Comments on the New York State Request for Information & Qualifications for Behavioral Health Benefit Administration: MCOs and HARPs

January 16, 2014

Through the Request for Information and Qualifications for Behavioral Health Benefit Administration, the NYS DOH, along with OMH and OASAS, builds upon the initiatives both developed by the Medicaid Redesign Team and included within the State's 1115 Medicaid Waiver application, which CHCANYS strongly supports. CHCANYS seeks to advance a comprehensive and integrated primary care approach that addresses patient needs and applauds the State's focus on behavioral health services and management. CHCANYS is pleased to provide comments and observations on the Request for Qualifications for Behavioral Health Benefit Administration (RFQ).

Sections of the RFQ, namely clinical management, cross-system collaboration, and quality management, embody the unique model of Federally Qualified Health Centers (FQHCs). FQHCs are designed to be fully-integrated, patient-centered medical homes; with mental health, oral health, and disease prevention as requisite components of a comprehensive primary care setting. In the five-year period 2007-2012, the number of patients using mental health services increased by 70%, the number using substance abuse services grew by 78%, and patients requiring various "enabling services[1]" increased by 29%. As a result of these shifts in service demand, approximately 90,000 FQHC patients in New York State received mental health services in 2012, about 13,000 received substance abuse counseling or treatment, and over 150,000 availed themselves of FQHC "enabling services".

FQHCs drive robust activity in primary care for effective diagnosis and management of behavioral and other chronic health disorders, as evidenced in the federal Uniform Data System reports for 2012. The eight most frequently observed diagnoses (primary or comorbidities) in that year include four behavioral health conditions: depression and mood disorders, anxiety disorders, (non-alcohol) substance disorders, and other mental disorders. Notably, depression is the third most common diagnosis in health center visits, after hypertension and diabetes. (The other chronic conditions among the top eight diagnoses were asthma and obesity/overweight.) The Uniform Data System reports show nine in ten health centers in New York provided mental health services.[2]

I. Recommendations

A. Comments on Clinical Management: *Behavioral Health Integration: Federally Qualified Health Centers (FQHCs) Are Model Drivers of Integrated Clinical Management*

The State should take appropriate steps to ensure the inclusion of FQHCs in HARP and Managed Care Networks, including but not limited to recognizing FQHCs that are co-licensed as medical Article 28 facilities and substance abuse Article 32 facilities and/or mental health Article 31 clinics.

The FQHC model promotes the integration of behavioral health and primary care, while employing strategies to ensure continuity of care. FQHCs, through a team-based approach, can employ the six core

[1] Enabling services include translation, transportation, and care management.
[2] HRSA Uniform Data System (UDS) Reports.

components of successful behavioral health integration, namely: (i) co-located services; (ii) good communication and collaboration among behavioral health and primary care providers; (iii) shared behavioral health treatment plans; (iv) shared problem lists; (v) shared medication lists and lab results; and (vi) joint decision making by behavioral and medical providers on patient treatment.[3] A national *2010 Assessment of Behavioral Health in FQHCs* found that nearly 65% of responding health centers met all six components of integrated care. Pursuant to their model, FQHCs have the capacity to implement behavioral health clinical measures into care management and to further inform behavioral health integration efforts based on their practices.[4]

Additionally, growing FQHC capacity – and thereby increasing access to high-quality, cost-effective, and community-based primary care – will prove critical to both the provision of behavioral health and medical care to the influx of newly insured patients participating in the New York State of Health Marketplace, as well as to efforts to maintain a safety net for those who remain uninsured, while controlling costs. In terms of their cost-effectiveness, FQHCs are leaders in reducing inappropriate and unnecessary ER utilization and hospital admissions. For these reasons, with greater emphasis being placed on care integration and cost containment, FQHCs are natural partners in the integration of behavioral health services with primary care.

B. Comments on Cross System Collaboration*: FQHCs' Programs and Services Align Integration of Primary Care and Behavioral Health Services*

As the State shifts its focus from emergency and in-patient services to expanding the primary care infrastructure, it should continue its efforts to partner with community-based innovators, such as FQHCs, in order to build upon existing, successful integration models. In particular, the State should augment primary care activities to diagnose and manage chronic conditions by utilizing FQHCs' existing community-based programs and services. Notably, FQHCs: (i) have connectivity to local service systems via operative patient referral protocols; (ii) have experience in the provision of behavioral health services and chronic care management; and (iii) make viable partners for local health departments due to their community-based infrastructure and relations with schools, community centers, arts programs, and other health systems partners.

C. Comments on Quality Management: *FQHCs Recognized as Early EHR Adopters and Quality Leaders in Their Integration Efforts*[5]

FQHCs are a vanguard of patient-centered medical homes, using technology to develop best practices necessary to provide high quality primary care programs and services. FQHCs have been at the forefront of the transition from volume to value, and their use of HIT to increase care coordination, drive improvements in care quality and outcomes, and reduce costs is woven into the fabric of daily practice and patient care. With approximately 97% of FQHCs in New York having implemented electronic health records, health centers have valuable experience in using HIT to advance patient care through quality improvement initiatives. As a result, FQHCs can be valuable members of behavioral health quality management learning collaboratives by sharing best practices and providing insights into their use of HIT to drive quality improvement.

