



Serving the Needs of Medicaid Enrollees with Integrated Behavioral Health Services in Safety Net Primary Care Settings

April 18, 2008

This Issue Brief was prepared by the National Association of State Medicaid Directors (NASMD) under contract with the Health Resources and Services Administration, U.S. Department of Health and Human Services.

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Introduction

A recent trend in behavioral health care has been the increasing integration of behavioral health services¹ into primary care settings. This paper discusses the benefits of such integration and the role of safety net primary care providers as behavioral health providers within the Medicaid program. The Health Resources and Services Administration (HRSA) is a grant funding source for safety net providers and programs, and has encouraged FQHCs, Ryan White HIV/AIDS program organizations, maternal and child health clinics, and Rural Health providers, to develop and implement dynamic behavioral health initiatives as Medicaid providers. As demonstrated in the following four state initiatives, state Medicaid agencies are pursuing a range of approaches for the integration of behavioral health services in primary care settings – fostering positive working relationships between primary care safety net providers and the specialty mental health sector for the benefit of Medicaid enrollees. Two fundamental characteristics of these approaches are the organizational structure and the reimbursement model for behavioral health services. Each of these characteristics is discussed within the context of various state programs.

This paper does not attempt to speak to the totality of issues that should be addressed in the discussion of integrated behavioral health care services. Other important issues of concern include: maintaining patient continuity of care when a state “carves out” behavioral health services within a Medicaid Managed Care Organization contract; training primary care providers to better recognize clinical signs of a mood disorder for prompt referral to behavioral health treatment, and finally, the impact of reimbursement rates on provider availability and timely access to necessary services. These issues have a tremendous cumulative impact on the effectiveness of mental health service delivery in America and largely remain unresolved. The state programs examined here have all used various approaches to ameliorate these systemic concerns, but no one solution has yet emerged

¹ For the purposes of this paper, behavioral health services are defined to include both mental health and substance abuse services.

Background

Integrated Health Care Systems

Behavioral health care is widely considered essential to ensuring the well-being of individuals and a critical component of strengthening the nation's health care system. However, a coordinated, cost effective behavioral health care system that provides access to high quality preventive, diagnostic, and treatment services is a more recent phenomena. Today, the nation is moving towards integrated systems of care that address both behavioral and medical needs.

In their lifetime, approximately one half of the United States population will meet criteria for a mental diagnosis, as defined by the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV).² This finding is supported by the President's New Freedom Commission on Mental Health. According to the commission's 2003 report, mental illness is frequently detected long after its onset. As a result, services focus on living with disability, rather than on how to achieve the improved outcomes that are associated with effective early intervention. The Commission recommended a dynamic shift in care, toward a model that emphasizes early intervention and disability prevention.³ Behavioral health conditions are not uncommon among Medicaid beneficiaries, and are often complicated by co-morbid physical conditions. Providing behavioral health services in primary care settings may facilitate the provision of preventive and early intervention services, primarily as a result of close proximity and the development of working relationships between primary care and behavioral health providers. Research has demonstrated that this organizational structure may also lead to the promotion of coordinated care for beneficiaries. Experiences in developing systems of integrated care, to date, demonstrate that a confluence of factors is necessary in order to realize the full benefits

² Kessler, R. et al. Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Co-morbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62:593-602, 603-613.

³ New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

of integration. First, these stakeholders must work collaboratively to develop policies and secure resources to support the transition to integrated medical and behavioral health services. And second, integration initiatives must be driven by a strong leadership that can identify challenges, work with all stakeholders to address any barriers, and ensure that resources are available to sustain the initiative.

