FINAL REPORT

Special Joint Commission to Study the Integration of Primary Care and Behavioral Health

Findings and Recommendations

Report Submitted to the
Rhode Island Senate and House of Representatives

TABLE OF CONTENTS

COMMISSION MEMBERSHIP

Senator Joshua B. Miller
D-Dist. 28, Cranston, Warwick
Co-Chairperson

Representative David Bennett
D-Dist. 20, Warwick
Co-Chairperson

Michael Fine, MD
Director, Department of Health

Craig S. Stenning
Director of the Department of Behavioral Healthcare,
Behavioral Healthcare, Developmental Disabilities, and Hospitals

Linda McDonald, RN
President, United Nurses and Allied Professionals

Edward J. Quinlan
President, Hospital Association of Rhode Island

Debra Hurwitz, MBA, BSN, RN
Co-Director, CSI-RI

Elizabeth B. Lange, MD
President, American Academy of Pediatrics Rhode Island Chapter

Jim Carney, PA-C, DFAAPA
President, Rhode Island Academy of Physicians Assistants

Newell E. Warde, Ph.D.
Executive Director, Rhode Island Medical Society

Jack Hutson, CAE
President, Rhode Island Psychological Association

Sylvia Weber, MSN PCNS
Designee, Rhode Island State Nurses Association

Richard Harris, MSW, LICSW
Executive Director, National Association
Of Social Workers Rhode Island Chapter

Jane Hayward
President & CEO, Rhode Island Health Center Association

Augustine Manocchia, MD
Chief Medical Officer, Blue Cross and Blue Shield of Rhode Island

Terrie Fox Wetle, Ph.D.
Associate Dean of Medicine,
Dean of the Brown University School of Public Health

Stephen J. Farrell
President, United Healthcare of New England

Ken Pariseau
Manager of Government Affairs, Neighborhood Health Plan of Rhode Island

Craig M. Syata, MPA
President & CEO, Rhode Island Council of Community
Mental Health Organizations

David Spencer
Executive Director, Drug and Alcohol Treatment Association of Rhode Island

Report prepared by the House and Senate Policy Offices

LETTER FROM THE CO-CHAIRS

On behalf of the Special Joint Commission to Study the Integration of Behavioral Health and Primary Care and Establishment of a Primary Care Trust, we are pleased to submit this report, the culmination of a series of hearings held from September, 2013, to January, 2014. This report represents the information presented preceding, throughout, and subsequent to the hearings from the dedicated professionals that work within Rhode Island's healthcare system, as well as from experts in other states.

The Special Joint Commission was convened to study the current status of primary care and behavioral health in Rhode Island, consult available research, data, and analyses of the impact of primary care and behavioral health service availability and delivery system architecture on population outcomes, and consider the opportunity to create a Primary Care Trust or other mechanism to fund and otherwise support a comprehensive integrated primary care and behavioral health system for all Rhode Islanders. All deliberations were supported by testimony from an array of stakeholders, including physicians, nurses, payers, psychologists, and state agencies. The hearings allowed the Commission members to learn of best practices within our state as well as other states, exchange ideas, examine policies, weigh priorities, and vet recommendations for consideration. The discussions were informed, collegial, respectful, and focused on the shared goal of solidifying the healthcare systems available to all Rhode Islanders. The Special Joint Commission's efforts were further energized by the November 8, 2013, joint announcement by the U.S. Departments of Health and Human Services, Labor, and the Treasury of a final rule that increased parity between mental health/substance use disorder benefits and medical/surgical benefits in group and individual health plans. The January 10, 2014, report of the Office of the Lieutenant Governor Elizabeth Roberts, *Rhode Island State Healthcare Innovation Plan*, also pointed to the central importance that comprehensive care plays in supporting a healthier Rhode Island.

We would like to express our gratitude to every member of the Commission for their willingness to take part in these discussions, and we appreciate the contributions of the many experts who took time from their busy schedules to appear before us. The Special Joint Commission offers these findings and recommendations that integrated behavioral health and primary care can be further strengthened, resulting in a better quality of life for Rhode Islanders and potential cost savings to the state.

Sincerely,

Co-Chairman Senator Joshua Miller
District 28 – Providence, Cranston

Co-Chairman Representative David Bennett
District 20 – Warwick

TIMELINE

September 25, 2013

- Alexander Blount, Ed.D., Director, Center for Integrated Primary Care and Professor of Family Medicine and Psychiatry, University of Massachusetts Medical School
- Michael Fine, MD, Director, Rhode Island Department of Health

October 30, 2013

- Ms. Rebecca Boss, Administrator of Behavioral Healthcare Services, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals

November 20, 2013

- Mr. Daniel Meuse, Deputy Chief of Staff, Office of Lieutenant Governor Elizabeth Roberts

December 18, 2013

- David Brumley, MD, Senior Medical Director, Tufts Health Plan
- Augustine Manocchia, MD, and Maria Sekac, LICSW, Blue Cross Blue Shield of Rhode Island
- Roanne Osbourne-Gaskin, MD, Associate Medical Director for Neighborhood Health Plan

January 8, 2014

- Patricia R. Recupero, JD, MD, President and Chief Executive Officer - Butler Hospital
- Peter M. Oppenheimer, Ph.D., Feil & Oppenheimer Psychological Services
- Lisa Rocchio, Ph.D., President, Rhode Island Psychological Association
- Matthew Salisbury, MD, Rhode Island Primary Care Physicians Corporation

January 15, 2014

Review of draft and discussion of commission report and recommendations

EXECUTIVE SUMMARY

The work of the Special Joint Commission to Study the Integration of Primary Care and Behavioral Health emerged from years of in-depth study by legislators, advocates, and providers in Rhode Island. In 2013, legislation passed by the General Assembly (S 834/H 6288) established a Special Joint Legislative Commission to Study the Integration of Behavioral Health and Primary Care and Establishment of a Primary Care Trust. As its name indicates, this 21-member Commission was charged with examining the current behavioral health and primary care system in the Ocean State, and with identifying opportunities to further integrate clinical and payment reform and examine the feasibility of establishing a primary care trust. The Commission met over a five-month period from September 2013 to January 2014 and took expert testimony from primary care providers, behavioral health specialists, leaders of state agencies, and other professionals with experience in integrated care. The following findings and recommendations emerged from the testimony and discussions.

