHealth and MaineCare Accountable Communities)

Shifting payment mechanisms based on quality performance rather than volume of services has potential for a large impact on health care reimbursement and health system organization. For behavioral health integration, this is important because the fee-for-service model of payment has provided inadequate reimbursement for care management and more generally has not valued and paid for activities that are focused on prevention and general wellness. This has the potential to change as organizations move to a structure of accountable care organizations (ACOs). The Patient Protection and Affordable Care Act (ACA) of 2010 supported the introduction of bundled payments for a range of services, including the creation of ACOs. CMS' Center for Medicare and Medicaid Innovation developed ACO pilot programs beginning April 1, 2012, along with demonstration projects for bundled payments for episodes of care in Medicaid.

In Maine, there has been a high level of participation in the CMS funded ACOs, with one Pioneer ACO and three shared savings ACO pilots³. MaineHealth has been part of the Medicare Shared Savings program and has ACO contracts with commercial insurers. For this reason, it is shifting to a new model of payment for almost all of the patients it serves

For MaineHealth, working within the ACO framework has shifted how it approaches data and how it approaches care management. Both of these areas have a potential impact on how behavioral health is integrated into the network of services going forward. The shift of the payment model has led to examination of data in new ways, including identifying populations with the highest utilization of services and the cost implications of providing more comprehensive and coordinated care. Behavioral health is certainly an area where there is interest in examining the utilization of services and cost.

³Pioneer ACO: Beacon LLC (EMHS part of Beacon Community); Shared Savings ACOs: MaineHealth, Maine Community Accountable Care, Central Maine.

However, because the ACO model has initially focused on the Medicare population, the first priorities have been to examine end of life care, which is a greater cost driver in this population.

As MaineHealth expands its ACO work to include the MaineCare (Medicaid) population, there is the expectation that there will be a closer examination of behavioral health. A major part of the ACO model is driven by utilizing data to inform priorities for action, and it is expected that behavioral health will be a major component of utilization of services for the Medicaid population. *“What is interesting about the ACO model is you can’t ignore things. Before people were able to define their own reality. With the new informatics capacity, we now have the ability to consider the real utilization patterns and costs.”*- Andrea Dodge Pastone, MaineHealth. This new emphasis on using data is likely to highlight mental health as a cost driver and potentially the value of integrated behavioral health services.

As an important component of behavioral health, the new emphasis on care management is one opportunity to advance integrated care under the ACO model. As MaineHealth reviews its current practices and structure for care management, it is considering how to target care management resources to the populations most at risk. In addition, MaineHealth is exploring how to connect care management with community and social services. This is a new emphasis and role for the health system, which has traditionally had limited relationships with community and social service providers. Renewed attention and investment in care management holds promise for sustaining part of the model for integrated behavioral health that has been traditionally underfunded.

Eastern Maine Healthcare Systems (EMHS) is another shared savings ACOs in the state. For EMHS, care coordination has also been a priority, and they have invested in developing standards for training, placing, and supervising RN care managers across their affiliated practices. In addition they have worked towards NCQA certification for Case Management, making them the first in Maine to do so. The investment in care management has been strategic in supporting the ACO model, and simultaneously has provided an important component of integrated behavioral health. An additional structural change at EMHS that supports integration is the institution of monthly population health meetings which include medical directors, care management directors, behavioral health administrators and practice administrators. These meetings are seen as critical to delivering integrated care.

Looking towards the future, one payment model offered through the Pioneer program is a quasi-capitated model. EMHS has not opted for this payment method yet, but within this payment approach the provider is free from the constructs of what gets paid in the fee-for-service model, allowing them more innovative approaches to care delivery. EMHS is also expanding beyond the Medicare population of the Pioneer ACO through participating in the Maine Accountable Communities with a large pediatric population that serves many children insured by Medicaid. This will be their first venture into an ACO model for Medicaid, with the long term intention of bringing all of the patients they serve into an ACO payment arrangement that will support population health.