Behavioral Health Integration in Medicaid

Medicaid is the federal-state program that serves as the principal safety-net health insurance program for low-income Americans. The Medicaid program covers over 50 million low-income people, many of whom have multiple chronic conditions. Medicaid is the main public funding source for behavioral health services and the primary source of funding for public managed behavioral health care programs. At the state level, contributions from the Medicaid program account for nearly 50 percent of behavioral health care spending – the largest component of the states’ overall spending on behavioral health services.⁴ In 2003, between 9 and 13 percent of all Medicaid dollars were spent on behavioral health care. While these services are provided in a range of settings, primary care settings are increasingly utilized for delivery of behavioral health services.

<p>Fee-for-Service – The unit of payment is the visit or the procedure.</p> <p>Capitation – One payment is made for each individual’s health care during a set time period. Typically associated with managed care.</p> <p>Carve-out – Reimbursement is “carved-out” of the capitation and paid separately.</p>	<p>States have used the flexibility of the Medicaid program to design new programs and reimbursement models and to strengthen existing initiatives that seek to integrate behavioral health services into primary care settings. Experience to date demonstrates that states have been successful in varying their approaches in ways that meet the unique needs of Medicaid enrollees. For example, some states employ a managed care model to deliver behavioral health services. Within managed care programs there is wide variation,</p>
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⁴ Mayberg, S. “Medicaid’s Future: Navigating Rapids, Rip Tides, and Reform.” California Department of Mental Health. Presentation at the National Academy for State Health Policy Conference, Portland, OR. August 4, 2003.

with some states using capitation and a “carve-out” approach, whereby certain services are provided on a fee-for-service basis, while others utilize managed behavioral health care entities. Other states provide for behavioral health services using the traditional fee-for-service (FFS) model. Medicaid agencies also are leveraging the expertise of qualified non-physician providers to deliver some behavioral health services, such as licensed clinical social workers (LCSW) and licensed professional counselors (LPC).

Essential to the success of these initiatives is the participation of and collaboration with Medicaid’s safety net of primary care providers, particularly since they often are the first practitioners to identify a mental health issue. Safety net organizations employ uniquely trained providers that are able to screen patients, provide a level of care management, treat certain behavioral health conditions, and refer to appropriate specialty care providers when necessary. Medicaid safety net providers fill a specific need for the individuals they serve, providing coordinated behavioral health services in an environment that is convenient and accessible for Medicaid beneficiaries. Their role is particularly crucial in rural localities and shortage designated urban areas; as such areas typically have fewer mental health providers and inpatient facilities, as well as lower utilization rates for mental health services than other provider settings.⁵

HRSA provides financial support for a number of programs that comprise the nation’s health care safety net. These programs are designed to provide care to the uninsured population, people living with HIV/AIDS, and pregnant women, mothers and children. Among HRSA grantees are: federally qualified health centers (FQHCs), Healthy Start maternal and child health programs, and Ryan White HIV/AIDS programs. Across these programs, and within the set of grantees for each individual program, there are a range of primary care settings that incorporate and integrate the provision of behavioral health services with the delivery of medical and social services.

The increasing demand for behavioral health services has required that each of these programs and the participating providers evolve to meet the behavioral health needs of the

⁵ “The Role of Rural Primary Care Physicians in the Provision of Mental Health Services”, Letter to the Field No. 5, by Jack M. Geller, et. a., Marshfield Medical Research Foundation. Available online at www.wiche.edu/mentalhealth/frontier/lettert.html.

people they serve, including Medicaid enrollees. In 2006, there were 1.4 million visits to FQHCs for depression and other mood disorders alone.⁶ In 2006, 35 percent of the people served by FQHCs were Medicaid beneficiaries,⁷ and 76 percent of health centers provided mental health services onsite, while 99.4 percent of health centers provided mental health services onsite or by referral.⁸ The Institute of Medicine reports that as many as 50 percent of HIV/AIDS patients may experience a behavioral health co-morbidity.⁹ In addition, with respect to maternal and child health, 1 in 10 young people suffer from mental illness severe enough to cause some level of impairment, with fewer than 20 percent receiving treatment in any given year.¹⁰

FQHCs	Maternal & Child Health	HIV/AIDS
1.4 million visits for depression	1 in 10 young people suffer from mental illness	50% of patients have behavioral health co-morbidity

Safety net primary care providers play a unique role for the populations they serve, while also filling a need in the Medicaid program. The provision of behavioral health services in the primary care setting is a critical component of the overall behavioral health system across the states. This paper profiles four states (Michigan, New Jersey, Delaware, and Oklahoma) to illustrate positive programming and policy in the areas of behavioral health service provision, with specific consideration of the essential role of Medicaid.