Findings:

- Leadership is critical in working to achieve full integration of behavioral health, substance abuse, and physical health care needs.

- Rhode Island needs to develop consensus that integrating primary care and behavioral health is important for the state. Examples of projects currently underway throughout the state – including the Rhode Island Chronic Care Sustainability Initiative (CSI-RI), Blue Cross / Blue Shield of Rhode Island's Patient Centered Medical Homes (PCMHs), United HealthCare of New England's Accountable Coordinated Care Organization (ACCO), and Federally Qualified Health Centers (FQHCs) – testify to the widespread interest in exploring how different approaches to integrated care can be deployed to meet the needs of Rhode Islanders.

- While clinical integration is important, to be effective it needs to be accompanied by other actions, including training primary care practitioners and behavioral health practitioners, embedding opportunities for collaboration and communication, and providing technical assistance.

- Primary care and behavioral health integration needs to have a strong financing component to achieve success.

- While access to behavioral and medical health services in addition to case management and other support services is critical for individuals with comprehensive needs, equally important is the parity of insurance coverage.

- The Affordable Care Act (ACA) may impact the access and coverage of comprehensive mental and medical services for Rhode Islanders in need of behavioral health and/ or substance abuse services.

- Data on behavioral health disorders in Rhode Island need to be carefully collected, compiled, and examined by clinical and policy professionals to assess trends, spending, and utilization patterns across the continuum of services.

Recommendations:

1) As investments are made in the state's health care system, the Office of the Health Insurance Commissioner should ensure that mechansisms are available at every level to connect, coordinate, and support the delivery of care.

2) The Health Care Planning and Accountability Advisory Council should investigate opportunities to ensure that access to integrated primary medical and behavioral health care is maximized, and that patients seeking care are able to access it.

3) Examine opportunities to create a robust legislative pilot for an integrated primary care and behavioral care and health promotion model, working with data being produced by and for the Health Care Planning and Accountability Advisory Council to identify the state's existing behavioral health care capacity and to target unmet needs.

4) Focus on early intervention by creating incentives that increase access to behavioral health and substance abuse practitioners and services to underserved populations in Rhode Island, which include children, adolescents, and geriatric patients.

5) Explore how different payment and service delivery models can foster movement toward more integrated care.

6) Payers should incentivize payment for providers that meet quality standards and best practice guidelines in integrating care and implementing behavioral health interventions. Payers and providers should build on existing practice guidelines to reach common acceptance of measurements to show adherence to best practices and other quality metrics.

7) The Department of Health should take the leadership in reviewing critical policies affecting integrated care.

8) Rhode Island's statutory framework should be examined to determine whether and how it may be changed to better support integrated care.

9) Examine opportunities to build upon and expand the infrastructure of the Chronic Care Sustainability Initiative (CSI-RI) for technical assistance.

10) Leverage existing efforts – in Rhode Island and elsewhere – to integrate primary care and behavioral health.

11) Explore collaboration compacts between behavioral health providers and practices that are organized as coordinated, co-located, and/or integrated, across settings and medical practices of different sizes.

12) The Department of Health and the Office of the Health Insurance Commissioner should spearhead initiatives that focus on improving record sharing, capturing accurate, comprehensive data on health care system resources, and supporting population management.

INTRODUCTION

State policymakers, planners, and providers of primary health and behavioral healthcare in Rhode Island and across the United States dedicate themselves to creating effective systems that efficiently deliver high quality care across the state's population.[1] Over the past two decades, the state has made tremendous strides in increasing access to health insurance for medical conditions, particularly among children. State decision-makers have confronted stubborn challenges, however, when it has come to ensuring access to behavioral health services, a term which encompasses mental health and substance use disorders. Behavioral health services fail to reach as many as 60 percent of those Rhode Islanders in need.[2]

The number and proportion of Rhode Islanders with behavioral health challenges underscore the need for improvement. Rhode Island ranks in the top fifth of states in terms of severity of all thirteen mental illness indicators used in the National Survey on Drug Use and Health. Behavioral health diagnoses appear with frequency across Medicare, Medicaid, and commercial payers in Rhode Island.[3] Many individuals with behavioral health challenges in Rhode Island also suffer from chronic physical disorders (and vice versa). For example, two-third of Rhode Island's mental health clients have at least one of a list of serious diseases that include asthma, obesity, hypertension, and COPD, and many clients have more than one of these conditions. Nationally, Rhode Island has the highest rate of adults with Serious Mental Illness (SMI) – more than 7 percent, far above the national average of 4.6 percent – a diagnosis associated with elevated rates of hypertension, diabetes, obesity, and cardiovascular disease.[4]

In addition to the tremendous negative impact this situation brings to individuals, untreated and undertreated behavioral health conditions exert a financial toll more broadly. Employees with