Maine Accountable Communities, which was implemented in May 2014, is an ACO initiative through MaineCare that focuses on the Medicaid population and has perhaps the most potential to support delivery of integrated behavioral health. Maine is one of two states nationally (the other is Minnesota) that have been selected to pilot a Medicaid ACO where shared savings will be provided to those organizations that demonstrate cost savings and achievement of quality of care standards. Lessons learned through this initiative in Maine and Minnesota will no doubt inform how ACOs generally move forward to incorporate all populations.

The design of the Accountable Communities Initiative incorporates behavioral health, and by extension supports integration of behavioral health, in three key ways: 1) measuring cost, 2) monitoring health outcomes, and 3) leveraging existing state infrastructure for care coordination, chronic disease, behavioral health, and long term services and supports.

Behavioral healthcare features prominently in how the Accountable Communities will be monitored for quality performance. Two of the quality measures that are tied to payment are behavioral health measures, including a measure of follow-up after hospitalization for mental illness and a measure of initiation/engagement in alcohol and substance abuse treatment. In addition, there are several other measures related to behavioral health that will be tracked and monitored but will not be linked to payment.

The full impact of this level of monitoring of behavioral health outcomes as part of the ACO will not be known until the implementation of the ACOs. However, this attention is likely to further solidify and maintain the momentum of organizations' current efforts in integrated care. It may also help initiate new partnerships and more sophisticated integration, particularly in the area of integration of substance use screening in primary care. Initial pushback on the inclusion of the substance abuse measure by primary care providers indicates this is an area where they are not yet comfortable being held accountable.

Care management and partnership are required components of each of the Accountable Communities. In the initial round of applications received by the state, each of the Accountable Communities included a mix of partnerships with community-based practices (some existing relationships, some new). Lead organizations are encouraged, but not mandated, to distribute a portion of the shared savings with the community based partner organizations. Thus, the structure of the ACO should provide both a financial incentive for collaboration and integration of services, as well as a means to financially support those partnerships.

State Innovation Model Grant - Maine Health Management Coalition

The Maine State Innovation Model, a major statewide initiative that will impact payment, quality, and system design for cares, started in 2013 and is funded through CMS' Center for Medicare and Medicaid Innovation. Maine is one of only six states funded to test new models. Maine's Department of Health and Human Services (DHHS) Office of MaineCare Services is working with public and private organizations across the state and across MaineCare, Medicare, and Children's Health Insurance Program (CHIP) populations to advance health care delivery and payment reform. DHHS has selected the Maine Health Management Coalition (MHMC), Maine Quality Counts, and HealthInfoNet as implementing partners, with MHMC as the lead implementing partner. MHMC is a non-profit organization whose over 60 members include public and private employers, hospitals, health plans, and doctors working together to measure and report healthcare value. MHMC helps employers and their employees use this information to make informed decisions⁴.

The SIM Operations Plan identifies six components, or key areas of focus, for the work to achieve the objectives of reform that are aligned with the *Triple Aim* goals of improving the health of the population, improving the experience of care for Maine residents, and reducing the total cost of care. Most relevant to behavioral integration is the component of the plan "assisting behavioral health providers to transition to Health Home status through:

⁴ <http://www.mehmc.org/about-us/who-we-are> - accessed on 02/25/2014.

- 1) Participation in HealthInfoNet,
- 2) Soliciting behavioral health providers to participate in Stage B Health Homes,
- 3) A learning collaborative focused on integration of primary care and behavioral health, and
- 4) Development of behavioral health quality measures for public reporting.”⁵

MHMC is leading two efforts under the SIM that will make data on the value of behavioral health and integrated behavioral health more readily available than ever before. The first is developing better metrics for monitoring and improving quality of care, and the second is reviewing behavioral health costs as part of their strategies to reduce healthcare costs. This work builds on MHMC’s long history of measuring and reporting on health care value. In its early work of developing quality measures for public reporting, depression was a specific condition of focus, but early efforts in this area had faltered. Under SIM there is now new emphasis to consider the best behavioral health metrics, to be used not only for public reporting but ultimately by health plans for rating providers as part of their tiered provider networks. The challenge for behavioral health metrics has been identifying viable ways to measure behavioral health in ways that providers and consumers agree to, where measures are scientifically valid. Behavioral health is now on the radar of the major employers in the state, and as the major purchasers, they are interested in seeing behavioral health metrics and designing benefits around those measures-