Methodology

The information for this paper is based on a series of interviews conducted during the summer of 2006. Representatives from the Medicaid agencies in Delaware, Michigan, New Jersey, and Oklahoma completed questionnaires and participated in conference calls to discuss the provision of mental health services in their respective state Medicaid programs.

⁶ Bureau of Primary Health Care, HRSA, DHHS, 2006 Uniform Data System.

⁷ 2004 Access to Community Health Databook: New Jersey. National Association of Community Health Centers, Inc.

⁸ Bureau of Primary Health Care, HRSA, DHHS, 2006 Uniform Data System.

⁹ Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White. Institute of Medicine. Released May 13, 2004.

¹⁰ *National Action Agenda for Children's Mental Health, U.S. Surgeon General, 2000. Available online at <http://www.hhs.gov/surgeongeneral/news/pressreleases/pressreleasechildren.htm>*

In addition, conference calls were held with representatives from various HRSA-funded safety net organizations in those same four states. When possible, a joint call was held with several provider organizations in each of the states. This allowed for an opportunity to increase communication within the states and share information across provider groups, with Medicaid as the common denominator.

State Snapshots

Michigan

Michigan has pursued several models for the provision of behavioral health care in its efforts to integrate these services with primary care medical services. Michigan's models emphasize the importance of care coordination and utilize the unique expertise of safety net providers to ensure positive health outcomes.

The Michigan Medicaid program organizes the provision of behavioral health services separately for the severely and persistently mentally ill (SPMI) population and the mild to moderate mentally ill population. Through the state's 1915(b) waiver, the Michigan Specialty Services and Supports Waiver Program, Medicaid is obligated to provide services to the SPMI and substance abuse populations. The waiver is tied to the community mental health system, and the state pays capitated rates. This relationship essentially functions as a managed care system that uses community mental health; a quasi-public system. For the Medicaid population with mild to moderate behavioral health needs, services are received either on a fee-for-service basis, or through one of the state's 16 managed care plans. Individuals that may receive behavioral health services in a primary care setting are likely to do so through a managed care organization, which in turn contracts with a behavioral health provider. Behavioral health services are partially carved out of the managed care contracts, as the carve-out applies only to substance abuse services and specialty services for the SPMI population. The managed care organizations support the provision of services in safety net settings, through their funding structure, and the state Medicaid agency encourages the use of FQHCs. Michigan Medicaid has begun to reimburse brief therapy visits, which gives safety net providers with qualified professionals the opportunity to provide behavioral health services as an adjunct to a medical visit when behavioral health issues are identified. Physical

and behavioral health coordination is a priority for Michigan Medicaid. The state focuses on this type of care coordination on its annual site visits to the state's managed care organizations. Each plan is required to demonstrate its efforts to coordinate the physical and behavioral health services and illustrate best practices.

Thunder Bay Community Health Center is a FQHC located in rural Hillman, Michigan. Approximately 40 percent of Thunder Bay's clients are Medicaid beneficiaries, and the center is the sole primary care-behavioral health provider in the area. Thunder Bay has operated an integrated behavioral health program for five years and offers regularly scheduled visits for behavioral health care, as well as on-the-spot services for individuals that have not made an appointment but require care. The behavioral health providers, referred to as consultants at Thunder Bay, share a single chart with the primary care physicians for each client – a key component of the full integration model. Thunder Bay employs several behavioral health providers, including a full-time licensed psychologist, a full-time licensed professional counselor, and a part-time psychologist, licensed clinical social worker and

Demonstrations and Waivers

Section 1115 Research & Demonstration Projects: This section provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.