[1] In this document, the term "behavioral health services" includes those that address mental health and substance use disorders. See the glossary for further detail.
[2] Collins, C., D.L. Hewson, R. Munger, & T. Wade (2010). *Evolving models of behavioral health integration in primary care*. New York, NY: The Milbank Memorial Fund. Retrieved online January 7, 2014, from http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf.
[3] Office of Lt. Governor Elizabeth Roberts (2014). *Rhode Island State Healthcare Innovation Plan*. Retrieved online January 10, 2014, from http://www.healthcare.ri.gov/healthyri/resources/SHIPwithAppendix.pdf.
[4] Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) (2011). *Rhode Island State Health Plan*. Retrieved online September 9, 2013, from http://www.bhddh.ri.gov/bhservices/pdf/2012-13%20Combined%20Plan-Submitted.pdf.

poor health can cost employers in excess of $13,000 per year, while untreated behavioral health problems bring in more than $535 million in excess costs for every 100,000 Medicaid recipients.[5] Total health care costs for outpatients with depression are 50% to 100% higher than for those without depressive disorder.[6] People with untreated behavioral health disorders are more likely to be incarcerated, are more likely to present to emergency rooms for acute care treatment, and can limit productivity in the workplace.[78]

In the U.S., the majority of patients with mental health needs rely solely on their primary health care provider (e.g., family medicine, general internal medicine, pediatrics).[9] That is, most patients in need of behavioral health services will not make use of referrals to specialty behavioral care, where mental health and substance abuse services are provided in separate facilities. For this reason, using primary care settings as an entre point to provide behavioral health services has emerged as a central strategy to improve outcomes.

As Collins et al. (2010) describe, collaborative care and integrated care are the two terms most often used (in sometimes overlapping ways) to describe the interface of primary care and behavioral health care. Collaborative care involves behavioral health providers working with primary care practitioners, while integrated care involves behavioral health providers working within and as part of a primary care team. From the patient's perspective, in collaborative care, patients perceive that they are getting a separate service from a specialist. That is, behavioral health care may be coordinated with primary care, but the actual delivery of services may occur in different settings. Treatment can also be co-located, with behavioral health and primary care

---

[5] Blount, F.A. (2013). *The necessity for integrating behavioral health in primary care*. Testimony provided September 25, 2013, to the Special Joint Legislative Commission to Study the Integration of Primary Care and Behavioral Health.

[6] American Counseling Association (2013). *Cost offsets and treatment needs: Large potential Medicare savings associated with improving access to outpatient mental health care*. www.counseling.org/publicpolicy.

[7] National Council for Community Behavioral Healthcare. *State spending on untreated mental illnesses and substance use disorders*. Retrieved online January 6, 2014, from http://www.ncdsv.org/images/NCCBH_StateSpendingUntreatedMenIllness_2010.pdf.

[8] World Health Organization (2008). *The global burden of disease: 2004 update*, Table A2: Burden of disease in DALYs by cause, sex and income group in WHO regions, estimates for 2004. Geneva, Switzerland: WHO, 2008. As cited by NIMH. http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_AnnexA.pdf. As cited by the National institute of Mental Health. http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#WHOReportBurden

[9] Blount, F.A.& B.F. Miller (2009). Addressing the workforce crisis in integrated primary care. *Journal of Clinical Psychology in Medical Settings*, DOI 10.1007/s10880-008-9142-7.

separately provided in the same location. Alternatively, treatment can be fully integrated, which means that behavioral health and medical services are provided as part of a single treatment plan. From the patient's perspective, in an integrated approach, behavioral health is perceived as a routine part of their medical health care (and vice versa).[10]

These collaborative and integrated care models have encountered a number of barriers that challenge large-scale implementation. As some presenters to the Special Joint Commission pointed out, the professional and organizational cultures of primary care providers and behavioral health providers can introduce hurdles. Styles of communication, expectations regarding how much time to spend consulting with the patient and speaking with one another, beliefs about the nature of privacy and care management, and available training can differ across provider settings. A considerable hurdle to more integrated approaches to primary care and behavioral health is financing, a barrier that differs between the uninsured, Medicaid, and commercially-insured patients. Time and again, presenters to the Special Joint Legislative Commission identified the current approach to compensation (fee-for-service) and an absence of alternatives as critical impediments to integrated care. There is a decided lack of appropriate codes across provider settings, and public and commercial carriers have wide variations in mental health and substance abuse coverage, codes, co-payments, and prior authorization requirements. Payers may prevent therapy codes from being billed on the same day as an E/M code: Medicare, for example, does not allow the majority of the therapy codes to be billed on the same day.[11]

To date, collaboration and integration of primary care and behavioral health care have taken place at modest scale and with considerable variation, in Rhode Island and elsewhere. Across these initiatives, the evidence surrounding the integration of primary care and behavioral health has grown in the past decade, with coordinated approaches providing little evidence of cost effectiveness and medical improvement; co-located approaches providing moderate cost and

[10] Collins et al (2010).

[11] Ibid.

clinical evidence and staff and patient satisfaction; and integration providing clinical and cost evidence, as well as patient and provider satisfaction.[12]

As innovative approaches to the integration of primary care and behavioral health mature, there is greater understanding of the constraints the existing health infrastructure imposes on the success of the new models. In Rhode Island, the members of the Special Joint Commission to Study the Integration of Primary Care and Behavioral Health – including primary care providers, behavioral health specialists, clinical practitioners, payers, and state policy makers – met over a five-month period from September 2013 to January 2014 to identify changes to the primary and behavioral health care systems that might lead to a more integrated system, better population outcomes, and cost efficiencies to the state. The remainder of the report presents a series of findings and recommendations that stem from the presentations provided to the Special Joint Commission, as well as from its deliberations. The report describes actions that can be taken with the tools and resources that are available right now, changes that can occur through legislation at the state level, and systematic improvements that will require broader participation and support.