The current process for metric development at MHMC is developing an expert work group to review, vet, and endorse metrics for behavioral health. Behavioral health metrics will include measures to assess integration of behavioral and physical health and quality of behavioral health. The expert work group will consider integrated care broadly and will not limit it to co-located physical and behavioral health. The current emphasis is on metrics for the general community population and not specifically those with severe and persistent mental illness.

The metrics will be based on claims data, and as part of the SIM work, look specifically at MaineCare and Medicare claims. This will be the first time Maine will examine behavioral health claims data in a robust way. In addition, the public reporting of these data will be expanded under the SIM grant with a new website under development for public access to the chosen quality metrics. This new site will make behavioral health metrics public for the first time in Maine. The intent of the public reporting is to encourage value in health care by offering high quality services at a reasonable cost. Adding behavioral health metrics to the public reporting data set has the potential to advance integrated care as a component of high value health care.

The review of behavioral health costs is the second area of work MHMC will be leading as part of SIM. The development of new payment models is one of the four components of the SIM Operations Plan. The SIM activities to develop new payment models include encouraging transparent data reporting on cost and outcomes and identifying actionable strategies to reduce healthcare costs. MHMC will be leading a SIM-initiated work group dedicated to reviewing behavioral health costs, as behavioral health conditions are recognized as a significant cost driver for the overall health cost of the MaineCare population. The review of cost data will provide another opportunity to understand more deeply the current costs of care due to behavioral health needs and potentially better understand the value integrated health brings to meeting the goal of providing high quality, lower cost services with better consumer health outcomes.

⁵ Maine State Innovation Model (SIM) Summary (July 29, 2013).

Maine Primary Care Association

The Maine Primary Care Association (MPCA) is a membership organization representing the state's 19 federally qualified health centers (FQHCs), or community health centers, that serve as a key component of Maine's health care safety net, providing care in 65 locations spanning the state. Under the focus of "continuous quality improvement" the MPCA has placed an emphasis on behavioral health integration as a part of comprehensive care in primary care settings.

The MPCA has been working toward its goal of integrating behavioral health at each of its member FQHCs. As of January 2014, there has been at least some level of integration at all but one of those health centers. From MPCA's perspective, Maine's work toward behavioral health integration for the safety net population is ahead of the curve compared to many other states. While the definition of what it means to be "fully integrated" is evolving, many of the health centers have been adopting a model of warm hand-offs through co-location of behavioral health services in the primary care setting. In the process, health centers are finding ways to strike a balance with flexible scheduling and new work flows, to have regular appointments while allowing enough open time in schedule for crisis or warm hand-offs with behavioral health providers, and to develop scripts between providers to facilitate hand-off. Moving forward, MPCA hopes that behavioral health integration will spread to every site of each FQHC. MPCA is encouraging the sharing of strategies between health centers as an important means of achieving that goal.

In order to foster collaboration between FQHCs and develop working relationships around behavioral health integration, MPCA is hosting a two-year learning peer partnership collaborative, funded by MeHAF. One third of the FQHCs in Maine participated in year one of the program, in which seven core sites built mentor relationships around individual integration projects, including developing a role for Medical Assistants in behavioral health work flows and integration, training of providers in warm hand-offs, and integrating screening tools into regular work flows. Participants continue to have interest in learning more about how to operationalize integrated behavioral health within their organization.