Section 1915(b) Managed Care/Freedom of Choice Waivers: This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.

Section 1915(c) Home and Community-Based Services Waivers: This section provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid

alternative to providing comprehensive long-term services in institutional settings.

psychiatrist. In order to facilitate the movement from primary care to behavioral healthcare, a registered nurse does limited case management, making referrals to the behavioral health consultants when appropriate.

Thunder Bay bills Medicaid directly for all behavioral health consultants except for psychiatrists, who bill under a physician's provider number. After a Medicaid client has been in Thunder Bay's behavioral health system for more than a year, the individual is classified as SPMI. Medicaid enrollees are allotted 20 FQHC behavioral health visits per year. After these visits have taken place, the client is referred to the community mental health system to receive care. At that point, Thunder Bay essentially transitions into a role of case manager for the client and works to ensure that the patient is receiving all the medical and behavioral health care he or she needs. The state Medicaid agency has made it a priority to meet with providers and executive staff to ensure that clients are being appropriately cared for and, as a result, furthering care coordination across the systems.

Behavioral health services are also provided within Michigan's tribal population. Medicaid is a main funding source for several of the tribal behavioral health programs in Michigan. Some of the tribes are also part of the Maternal and Infant Health Program, a Medicaid funded program that provides specialized preventive services to pregnant women, mothers, and their infants, including behavioral health services. Another model for the integration of behavioral health services within the safety net primary care setting is the Healthy Start maternal and child health program operated by the Inter-Tribal Council of Michigan, a consortium of Michigan's federally recognized tribes. The majority of the Michigan Healthy Start clients are Medicaid beneficiaries. The Healthy Start nurses on staff provide primary care for women and children, including screenings for depression and other behavioral health conditions. In addition, the Healthy Start nurses provide "wrap around"

services, or services that support and supplement, those provided by the primary care provider (PCP). For example, these nurses are uniquely positioned to initiate comprehensive depression screening because of their close contact with women who utilize the program and are at an increased risk for behavioral health problems, such as depression and substance abuse. The nurses do not provide direct behavioral health services, but rather refer clients to one of two places. Clients with more severe illnesses are referred to the specialty community mental health system. For the mild to moderate cases, clients are typically referred to their medical provider within their tribe. Each tribe has its own behavioral health program and most include a certified addictions counselor (CAC) and a LCSW at a minimum. Following referrals, the Healthy Start nurses monitor the clients to ensure clients are receiving the comprehensive care they need.

New Jersey

New Jersey has focused its integration efforts on bridging communication barriers at the state agency level as well as with and among providers.¹¹ The initiatives described below have demonstrated the ability to increase access to services through care coordination and also provide examples of ways to simplify collaboration between primary care and behavioral health services providers.

New Jersey Medicaid recipients with mild to moderate behavioral health needs, like most other Medicaid beneficiaries in the state, are enrolled in managed care. However, behavioral health services provided in the primary care setting are carved out of managed

¹¹ In the New Jersey Medicaid program, specialty adult behavioral health services are administered by the Division of Mental Health Services within the Department of Human Services (DHS). Children's mental health services are coordinated by two independent agencies, the Department of Human Services and the Department of Children and Families (DCF). Intensive therapeutic placement services for children with severe mental illness are coordinated through the State Division of Mental Health Services within DHS. Within DCF, the Division of Children's Behavioral Health Services seeks to help emotionally disturbed children and their families access all of the services they need by coordinating those services for them across all child-serving systems in the state. Services include, but are not limited to, counseling for children and their parents, respite care, mentoring, and assistance with educational issues.

care contracts and paid for by Medicaid on a fee-for-service basis. New Jersey Medicaid has created an extensive network of providers for behavioral health services. New Jersey Medicaid reimburses for services provided by psychologists, licensed marriage and family therapists (LMFT), licensed clinical social workers (LCSW), and licensed professional counselors (LPC), as well as psychiatrists, nurse practitioners (NP), and advanced practice nurses (APN).

