

PCM Adult BHI Design Group 2

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Consumer Comments, Questions, Feedback from Meeting 1

- Need to understand how the proposed payment model options will impact patient care
- Need for better screening for early identification of behavioral health issues including but not limited to depression and substance abuse
- Need to include social determinants of health as part of the assessment
- Need to recognize the opioid crisis
- Patients with behavioral health problem have shorter life expectancy
- Clinicians need training in initial mental health assessment and treatment
- Having a mental health clinician (SW, APRN) in the office as part of the team can improve appropriate treatment options
- Reimbursement for behavioral health services is adequate
- Insurance companies provide inadequate information lists for referrals to behavioral health services and causes delays in treatment
- Many behavioral health service providers do not accept insurance
- Inadequacies in the behavioral health system may lessen the impact of additional connections through primary care

FHC: are we missing anything?

- Consumer: I don't think so. I think we'll probably address some issues that are maybe related as we get into it and don't have anything to add right at this moment
- Provider/Consumer: this is a good list, suggest we put a separate item for cultural confidence, something for linguistic disparities

Primary Care Modernization Model

- Advanced Networks and FQHCs that participate in shared savings arrangements will be eligible to participate in the PCM payment initiative
- The payment model offers flexibility from rigid limits on PCP office visit durations and how services are delivered. It will cover codes and services provided by primary care practices.
- Behavioral health providers (and other specialists) will be paid under separate arrangements with payers. The addition of behavioral health capacity to primary care could help increase access to BH specialists through prevention and short-term interventions.
- Other design groups are addressing the opioid crisis, including Pain Management prevention strategies and Medication Assisted Treatment
- The timeline for implementation of the PCM payment model is late 2020/early 2021.

Design Group Recommendations from Meeting 1

- PCM Model should support:
 - Training for both primary care and behavioral health providers on teaming and collaboration
 - Flexibility to provide services in different settings: primary care office, home or shelter
 - Development of outcome measures that reflect a PCP's progress towards defined goals
 - New case specialist and care management services that are the focus of recent certifications
 - Patient populations who have higher illness burdens and/or SDOH challenges will need more intensive behavioral health staffing integrated into the care team
 - PCM Payment Model should provide an adequate level of reimbursement to network and practices to fully implement these strategies
- Consumer: (comment for slide 4) The 2nd and the 3rd bullet related to the payment model and behavioral health specialty makes complete sense to me to keep the specialists separate. However, I think for providers who are ready to move to a fully integrated model, that could present some challenges. Will a behavioral health specialist be able to work side-by-side with a behavioral health clinician?
 - FHC Expert: Reframe it a little. The behaviorist who is part of the care team (and traditional behavioral health) ideally is attached to primary care. Then, its part of the bundle.
 - Are regulatory agencies that license facilities that do behavioral health of a similar mind?
 - Consumer: We are talking about full integration on the behavioral health care team which is a different level of coordination then what is described here. There is a higher level of integration that can take place
- Provider: The behavioral health case manager/care coordinator is separate from a behavioral health provider, but I agree with what the Consumer is saying.
- Provider: You define behavioral provider differently in a couple of different places.
- State: We can't bill into the PMPM the services of an integrated BHS or BHC unless it's going to happen.
- Provider/Consumer: Just want to make sure the annual limit for these licensed services is no different than from primary care.
- State: There are working primary practice models with full integration.
- Consumer: If not every practice could do it in modernization, perhaps there can be some pathway.
 - State: We are focused on FQHCs, integrated care partners, and mental health. What is it about those settings that wouldn't get them to fully integrated health within three years?
 - Consumer: This is not necessarily a barrier. It just takes time to move cultures and develop a full commitment to that type of practice because its very different to what's currently being done in many primary care settings.
- State: I don't get how if we basically say the package is, "You'll hire a BHS and a BHC and here's a model for your workflows." It's not clear to me why we wouldn't push the envelope on this,

especially when we have a shortage of integrated behavioral health. Improving access by onboarding and integrating behavioral health is the goal.

- Consumer: Right now, a BHS wouldn't be paid for within the bundle, it would be the BHC.
 - State: No, I didn't say that. You can have the services of a BHS built into the bundle for flexible support of the practices with a range of services. So, the practice doesn't have to worry whether any given activity isn't eligible for billing and lightens administrative requirements.
 - In terms of billing in a BHS, why can't we expect this to happen?
 - Consumer: It sounds fabulous.
 - FHC Expert: The workforce availability and training take a fair amount of time.
 - State: Modeled it out to a PMPM in Rhode Island, so it can be done.
 - Consumer is saying they want someone to be able to collocate it.
- State: Onsite, collocated is the optimal. You could introduce the cost of the BHS to the PMPM payment. Just because we roll in the cost of the BHS doesn't mean collocation is the only way this could work.
- Virtual video support does provide for a level of dedicated BH resources to practices that they don't have today.
- Consumer: I support the use of telemedicine & telepsychiatry. This is the ideal way to be able to do this along with collocated services.
- State: I think we are going to have to be specific with the Payment Reform Council. We can create bundle payment options where the primary care PMPM includes full integration resources. The question is, should we model from a pay integration perspective? Once we have a plan for higher up to integrate over the course of 5 years.
- Consumer: I agree. We want to provide incentive and acknowledge the reality of the current level. I would think we need to have a conversation about the behavioral health coordinator. Would need to take up SDOH. I want to make a distinction of what the behavioral health coordinator is taking on in the versions you are talking about.