[12] Blount, A. (2013). *The necessity for integrating behavioral health in primary care*. Testimony provided September 25, 2013, to the Special Joint Legislative Commission to Study the Integration of Primary Care and Behavioral Health.

FINDINGS

- **Leadership is critical in working to achieve full integration of behavioral health, substance abuse, and physical health care needs**.

Testimony provided before the Joint Commission pointed to gaps and inefficiencies in the existing healthcare system. In his testimony, Dr. Alexander Blount, Director of the Center for Integrated Primary Care, Professor of Family Medicine and Community Health and Psychiatry at the University of Massachusetts Medical School in Worcester, MA and the Director of Behavioral Science, noted that International Business Machines (IBM) recently stated that the company is no longer going to invest in jobs or work in South Florida, as specialty care and healthcare costs are extremely expensive there. Conversely, IBM has shifted jobs to Dubuque, Iowa, which has a very strong infrastructure and prevalence of primary care physicians, with low specialty care costs. Companies are beginning to make business decisions that take the surrounding healthcare system into account, especially when the cost of healthcare and jobs are such important factors in the overall picture of our economy *(Commission Hearing September 25, 2013)*.

Peter Oppenheimer, Ph.D., President of Feil & Oppenheimer Psychological Services, revealed deficiencies in the delivery of healthcare *(Commission Hearing, January 8, 2014)* (Table 1, next page). Dr. Oppenheimer described the delivery of healthcare, which consists of:

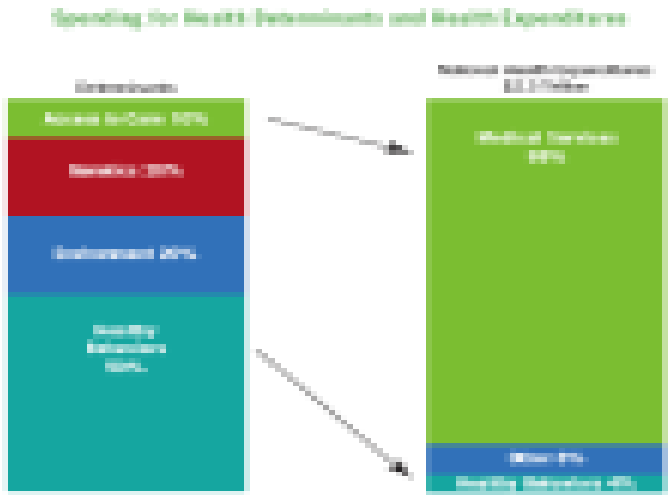
- **97%** of our healthcare spending on medical services
  - Most experts estimate about 1/3 of what we spend on medical services is unnecessary.
- Medical services contribute only about **10%** to population health outcomes
- **90%** of population health outcomes are produced by:
  - Education
  - Environment
  - Housing
  - Behavior
  - Genetics
  - Social organization

While many Americans continue to struggle with mental healthcare access, Rhode Island has taken necessary steps that work towards eliminating many of the obstacles to access. However, as Rick Harris of the Rhode Island Chapter of National Association of Social Workers (NASWRI) observed, mental health service utilization in Rhode Island is higher than in most states. Moreover, data from MHCA/OASIS of Rhode Island are consistent with the literature in the field documenting that individuals living with mental illness who are in treatment in the public mental health system die 25 years earlier than age-matched members of the general population. As a result, thousands of Rhode Islanders will be

negatively affected if integrated services are not available, even as the cost of healthcare continues to rise.

Table 1: Spending Data from Dr. Oppenheimer, Presented January 8, 2013

Spending for Health Determinants and Health Expenditures



Healthy People/Healthy Economy Coalition (2011). First annual report card. Boston MA: Boston Foundation and NEHI

- **Rhode Island needs to develop consensus that integrating primary care and behavioral health is important for the state. Examples of projects currently underway throughout the state – including the Rhode Island Chronic Care Sustainability Initiative (CSI-RI), Blue Cross / Blue Shield of Rhode Island's Patient Centered Medical Homes (PCMHs), United HealthCare of New England's Accountable Coordinated Care Organization (ACCO), and Federally Qualified Health Centers (FQHCs) – testify to the widespread interest in exploring how different approaches to integrated care can be deployed to meet the needs of Rhode Islanders**.

  The members of the Joint Commission voiced consensus regarding the positive benefits of integration. They maintained, however, that multiple and varying models of coordinated/integrated care will be needed in order to meet the health needs of the population *(Commission Hearing, December 18, 2013)*. They indicated that the co-location model is neither the only, nor the best, model for all circumstances. Rick Harris of the Rhode Island Chapter of National Association of Social Workers described a wide variety of options, including substantial professional and support networks, coordinated

services, vehicles for improved communication and planning, and future service paradigms as other options to co-location.