The funding from MeHAF provides a stipend to mentor sites for providing support and a small stipend to mentee sites for data collection and reporting. Health centers reported that the technical assistance was valuable, but most important was the opportunity for relationship building with a peer health center that could be a resource to them on this topic. The structure to enhance these partnerships include required participation in the learning collaborative, two in-person meetings, and monthly conference calls to discuss individual projects and learn about emerging trends in the field of behavioral health integration. Sites were evaluated through monthly data check-ins and reported on the total percent of the population receiving behavioral health and primary care, the total percentage that received a referral, the percent of chronic care patients getting regular behavioral health integration support, and the proportion of patients completing regular self-assessments. The second year of the peer partnership learning collaborative is still in development, but many of the current participating health centers are interested in continuing as mentor sites in the next round.

The MPCA's support of behavioral health integration provided experience for health centers in applying for patient centered medical homes, behavioral health homes, and other current initiatives in Maine. FQHCs are represented on the Steering Committee for the State Innovation Model grant, 2 FQHCs applied to participate in the Maine Accountable Care Communities shared savings ACO, and 15 are participating in the Health Homes pilot.

MaineCare Health Homes and Behavioral Health Homes

Stage A of Maine's Health Homes initiative began in January of 2013 with 150 participating primary care practices and community care teams for MaineCare patients who have two chronic diseases or have one chronic disease and are at risk for another. Stage A Health Homes are aligned with the state's patient centered medical home initiative and are an opportunity for sustainable funding from MaineCare through a per member per month payment model. Maine's Health Homes, following ACA guidelines, offer care management of physical and mental health needs, care coordination and health promotion, help in transitional care, support for self-management of physical and mental health conditions, referral to other services, and the use of health information technology to link services. Though not federally required, Maine included integration of behavioral health services into health homes as a core requirement. Maine received NCQA recognition for its Stage A Health Homes on December 31, 2013, which continues receipt of the PMPM payments. Quality Counts provides technical assistance for practice transformation to the Stage A Health Homes and supports the development of Stage B Behavioral Health Homes through a learning collaborative (funding for both provided through the SIM grant).

Starting in April 2014, MaineCare offers Stage B Behavioral Health Homes, a new service for adults and children with significant behavioral health needs. Building upon the foundation of Maine's Stage A primary care Health Homes initiative, Stage B behavioral health care organizations will serve as the health home and work toward integrating primary care services for their behavioral health patients.

Stage B applicants must be community-based, licensed mental health providers that partner with one or more primary care practices to manage and coordinate the physical and behavioral health care of individuals with significant mental health and co-occurring needs. They will serve a specialty population of adults and children who have needs that are not able to be managed in a primary care office, providing each member with case management and community services integration from the participating partners. MaineCare approved 27 geographically- dispersed practices in early 2014 to become behavioral health home organizations. Awardees will begin implementation in April 2014. Several measures will be tracked for quality reporting, including NCQA, HEDIS, and Health Home core measures as well as Stage B-specific measures targeted at behavioral health integration. Measures will be collected through claims data, clinical data, and a mental health and wellness survey (collecting patient experience data).

Cross-Cutting Findings

The sustainability of integration is dependent on the clinical model delivering desired outcomes of patients and providers, the availability of the infrastructure to support integration, and the financial models to support it. Here we describe our findings in these three areas based on the key informant interviews and review of other materials.

Clinical Integration

The scope of clinical integration of behavioral health in Maine is impressive. There is no longer the question of whether behavioral health and primary care should be integrated, but rather how best to do it. Incorporating behavioral health as one of the ten required components of the patient-centered medical home was a critical policy intervention that ensured that behavioral health integration was the norm as the health system in Maine transitions to a system where primary care serves as the hub and coordinator of health services. The 75 practices affiliated with the PCMH pilot will continue to have

access to PMPM funding through the end of 2014, which is important to providing the case management and other support services that are critical to integrated services delivery. At the time of writing this brief, there were 150 MaineCare (Medicaid) Stage A Health Homes in Maine.

Similar to the PCMH initiative, Maine's Behavioral Health Homes included a state-specific requirement of behavioral health and primary care integration, above and beyond what was required by the federal funding. The experience with PCMH will be carried over into the Behavioral Health Homes Stage B, which focuses on behavioral health settings integrating primary care to better care for those living with serious mental illness.