A partnership that was initiated three years ago between Henry J. Austin (HJA) Health Center, a federally qualified health center, and a local community mental health organization, *The Family Guidance Center Corporation*, has allowed HJA to fully integrate behavioral health services at its primary care setting. The Family Guidance Center provides on-site behavioral health staff for HJA, including one full-time licensed clinical social worker and a part-time advanced practice nurse. An off-site supervising psychiatrist meets regularly with HJA's behavioral health staff. HJA offers a broad list of behavioral health services and functions as a first contact and makes referrals in complex cases. In order to ensure the full integration of behavioral health into the organization, primary care physicians and behavioral health providers have provider meetings once a week. These meetings allow for providers to consider cases from both the primary care and behavioral health perspectives, supporting HJA's holistic philosophy of care.

The organization serves a large number of Medicaid beneficiaries, and works with the Medicaid agency to ensure the successful integration of behavioral health services, among other initiatives. HJA uses Medicaid Prospective Payment System (PPS) reimbursement to appropriately support its behavioral health program. Under PPS, states pay FQHCs the average of their reasonable costs for providing Medicaid-covered services, adjusted for any increase or decrease in the scope of services. The FQHC bills Medicaid directly for behavioral health visits since these services are carved out of Medicaid managed care. As part of the partnership, the health center manages the task of billing on behalf of the behavioral health staff.

New Jersey has recently implemented another initiative which leverages the experience of the HJA program to increase care coordination. The Mental & Physical

Healthcare Coordination (MPHC) Project is a new collaborative effort between Greater Trenton Behavioral Health Care (GTBHC), the Henry J. Austin Health Center, the Division of Medical Assistance & Health Services (DMAHS), and the Division of Mental Health Services (DMHS); the partnership coordinates physical and mental health needs and improves the quality of life for Medicaid beneficiaries seeking care in a safety net primary care setting. One of the primary goals of this effort is to ensure that mental health clients are accessing services at primary care settings, specifically to obtain physicals and any follow-up care. The state is also working to eliminate communication barriers between physical and mental health providers, as well as incorporate initiatives that will allow clients to obtain the tools they need to monitor and maintain their physical health status.

The mental health provider, Greater Trenton Behavioral Health Care, identified a group of clients that met certain criteria, which included being between the ages of 20 and 60, having Medicaid coverage but not having an established medical home. Individuals choosing to participate in the demonstration receive assistance from mental health staff in making appointments, getting transportation, communicating pharmacy problems, obtaining health education, and addressing other needs they may have. DMAHS and DMHS meet with facility staff periodically to ensure appropriate care coordination.

The Camden Healthy Start program exemplifies another model of integration of behavioral health and primary care services within the safety net setting. The program is not a direct provider of behavioral health services, but rather employs maternal and child health case managers who often link clients to needed behavioral health services. While the case management services are paid for with Healthy Start grant funds, the behavioral health services are generally paid for by Medicaid. The case managers work with women that have been identified as at risk for depression by prenatal centers or through an obstetrics triage process. When a woman needs more intensive behavioral health services, the case managers make referrals to appropriate providers that are reimbursed by Medicaid as behavioral health specialists. The Healthy Start program has been very effective, particularly when women enter the program early and can avoid experiencing full blown postpartum depression. In addition, the program is also very successful at making referrals for inpatient and outpatient psychiatric care. All referrals are tracked in order to ensure appropriate care coordination for

the women. The Camden Healthy Start program is now exploring additional opportunities to collaborate with the state Medicaid agency.