The Joint Commission also discussed current reimbursement models that encourage co-location. Dr. Augustus Manocchia of Blue Cross Blue Shield of Rhode Island recognized that the medical visit is likely the first touch point for many patients. He voiced support for the identification of behavioral health concerns in primary care by incentivizing the use of screening tools. For example, the use of screening tools for depression and anxiety is a quality metric for primary care medical homes (PCMHs). Moreover, Dr. Lisa Rocchio from the Rhode Island Psychological Association made a suggestion that existing CPT codes, such as those for collateral contacts between different providers and other supports, such as schools and dieticians, should be reimbursed to facilitate coordination of care. *(Commission Hearing, December 18, 2013).*

Dr. Osbourne-Gaskin, Associate Medical Director for Neighborhood Health Plan of Rhode Island, emphasized the natural relationship between integrated care and the triple AIM for healthcare. This perspective was echoed by UniterHealthcare CEO Stephen J. Farrell, who stated that achieving the triple aim (improving the patient experience, improving the overall population health and reducing the per capita cost of care) should be aligned with integration.

- **While clinical integration is important, to be effective it needs to be accompanied by other actions, including training primary care practitioners and behavioral health practitioners, embedding opportunities for collaboration and communication, and providing technical assistance**.

Several members of the commission discussed training and education as critical components to the success of integration (*Commission Hearing, September 25, 2013)*. David Spencer from the Drug and Alcohol Treatment Association of Rhode Island (DATA) shared his experiences with opportunities surrounding training and education with primary care physicians relative to behavioral health and substance abuse. Dr. Blount reinforced this notion and discussed the importance of training and MOUs. He noted, however, that the models for integration are most effective when primary care is brought into the behavioral health setting.

Additionally, Dr. Blount highlighted the positive impact of teaching patients, making resources available, problem-solving, and coordinating with primary care physicians. For example, a database of physicians in practice and those who require care create different types of interaction which involve the whole health team.

According to Debra Hurwitz of CSI-RI, an important challenge to the integration of primary care and behavioral health services is the exchange of information between providers. Matthew Salisbury, MD, Rhode Island Primary Care Physicians Corporation, spoke of the importance of information sharing and introduced a web portal that is accessible to primary care physicians at the point of care *(Commission Hearing, January*

8, 2014). The portal is an efficient tool that tailors referrals based on individual patient goals and needs. The commission learned that this collaborative model aims to:

- Strengthen networks while building lasting relationships;
- Assist patients in making better choices and measure patient outcomes;
- Improve communication and access with behavioral health specialists;
- Contain costs

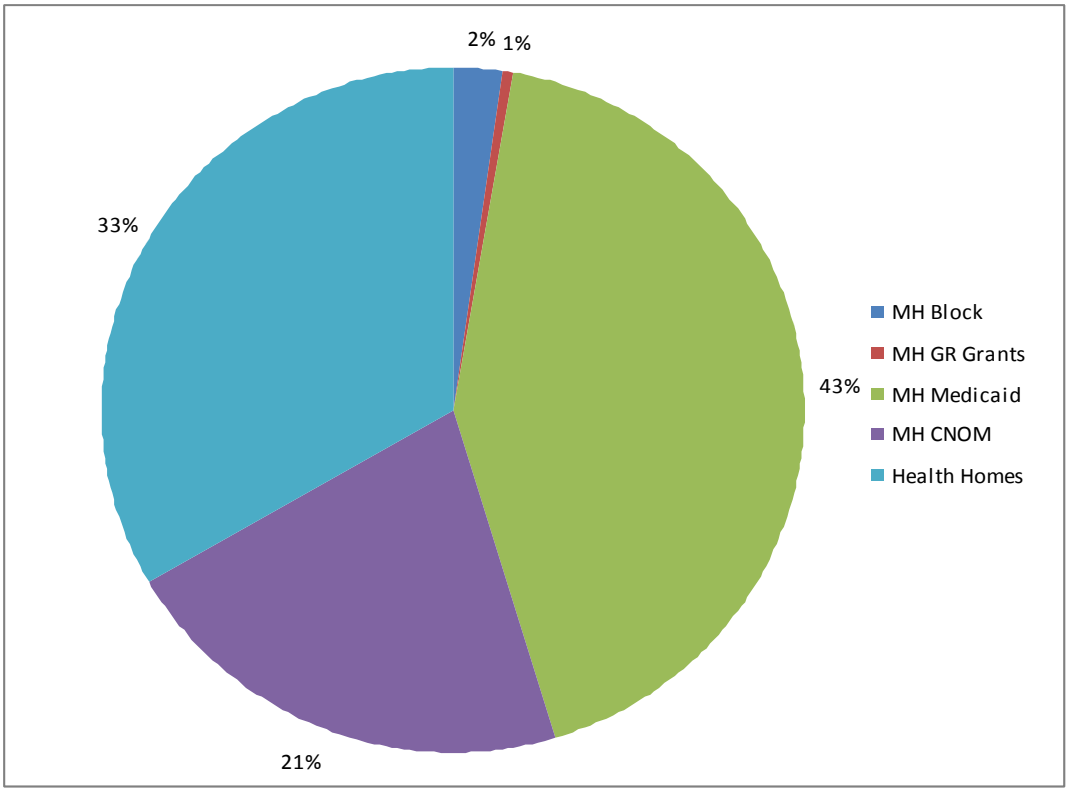
- **Primary care and behavioral health integration needs to have a strong financing component to achieve success.**

Financial barriers to integration were a consistent theme throughout the Joint Commission's deliberations. Jane Hayward from Rhode Island Health Centers emphasized the challenges associated with creating financing components that are conducive to patient needs, while maximizing patient visits and providing better support *(Commission Hearing September 25, 2013)*.