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[3] National Association of Community Health Centers (NACHC). *NACHC 2010 Assessment of Behavioral Health Services in FQHCs*. Clinical Division Report. (January 2011)

[4] National Association of Community Health Centers (NACHC). *Behavioral Health*. Retrieved on 12/23/2013 from: www.nachc.com/BehavorialHealth.cfm

[5] Heisey-Grove, D., et al. *Supporting Health Information Technology Adoption in FQHCs*. ONC Data Brief, no. 8. Washington, DC: Office of the National Coordinator for Health Information Technology. (February 2013)

D. Utility of Existing Community-based Resources in Quality Management

In addition to statewide data systems and tools, the State may also employ community-based data warehouses, such as the Center for Primary Care Informatics (CPCI), to help identify high cost, high risk patients and to target them for more intensive care management services. Once patients are identified as high risk and/or high cost by analytic tools associated with a program such as the CPCI, these patients can be prioritized to receive care management services to improve outcomes and lower costs including: care coordination, support for adherence to evidence-based treatment protocols and preventive care, and patient self-management.

In 2011, CHCANYS launched the CPCI, which provides detailed clinical data and advanced analytical support to guide and drive significant improvements in patient access to care, quality of care, patient and population health outcomes, and cost containment. The CPCI is providing data and analytic reporting to support health planning and the development of integrated care models. More specifically, the CPCI has four components: (i) a statewide data warehouse, which integrates data from health center Electronic Health Records and Practice Management systems into a single, centralized database that provides users with over 100 measures of clinical quality outcomes to target areas for improvement; (ii) an advanced data analytic capacity that provides complex analyses, including those that integrate external databases (including the potential to integrate data from an all-payer database or the SHIN-NY) with health center data which could support data analysis efforts for external stakeholders; (iii) visit planning and care management tools to support quality improvement at the point of care; and (iv) technical assistance to FQHCs to support improved performance and patient outcomes.

E. Further Recommendations

1. FQHCs to Serve as Training Sites for Behavioral Health Providers

Given their experience providing behavioral health and primary care services, coupled with their utility as effective models for behavioral health integration, FQHCs may serve as training sites for other behavioral health providers. As a means of recruiting primary care professionals to provide care for their patients, FQHCs participate in a variety of health professions' training programs at all levels.

2. Use of Telehealth Services in Behavioral Health Treatment

Telehealth health services are appropriate for behavioral health treatment and should be expanded in community-based, primary care environments such as FQHCs. Likewise, telemedicine services give FQHCs, particularly in rural areas, the ability to use technology as a means of providing access to quality care, improving health outcomes, and communicating with urban specialists.

II. Conclusion: Moving the Integration of Comprehensive Primary Health Care and Behavioral Health Services Forward

In order for integration efforts to be successful, New York State needs to address the primary care and behavioral health workforce shortages, with increased efforts focusing in upstate, rural areas. A recent study by the Center for Health Workforce Studies, in collaboration with CHCANYS, identified workforce shortages in geographic regions across New York State, including shortages in behavioral health. According to this statewide study, community-based health centers, including FQHCs, reported the highest vacancy rates for psychiatric NPs (39%), followed by psychiatrists (23%), community health workers (21%), family NPs (20%), substance abuse counselors (19%), and psychologists (18%). In

particular, downstate health centers had the highest vacancy rates for psychiatric NPs, while upstate health centers had the highest vacancy rates for psychiatrists and psychiatric NPs.[6]

For decades, a hallmark of the FQHC model has been the provision of services to all, regardless of ability to pay. This remains true for FQHCs today, and their demonstrated formal affiliations with specialty and hospital providers allow for "one stop shopping" for health care, including behavioral health services. Cost effectiveness is also an important part of the quality improvement approach under the FQHC model, as behavioral health diagnosis and chronic disease management contribute to decreased hospital admissions, further reducing health care costs. Ultimately, FQHCs offer a model of integrated, patient-centered care that is associated with demonstrated improved outcomes and cost savings.

About CHCANYS

CHCANYS is New York State's Primary Care Association, designated by the Health Services Resources Administration, through which a set of services and resources are provided. CHCANYS represents, and provides technical assistance and training to, a large primary care provider network across the State. All of the FQHCs and Look-alikes are part of this network. We also have as members organizations interested in becoming FQHCs and many of our stakeholder partners across the State.

Founded 40 years ago, CHCANYS' mission is to ensure that all New Yorkers, including those who are medically underserved, have continuous access to high-quality, community-based health care services, including a primary care home. To do this, CHCANYS serves as the voice of community health centers by leading providers of primary health care in New York State. CHCANYS works closely with more than 60 FQHCs that operate approximately 600 sites across the state. These community health centers are not-for-profit, patient-centered medical homes located in medically underserved areas.

Health centers serve 1.6 million New Yorkers annually and are central to New York's health care safety net. FQHCs serve low-income patients, two-thirds are below the poverty level; one-fifth are best served in a language other than English; three-fourths are racial and ethnic minorities; one-quarter are uninsured; nearly 100,000 FQHC patients are homeless and a similar number are elderly. FQHCs provide a model of care, which is integrated with affiliated specialty and hospital partners in communities all over New York.

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[6] The Center for Health Workforce Studies (CHWS). *The Community Health Center Workforce in New York*. (December 2013)