Delaware

The models illustrated in Delaware highlight examples of the benefits that can arise from the integration of behavioral health services through collaboration across providers and payers.

Behavioral health benefits in Delaware are paid either under the state's Medicaid 1115 demonstration program, the Diamond State Health Plan (DSHP), or through the Division of Substance Abuse and Mental Health (DSAMH). DSHP is a Medicaid managed care program that includes basic behavioral health services. Behavioral health services exceeding those provided in the basic benefit package are being provided through DSAMH and are reimbursed on a fee-for-service basis. Delaware currently has one provider group under contract with their managed care plan, Delaware Physicians Care, Inc. (DPCI). Delaware also has one Medicaid-only plan, Diamond State Partners, which is a new managed care program, administered by the Delaware Medical Assistance Program in partnership with participating providers.

In 2003, one of the state's external quality review organizations (EQRO) completed a focus study on how primary care providers (PCPs) handle situations involving behavioral health care services provided in primary care settings. In response, Delaware Medicaid provided all of their PCPs with a pocket "Slim Jim," a check list of questions that should be asked if the PCP believes a patient may need behavioral health services. As a result of these efforts, Delaware has seen improvements in the delivery of behavioral health services and an increase in patient access to providers, with regard to managed care. Building further on these successes, Delaware Medicaid made improved coordination among providers and services a priority of its EQRO efforts in state fiscal year 2007.

Delmarva Rural Ministries, Inc. (Delmarva), a federally qualified community and migrant health center, began integrating behavioral health services with primary care in

October 2005, and since then has experienced a notable increase in demand for behavioral health services. At Delmarva's Kent Community Health Center in Dover, one of Delmarva's service locations, a LCSW coordinates behavioral health services, and Medicaid reimburses Delmarva for the LCSW services. Delmarva also provides dental health and established a women's health program in 2005. This program is helping improve coordination of obstetric care and behavioral health services for women, including one of the most common, yet often untreated issues, postpartum depression.

Delmarva also has a contractual relationship with a not-for-profit substance abuse and mental health service provider, Connections Community Support Programs, Inc. (Connections). Connections, Delaware's largest provider of Medicaid behavioral health services, bills Medicaid directly for the services they provide to Medicaid enrollees. In addition, they bill Delmarva the balance for care provided to the uninsured, after applying Delmarva's sliding fee payment scale to the patient. Connections provides on-site substance abuse and mental health services for SMI patients at Delmarva's service locations, and includes an on-site certified addictions counselor and a psychiatric nurse practitioner, both on a part-time basis. Connections links individuals to a psychiatrist in their system when a patient needs services beyond the scope of the on-site psychiatric nurse practitioner or addictions counselor.

Delmarva has seen numerous benefits from having behavioral health services available onsite. The PCPs identify individuals that need to be seen by the LCSW, who in turn identifies individuals who need to be seen by the psychiatric nurse. This referral process has led to increased care coordination. The program's successes to date have laid the foundation for Delmarva, Delaware Medicaid, the Division of Substance Abuse and Mental Health (DSAHM), and the FQHCs to collaborate on new initiatives to provide behavioral health services for the FQHC's patients.

Delaware is drawing upon the expertise of health centers and other safety net providers in its new Primary Care Behavioral Health Initiative, a partnership between the Division of Medicaid and Medical Assistance, DSAMH, DPCI, Connections, and Westside Health, a Federally Qualified Health Center. These stakeholders share the common goal of

developing innovative programs for individuals with chronic illnesses, many of whom are non-native English speakers. In response, Connections has hired a bi-lingual mental health specialist to be onsite at the health center. The co-location program also places a mental health specialist at the community health center. Both providers serve on the DPCI provider panel, and thus their work is partially supported by Medicaid. The state has seen numerous benefits from the implementation of this program. Consumers are more accepting of behavioral health interventions that occur within the community health center, and are able to access additional behavioral health services when needed. In addition, the PCP has access to behavioral health screening tools, immediate triage, and consultation services, thus allowing for increased coordination of care across medical conditions.