Patricia Recupero, JD, MD, President and CEO of Butler Hospital stressed that the lack of in-patient care leads to overcrowding in state-managed mental health hospitals, even as outpatient resources are decreasing due to economic restraints *(Commission Hearing January 8, 2014)*. Moreover, the lack of access to in-patient beds, coupled with emergency room overcrowding, leads to access problems and undue hardships for behavioral health patients. The likely result will limit mental health benefits offered to individuals who require outpatient resources. Reimbursement rate cuts on behavioral health services and Medicare's coverage with higher co-pays provide barriers to access. The Joint Commission members agreed that parity in insurance coverage is necessary; however, some members pointed to challenges that arise because many providers are not accepting some insurances. As a result, patients who require behavioral health services are potentially harmed due to a deficiency of network participation.

Additionally, Rebecca Boss of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) described the stigma associated with mental illness, which often times prohibits a consumer from seeking medical treatment, with the result that many consumers are treated in an emergency room setting. She provided spending data for FY2013 that illustrated how BHDDH continues to direct funds to alternative settings, such as health homes (Table 2, next page).

Table 2: BHDDH Data, Presented October 30, 2013



- **While access to behavioral and medical health services in addition to case management and other support services is critical for individuals with comprehensive needs, equally important is the parity of insurance coverage.**

  An example of a co-location model grounded the Joint Commission's discussion of the important role of insurance coverage in supporting access to behavioral health services and providers. Testimony from Maria Sekac, Assistant Vice President of Blue Cross Blue Shield of Rhode Island (BCBSRI), described the company's co-location model, which supports seven practices and aims to address behavioral change to complement chronic care management *(Commission Hearing, December 18, 2013)*. However, several barriers to co-location were presented, including the need for standardization of processes used to identify members for referral. Moreover, not all participating physicians saw integrated services in the same way, causing treatment to vary relative to individual needs. Additionally, the co-location model introduced at BCBSRI had too few participants to provide the data to evaluate the initiative's success. While the model at BCBSRI was part of a larger strategic plan, the company recognized the significance of consistent

quality. The model also faced reimbursement challenges, and testimony indicated that the fee for service approach in general is a "road block."

Dr. Augustine Manocchia of BCBSRI also discussed barriers to utilization in co-location practices, which include:

1. Co pay structure is not conducive to the behavioral health needs of patients who require services;
2. Lack of uniformity by Primary Care Physicians when screening tools are introduced;
3. Requirement of a pre-visit meeting varies when Nurse Care Managers, Primary Care Physicians and behavioral health providers made decisions about patient needs.

Dr. Roanne Osborne-Gaskin, Associate Medical Director for Neighborhood Health Plan (NHP), pointed to the importance of collaboration, not just co-location. Furthermore, Dr. Gaskin informed the Joint Commission that NHP did not encounter issues surrounding co-pays for behavioral health services while describing the integrated approach at Duffy Community Health Center in Cape Cod, MA. The Joint Commission learned that the Commonwealth of Massachusetts does not have separate co-pays for behavioral health services as a specialty care reimbursement.

According to the Joint Commission, collaboration can be built into a schedule; however, challenges may arise due to non-payment of services. Collaboration and communication are critical when it comes to using existing CMS codes.

- **The Affordable Care Act (ACA) may impact the access and coverage of comprehensive mental and medical services for Rhode Islanders in need of behavioral health and/ or substance abuse services.**

Dr. Oppenheimer urged the Joint Commission to consider updating coverage for mental and substance abuse patients, so that consistency with federal parity is achieved *(Commission Hearing, January 8, 2014).*

While there is not a federal mandate to update the Rhode Island General Laws, members of the Joint Commission discussed options related to considering and aligning legislation and state statutory and regulatory language. Joint Commission members identified additional barriers to access, including high deductibles, high co-payments, and restrictions on outpatient behavioral health practitioners providing services to Medicaid recipients.

- **Data on behavioral health disorders in Rhode Island need to be carefully collected, compiled, and examined by clinical and policy professionals to assess trends, spending, and utilization patterns across the continuum of services.**

  Data that support linkages and access for patients seeking behavioral health services is critical in meeting the demand and for integration. While the behavioral health field faces barriers to integration, the data will continue to support efforts surrounding mental health and parity, while employing patient-focused models and appropriate services.

RECOMMENDATIONS

1) **As investments are made in the state's health care system, the Office of the Health Insurance Commissioner should ensure that mechansisms are available at every level to connect, coordinate, and support the delivery of care.**

Throughout the proceedings. Commission members and speakers pointed to the need to harmonize the decisions and actions of healthcare professionals, payers, and care managers. Commission members agreed that the Triple Aim of healthcare – improving the patient experience, improving the overall population health, and reducing the per capita cost of care – represents a shared goal across all of the stakeholders involved in integrated care.[13]

> "We agree that it is important to connect, coordinate and support the delivery of integrated healthcare. However, we do not think any single state agency is the right place for this effort. Instead, we recommend either that the work of the Joint Commission continue, or that this work be moved to the Health Care Planning and Accountability Advisory Council." (Jane A. Hayward, President & CEO, Rhode Island Health Center Association)

2) **The Health Care Planning and Accountability Advisory Council should investigate opportunities to ensure that access to integrated primary medical and behavioral health care is maximized, and that patients seeking care are able to access it.**

Commission members recognized a number of prospects that should be considered, including whether funding for services can be steamlined and whether opportunities created by the Affordable Care Act (e.g., expanded access to Medicaid and private health insurance) can be leveraged. The need for more providers to be trained in integrated care, and for more mental health providers to be trained in general, were recognized widely as subjects that merited further exploration. Additionally, commission members heard repeatedly that the state lacks a means to track inventory of inpatient and outpatient resources for patients with behavioral health needs, a situation which frustrates providers, emergency room workers in hospitals, and state policy makers who need to understand system capacity and unmet needs. One option may be considered is potentially a web-based tool that presents the real-time availability of inpatient and outpatient resources (e.g., available beds) which would enable providers to more effectively manage patients and allow policy makers to strengthen behvaioral health, locally and statewide. Finally, there may be additional opportunities that present the state with the chance to increase its capacity to treat behavioral health needs. For example, in the case of hospital transition or acqusitions in Rhode Island, one approach might be to ask the Department of Health whether allocating a certain number of behavioral health beds (based on the community's inventory) could be included in the negotiations, which would allow the community to help meet the statewide goals for a stronger behavioral health system.