FHC discussed the provided draft diagram and explained the idea is that the patient and the primary care practice team are at the center.

- Primary care practice manages everything to top of brief intervention.
- FHC: We heard we would modify this to also include a BHS to take on some of these functions.
- Where should the blue box end?
 - FHC Expert: Include anxiety screening as part of the core. There must be flexibility. If you're talking about a brief intervention, you can train MAs and CHWs to do this for mild to moderate substance use issues.
- Provider/Consumer: There are many patients in community health centers not seen. Extended therapy and counseling should be included.
- Consumer: What can be done within the practice and what needs to be referred out? I think one of the most critical elements of this is to know when a treatment requires a specialist.
- State: We have other licensed professionals in the second arrow that all can practice within their scope.
- State: How narrowly do you define the role of the BHC?

- The Alaskan model makes sense. The lines in the diagram are clearly defined between PC and BH. There should be a little more overlap where patients are managed primarily by a PC.
- Provider: Episodic care is also a role for the embedded behavioral health person. Our role is prevention, consultation, and then the brief intervention in episodic care.
- Consumer: Some things are missing in this diagram. In prevention, screenings as well as interventions → make sure screenings are included in that. We want to make sure we are putting substance abuse in there.
- FHC Expert: The issue around substance use treatment is important.
- Provider: When folks are mentioning screenings, there is just those two levels of screening. Targeted screening could be put into the behavioral health pocket and 2nd stage screening is another useful role.
- State: I would like to circle back and discuss the 2nd arrow and how it should be expanded to include other licensed BHS.
- Have it unambiguous that we are folding in a dedicated resource, and a dedicated resource doesn't necessarily mean on site.
- State: Extended therapy and counseling box could be changed.
- Brief interventions should be brief interventions/consultations.
 - Provider: Agrees
- FHC Expert: maybe we put into brief intervention or primary care but in a truly integrated system, the role is doing these things and the idea of the patient primary care team practices around like the BI
- Consumer: Would still like to see some wording around substance abuse
- FHC Expert: This idea that you're either providing or arranging and integrating a brief intervention component is a primary care function.
- Consumer: If someone has a real substance abuse problem, they need to be at a clinic.
- Provider: It is reasonable that a trained BHP is going to have some basic skills in substance abuse, but just like other conditions, they don't need to be experts. The care coordinator vs. the BHP (can screen and help determine what the next best step is).
- FHC Expert: FQHC that the social workers usually have experience in brief intervention or figuring out if the person needs treatment and will make the right referral
- FHC Expert: Technical assistance should be on the advisory committee.
- State: Felt duty-bound to visit the screening issue. We need to figure out how to resolve it and whether to resolve it.
 - State: There has been a debate as to whether every person should be screened every year. I think OHS does need to get to some kind of consensus recommendation.
 - FHC Expert: Depression and substance-use are no question. Anxiety, yes. This is the first time I've heard of trauma (what else, if anything?)
- Provider: It makes a lot of sense to include technology folks (tablets are great)
- Consumer: Substance abuse, anxiety, and depression at the core. Other assessments may be appropriate, but generally, you're covering for those three. I have concern over universal screenings. If you have a BHS as part of the payment bundle, that's going to help deal with the shortage issue. It's probably better to address screening as a standard. Not sure exactly which one should be included. The workforce needs to be a part of how we make this decision.

- Provider/Consumer: I conducted four basic screenings as a BHS, and I did this when I was working within a primary care setting.
- Provider: I do worry that making this mandatory is problematic.
 - FHC Expert: Agrees.
 - Provider/Consumer: Agrees.
- FHC: The next step is to ask the FHC Expert to develop a list of screenings that we will circulate and get confirmation from the group.

Performance monitoring recommended measures

- Consumer: Accountability is important, but not sure what measures are available. Want to be able to have that data and have it analyzed in improving health equities.
- Provider: When you make a referral outside of the practice, who is following up on that?
- FHC Expert: The number of things stated here in descriptive standards requires more work and thinking.
- FHC Expert: Participating in the data gathering is an important aspect of the program.
- FHC Expert: Performance expectation in the practice and what the data requirements are at the community level.
 - FHC: The data needed to measure that the integration is actually happening.
- Consumer: How many patients are being seen by a BHS, how many referrals are being done, how many community connections are being made, and how many follows up happen → There are some basic things to show the structure we are trying to put into place. It's important to know you're able to quantify it and are able to have data.
- Provider: In terms of health outcomes, are better ranges being met?
- FHC Expert: We must start small with some process outcomes and then build up.