Behavioral health service integration is also viewed as an important component of HIV and AIDS programs in Delaware. According to staff at the Christiana Health Care Services HIV program, it is estimated that more than 50 percent of individuals in Delaware with HIV or AIDS also suffer from a mental health condition and are Medicaid enrollees, thereby making Medicaid an important source of coverage for certain behavioral health services. The Christiana Health Care Services HIV Program, partially funded by HRSA, provides behavioral health services in the primary care setting for individuals with HIV and AIDS. The provision of behavioral health services in this setting is viewed as critical, as many patients with HIV or AIDS suffer from co-morbid disorders and are not amenable to receiving services outside of their primary care site. The care coordination and integration is particularly important in poly-pharmacy situations, as so many HIV and AIDS patients are taking several medications on a regular basis. At the program's Wilmington site, a LCSW serves on staff and works with the other nursing staff to conduct a baseline psychosocial assessment on all clients. When necessary, a behavioral health assessment is done and clients are connected with counseling services with the LCSW and/or psychiatric evaluations, if appropriate.

There are different models of behavioral health service provision at each HIV program site. Most HIV providers treat depression, and treatment of basic behavioral health conditions is often done in the primary care setting. Benefits from the integration of behavioral health services into primary care settings for individuals with HIV or AIDS

primarily center on medication reconciliation and safety given the complex medication regimens required for this population. Integration allows the disciplines to work together and create a coordinated plan of care. In addition, patients are able to see an infectious disease specialist and the mental health provider in the same day, which increases adherence to treatments. The close physical proximity is also beneficial in crisis circumstances, allowing providers to deal with specific situations more effectively.

Oklahoma

Oklahoma Medicaid and safety net providers face a unique challenge of meeting the needs for beneficiaries in a state with many rural communities. Several models are in place for the provision of behavioral health services, ensuring that all beneficiaries receive the care they need.

Oklahoma Health Care Authority's (OHCA) Medicaid program is primarily based on a traditional fee-for-service reimbursement model. The Medicaid agency has a statewide network of providers that includes hospitals, family practice doctors, pharmacies, and durable medical equipment companies. Behavioral health outpatient services, including pharmacological management and a variety of outpatient counseling and rehabilitative services, are Medicaid covered benefits for children and adults.

Outpatient behavioral health centers are at the core of the behavioral health delivery system in the state. Behavioral health centers provide a range of services, including counseling, medication management, and psychological testing. All of the centers provide mental health assessments, and some agencies provide case management services as well as social skills training. A few specialize in services to the severely mentally ill, outpatient drug and alcohol services, and services for children. There are two major types of behavioral health centers: those contracted by OHCA as private outpatient providers and those contracted by the Department of Mental Health Substance Abuse Services as Community Mental Health Centers. A small proportion of Medicaid beneficiaries are in a primary care case management (PCCM) model, known as SoonerCare. In the PCCM model, OHCA contracts directly with primary care providers throughout the state to provide basic health

care services. The program is partially capitated, so that providers are paid a monthly capitated rate for a fixed set of services with non-capitated services remaining compensable on a fee-for-service basis. Basic mental health services are included in the SoonerCare program.

The Oklahoma Medicaid agency has engaged in numerous efforts to improve the provision of behavioral health service beyond the traditional fee-for-service and PCCM models. As an example, the agency is working with the Oklahoma Health Sciences Center to determine how to most effectively train providers to appropriately assess behavioral health needs of patients in the primary care setting. A priority for OHCA is to determine how to better identify behavioral health issues and work with children in primary care settings.