The Federal Department of Health and Human Service's Region I Regional HRSA office challenged Maine to become the first state to have all of its FQHCs practicing integrated care. Supported by MPCA, they are attempting to do just that. Using funding through MeHAF, the MPCA is hosting a two-year peer partnership collaborative, where mentor sites (those already integrated) work with mentee sites on particular integration projects, such as training providers in warm hand-offs and incorporating screening tools into clinic flow.

Most of the clinical implementation sites funded by MeHAF maintained, at least to some extent their integrated services. Some others spread their integrated efforts significantly, most notably HealthReach Community Health Centers, Penobscot Community Health Care, and Tri-County Mental Health Services, which expanded integrated care services to all of their sites.

It is clear that in Maine behavioral health integration is entwined with health care delivery system transformation and one cannot be separated from the other. As with health systems transformation more broadly, the concept and practice of integrated care continues to evolve. How integrated care rolls out in an ACO model remains to be seen. Maine's Medicaid ACO pilot, Accountable Care Communities, emphasizes behavioral health, requiring coordination with behavioral health as part of the ACC requirements. There will also be behavioral health associated metrics that ACCs will collect. As health systems continue to tackle the cost issue, there is the recognition that behavioral health issues increase overall health costs. Behavioral health integration (whether through primary care as the starting point or behavioral health care as the starting point) is a potential solution. However, there was the sentiment among a few of the key informants that the ideal integration model is not yet known. As one key informant noted, the business case has not yet been made. It is also unclear to some key informants whether all patients require access to integrated behavioral health services and/or full PCMH services or whether better targeting more intense services through risk stratification is a better direction to move forward.

Infrastructure

Two "infrastructure" themes were identified through the key informant interviews that are essential to integrated care moving forward: 1) the continued focus on development of appropriate quality improvement metrics for behavioral health, and 2) the support and technical assistance still needed to help providers integrate. Behavioral health measures are still under development. There have been multiple attempts to develop them, but there is currently not widespread buy-in or use of these metrics. There is a renewed effort through the SIM grant to develop such measures, which the MHMC is spearheading. New initiatives, such as the Accountable Care Communities, will be instituting quality metrics for behavioral health and substance abuse that will offer important insights for other stakeholders.

Revising Maine’s law regarding the release of mental health records was a remarkable step forward for integrating services, where providers are able to view services received in mental health settings if patients consent and opt in to sharing their records. Following this change in state law, HIN is making good progress in bringing behavioral health providers onto the exchange, although they have been hampered by the lack of electronic health records in behavioral health systems, from where data are drawn for the HIN. The SIM grant is providing funding for HIN to support the adoption and use of EHRs for quality improvement in some behavioral health settings. There still remain many thorny issues related to sharing of behavioral health data through the health information exchange that HIN and other stakeholders continue to work through. One major barrier is Federal law 42 CFR, which governs the use of substance abuse data. Although HIN has been an active participant in discussions with SAMHSA related to this law, it is unlikely to change in the foreseeable future since it requires Congressional action.

Through funding from MeHAF and through SIM, practices have had significant support and technical assistance related to infrastructure that supports integrated care. This has included the MeHAF learning collaborative, technical assistance offered through QC to the PCMHs and Health Homes, support to HIN, and-peer mentoring assistance organized through the MPCA. This type of support and technical assistance is critical. QC and the MPCA’s support will continue, at least for the next year, which will help in ensuring that integration remains a priority for practices.

Payment

Payment reform is a significant driver for health system delivery reform, and that includes behavioral health integration. Through the Affordable Care Act, several innovations in payment reform have been encouraged through the Center for Medicare and Medicaid Innovation. In Maine, the innovations of patient centered medical home, ACO development, and the SIM grant are all encouraging changes to move from fee-for-service payment to new models of payment. While there is a lot of potential in these changing payment models, the early state of testing means that it will be several years before it is truly understood how these changes will impact integrated behavioral health. In addition, interviewees noted that it still remains challenging to measure the cost benefit of integrated service models compared to traditional primary care and behavioral health arrangements.