[13] The Institute for Healthcare Improvement http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx

3) **Examine opportunities to create a robust legislative pilot for an integrated primary care and behavioral care and health promotion model, working with data being produced by and for the Health Care Planning and Accountability Advisory Council to identify the state's existing behavioral health care capacity and to target unmet needs.**

The pilot should be conducted in a specific geographic location(s), feature an alternate or global fee structure that emphasizes value (as opposed to volume) to assess the impact of interventions aimed at population-based health outcomes. The pilot should be of large enough scale to generate the kind of information about outcomes and impact that can support policy decisions to either dismiss the approach or justify statewide expansion.

> "The Department of Health strongly agrees with this recommendation…We would note, however, that one concept presented to the Commission, the Community Health Team approach, is not at all the same as [is the one] presented in the Neighborhood Health Station pilot." (Dr. Michael Fine, Director, Department of Health)
>
> "We would recommend voluntary trials and pilots where the process leaves room for variation as opposed to mandates which are largely inflexible." (Stephen J. Farrell, CEO, UnitedHealthcare)

4) **Focus on early intervention by creating incentives that increase access to behavioral health and substance abuse practitioners and services to underserved populations in Rhode Island, which include children, adolescents, and geriatric patients.**

In Rhode Island, one in five children ages six to seventeen have a diagnosable mental or addictive disorder, while about one in ten has significant functional impairment. The majority of children and youth who need mental health treatment in Rhode Island, however, do not receive it through school, community, or clinical settings, despite showing symptoms or "action signs."[14] In her January 8, 2014, testimony in front of the Joint Commission, Dr. Patricia Recupero described how access to children's specialists is at a crisis point in the state. Commission members also spoke of the increasing population of older residents in Rhode Island, and of the mounting challenges associated with treating geriatric patients. These observations are backed up by analyses from the Institute of Medicine, which reports that the proportion of the population over the age of 65 in the U.S. will increase from 12.4% of the population in 2000 to 20% by the year 2030. During the same time period, the number of older adults with mental illness is expected to double. This demographic transition will increase the current shortfall of healthcare providers with geriatric expertise, specifically health care providers with geriatric mental health expertise.[15] With one-quarter (25%) of Ocean State residents expected to be over the age of 65 by 2030, the impact on geriatric

[14] Rhode Island Kids Count (2013). *Children's mental health*. Retrieved online January 21, 2013 from http://www.rikidscount.org/matriarch/documents/13_Factbook_Indicator_21.pdf.
[15] Institute of Medicine (2012). *IOM Study on Mental Health Workforce of Older Adults Fact Sheet*. Retrieved online January 24, 2104, from http://www.aagponline.org/aagp/index.php?src=gendocs&ref=FactSheetIOMStudyonMentalHealthWorkforceofOlderAdults&category=Advocacy

mental health in Rhode Island will be especially pronounced.[16] In terms of incentives, commission members described multiple options. For example, the state may opt to provide tuition forgiveness programs for providers with certain expertise, to motivate them to stay in the state.

5) Explore how different payment and service delivery models can foster movement toward more integrated care.

Throughout the Joint Commissions proceedings, members detailed the ways that the current payment and delivery structures raised barriers to high quality integrated care. Commission members discussed a number of alternative models that might support a better system of integrated care Rhode Island. For example, the state may consider pursuing the transformation of primary care that is already underway in the state's patient-centered medical homes; "bundled payments" to various providers who contribute services to the same beneficiry for a single illness or couse of treatment; and Accountable Care Organizations (ACOs) and ACO-like entities that incentivize health care providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes that provide for coordinated care, high quality, and efficient service delivery.[17]

> "CSI-RI has as a core requirement that each practice site must provide all patients with access to a nurse care manager whose services are paid for through the supplemental PMPM payment, a key feature of the multi-payer model. Such a system allows a practice to provide all patients with access to nurse care manager services and eliminates barriers such as patient co-pays and complex authorization procedures. A similar system could be created within primary care proactices to support patients with behavioral health and drug dependency needs." (Debra Hurtitz, MBA, BSN, (RN; Pany Yercaris, MD, MPH; Matthew Roman, LICSW, CPEHR; CSI-RI)
>
> "In order to achieve wide-spread adoption of integrated care, payment systems will need to reimburse for the time doctors participate in team meetings. Current payment practices present a real barrier to doctors being fully engaged and active members of integrated care teams." (Gary Bliss, The Providence Center)
>
> "We need a wide variety of options including substantial professional and support networks, coordinated services, vehicles for improved communication and planning, and service paradigms we haven't even thought of yet." (Rick Harris, LICSW, National Association of Social Workers, Rhode Island Chapter)

6) Payers should incentivize payment for providers that meet quality standards and best practice guidelines in integrating care and implementing behavioral health interventions. Payers and providers should build on existing practice guidelines to

[16] U.S. Department of Health and Human Services Administration on Aging (2012). *Rhode Island Policy Academy State Profile*. Retrieved online January 20, 2014, from http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Behavioral/docs2/Rhode%20Island%20Epi%20Profile%20Final.pdf.