Oklahoma also utilizes its network of federally qualified health centers to provide behavioral health care to over 82,000 individuals, especially those in rural areas. The Central Oklahoma Family Medical Center (COFMC), a FQHC located in the rural town of Konawa, implemented a behavioral health program in 2000 as part of its mission to ensure accessibility of care. Prior to the establishment of the program, low-income residents in the area were often without needed behavioral health care. Also in 2000, some of the area's mental health providers ended two psychosocial rehabilitation day treatment programs as a result of billing difficulties. In response, COFMC filled the gap by assuming responsibility for the two day treatment programs, and one of their nurse practitioners began making routine on-site visits with day treatment clients with medical needs. Currently, COFMC medical staff and lab staff conduct routine medication clinics at both day treatment sites. In addition, COFMC lab staff oversee blood draws and check psychotropic medication levels, among other services. For general behavioral health services, COFMC provides screenings, referrals, and/or treatment. Currently, COFMC's behavioral health providers include two licensed clinical social workers, one licensed track social worker, one licensed professional counselor and a consulting psychiatrist, among others. Recently, COFMC has expanded its behavioral health programs. A licensed professional counselor has been assigned as the children's program coordinator and will develop comprehensive behavioral health services for children and families. COFMC also contracts with area providers to ensure patients have access to a psychiatrist and social workers.

The rural facility in Konawa is a critical component of health care access for area residents and has the support of the state Medicaid agency. Prior to the integrated behavioral health initiative, psychiatrically impaired adults, children, and others who suffered from substance abuse or dependence issues had limited access to behavioral health care services. Today, at COFMC, approximately 70 percent of behavioral health services provided by their behavioral health care staff are covered by Medicaid. COFMC has seen numerous benefits from the integration of behavioral health into primary care, including increased access and more coordinated care among providers.

Oklahoma also has established an integrated behavioral health model through the Oklahoma State University-Center for Health Sciences-College of Osteopathic Medicine. The Center's comprehensive HIV primary care program is a highly integrated, one-stop delivery setting, wherein the vast majority of patients can receive all of their necessary services from providers that are sensitive to the unique issues facing individuals with HIV and AIDS. The program offers a full range of early intervention and primary care services, including psychology, psychiatry, prevention therapy, and behavioral health counseling services on-site or by referral. The interdisciplinary team approach to care results in a high level of efficiency and effectiveness in meeting patients' medical, mental health and social service needs. The program includes a licensed professional counselor, licensed alcohol and drug counselor, as well as a LCSW and psychiatrist. Medicaid is supportive of their programming, and the billing and reimbursement methods used have led to positive outcomes for the program, allowing beneficiaries to be seen by the appropriate provider at the appropriate time. The program functions as a first alert by identifying people with chronic mental illness and making referrals for the additional services they need.

Conclusion

A coordinated, cost effective health care system that provides access to quality behavioral health care services is an important goal for our Nation's health care system. These state snapshots highlight the range of new and innovative approaches to behavioral health services taking place across the states. However, these are simply snapshots – glances

at what is clearly an important, emerging trend. There is presently an increased focus among state Medicaid programs on behavioral and medical care coordination, and states are looking across their borders for models such as those discussed here. Other states are also exploring new approaches. For example, in Tennessee, Cherokee Health System uses behavioral consultants embedded in primary care teams, with psychiatric consultations available from within the organization. In this situation, payment for mental health and primary care is fully integrated under Medicaid. These examples can be adopted in other states that are interested in developing a more integrated, coordinated behavioral health care system.

HRSA-funded safety net providers are a prime example of primary care providers with whom Medicaid can work collaboratively in order to provide the best care for the enrollees that both parties are working to serve. As each of the core elements – stakeholder engagement, communication, supportive funding structures – fall into place, systems and programs can emerge that are both cost effective and supportive of improved clinical outcomes. The emergence of integrated behavioral health care systems provides a look at what may be expected of the overall health care system in the future. These models of integration and coordination provide high-quality, seamless care that could fulfill some of the objectives in the President’s New Freedom Commission Report. Sharing, and replicating such models is critical to the nation’s wellbeing.