In the future, it is expected that there will be more in-depth analysis of the total utilization of behavioral health services and their impact on total health care costs. This analysis will be conducted under the SIM grant by the Maine Health Management Coalition and may also be done by individual ACOs as they use data to better understand opportunities for cost savings. Analysis of behavioral health costs will improve the understanding of the value of integrated behavioral health.

The shared savings structure of ACOs has the potential to support integrated care in two important ways. Firstly, through analysis of data, there will be more information on the impact of mental health and behavioral health services on total cost and outcomes for patients. Through this analysis the business case for investment in integrated behavioral health could become better defined. Secondly, the ACO model offers a new way to pay for care management. This is important to sustaining integrated care, because care management is a key function of integrated behavioral health that practices struggle to finance. It is not clear that organizations will choose to invest cost savings received from ACO payment arrangements into supportive services such as care and case management. However, the new payment model offers more flexibility to pay for these services.

The increase in per member per month payment (PMPM) models further supports payment of care management and case management. Patient centered medical home PMPM payments in the pilot, if continued and expanded to non-pilot sites, can help support costs of care management in the primary care setting. The Behavioral Health Homes initiative PMPM payments will pay for case management and community integration, linking patients' behavioral health and primary care services. Reimbursement for integrated services has been a consistently large barrier to clinical integration. Supplemental payments, such as the PMPM payments through the PCMH and Health Home pilots, assist in enabling integrated services. A threat to some of the progress that has occurred around integration could be the reduction or elimination of PMPM support as the pilots wrap up. Potentially, ACO models will place new emphasis on care management supporting new payment models and new emphasis on its importance.

Conclusion

Integrated care is increasingly seen as an element of high quality health care services; although there is not one right model of integrated care for all settings and populations. There has certainly been a trajectory in Maine for clinical implementation and system transformation, from the seed money provided by MeHAF, to incorporation of integrated care into the PCMH pilot, into the Health Homes pilots and SIM initiative. How integrated care is incorporated into the ACOs will be the next important venue for clinical implementation. Maine, as one of two states participating in the Medicaid ACO, Maine's Accountable Care Communities Initiative, will be on the leading edge of understanding the impact of a Medicaid ACO for the integration of behavioral health, primary care, and other community services on the health of low-income populations more generally. The ACOs will also be the laboratories for developing and testing quality metrics and payment innovations related to behavioral health and primary care integration. Continuing to build the infrastructure, especially related to metrics and the capacity of behavioral health providers to be full partners in the emerging reformed health system, is critical for integrated care to move forward. Integrated care is fully entwined with health reform efforts in the State of Maine; how integrated services move forward is inseparable from the broader context of how health reform moves forward in Maine.

Attachment

Source List

| Key Informant/Source | Organization | Date |
|--|---|---|
| Lisa Letourneau, Executive Director | Maine Quality Counts | November 11, 2013 |
| Shaun Alfreds, Chief Operating Officer | HealthInfoNet | November 12, 2013 |
| Andrea Dodge Pastone, Vice President, Strategic Initiatives | MaineHealth | December 4, 2013 |
| Michelle Probert, Director of Strategic Initiatives | Office of MaineCare Services | December 16, 2013 |
| Ellen Schneider, SIM Project Director | Maine Health Management Coalition | December 16, 2013 |
| MaineCare Behavioral Health Homes presentation | Maine Quality Counts | November 26, 2013 (presentation date) – watched archived webinar on December 20, 2013 |
| Darcy Shargo, Chief Operating Officer | Maine Primary Care Association | January 15, 2014 |
| Maine State Innovation Model: The Operations Plan for Sustainable Health Care Reform | Maine Department of Health and Human Services | August 2013 (date on document) – reviewed December 2013 |
| Michael Donahue, Vice President of Network Development and ACO Activities | Eastern Maine Healthcare Systems | May 13, 2014 |