[17] For more information about innovative models, see the Center for Medicare and Medicaid Services Innovation Center, at http://innovation.cms.gov/index.html.

reach common acceptance of measurements to show adherence to best practices and other quality metrics.

Payers and providers should demonstrate their support for improving cross-team communication and care coordination among and between providers and their patients. Other comprehensive strategies and methods to educate and engage providers and patients should also be supported. As documnted in *Primary care spending in Rhode Island: Commerical health insurance compliance*, a January 2014 report of the Office of the Health Insurance Commissioner, Rhode Island is making steady progress in moving away from a fee for service approach to payment.[18]

"True behavioral healthcare parity cannot be obtained until the issue of high co-pays and high deductibles is alleviated...Where it makes sense, explore alternative payment methods that do not necessarily rely on 'fee-for-service' only. Eliminate 'double co-pays' when more than two services are provided on the same day. Monitor reliance on high deducatible insurance policies and provide mechanisms for individuals to receive health, mental health and substance use services when not affordable due to high deductible policies." (Rick Harris, LICSW, National Association of Social Workers, Rhode Island Chapter)

"The transition from fee-for-service to other innovative payment models should help speed this integration." (Dr. Augustine Manocchia, Chief Medical Officer, Blue Cross & Blue Shield of Rhode Island)

"Shared risk/savings models among payers and providers such that integration would be 'incentivized'
- Full Service Health Plans and MBHOs
- Medical and Specialist Providers

...It should be noted that eleminiating multiple co-pays on a single day may be operationally challenging in a multi-payer environment." (Stephen J. Farrell, CEO, UniedHealthcare)

"We agree that payment for using quality standards is a good incentive for payers to use." (Jane A. Hayward, President & CEO, Rhode Island Health Center Association)

7) The Department of Health should take the leadership in reviewing critical policies affecting integrated care.

Joint Commission members heard from several sources – such as during the testimony of Dr. Patricia Recupero, President & CEO of Butler Hospital – that Utilization Review (UR), the process by which organizations determine if medical and behavioral health services are appropriate and necessary, is a priority area. As the entity with statutory responsibility for UR, the Department of Health should consider UR in light of the state's behavioral health needs.

8) Rhode Island's statutory framework should be examined to determine whether and how it may be changed to better support integrated care.

[18] The report can be found online, at http://www.ohic.ri.gov/documents/Insurers/Reports%202/2013%20Primary%20Care%20Spend%20Report/1_Primary%20Care%20Spend_Final.pdf.

The state should undertake a thorough review to determine whether its statutory framework maximizes opportunities for integrated healthcare. For example, the Office of the Health Commissioner could review the current Rhode Island parity law (RIGL § 27-38.2) for opportunities to strengthen the current practices for coverage of mental illness and substance abuse disorders and ensure consistency with the requirements of the federal Mental Health Parity and Addiction Equity Act.

> "The recently passed Wellstone and Domenci Mental Health Parity and Addiction Equity Act of 2008 requires parity between Mental Health and Substance Use Disorder benefits and Medical/Surgical benefits with respect to financial requirements and treatment limitations under group health plans and group and individual health insurance coverage. Some oversight may be necessary since final regulations were just issued in November of last year and this is now the law." (David Spencer, MBA, MPA, Executive Director, Data of RI)
>
> "We believe that in order to meet our stated goal of integration of behavioral health and primary medical care, it is important to look at not only the financing of healthcare services, but also the statutory framework for licensing provider and facilities, the framework for departmental operations and the 'mental hygiene laws.'" (Jane A. Hayward, President & CEO, Rhode Island Health Center Association)
>
> "Case Management should be defined in state laws and regulations using the Utilization Review law as a model." (Lisa Rocchio, Ph.D., Past-President, Rhode Island Psychological Association)

9) Examine opportunities to build upon and expand the infrastructure of the Chronic Care Sustainability Initiative (CSI-RI) for technical assistance.

The Joint Commission heard on multiple occasions about CSI-RI's training and support efforts. Members were positively impressed with the content of the training and support, which include data collection, reporting, and use; strategies for reducing hospital visits and emergency room admissions; working in teams; and adopting a culture of innovation.[19] Commission members maintained that integrated care in the state would benefit from CSI-RI's broadening the scope and scale of its training and support to include a wider array of healthcare professionals, as well as more activities.

> "Timely and effective information exchange is critical to team-based care, but is often hampered by privacy concerns, additional confidentiality rules related to the sharing of substance abuse treatment, barriers to interoperability between electronic health records (EHRs), and low adoption of EHRs among behavioral health providers.. CSI-RI recommends state-wide training on what information sharing is permissible between behavioral health providers and medical providers." (Debra Hurtitz, MBA, BSN, RN; Pany Yercaris, MD, MPH; Matthew Roman, LICSW, CPEHR; CSI-RI)

[19] Further information on CSI-RI's efforts can be found at http://www.pcmhri.org/pcmh-ri-programs.

10) Leverage existing efforts – in Rhode Island and elsewhere – to integrate primary care and behavioral health.

Joint Commission members pointed out that initiatives to provide an integrated healthcare system are taking place inside and outside the borders of the Ocean State, and that these efforts have identified strategies and quality measures, invested human and physical resources in different ways, and accumulated evidence-based knowledge of what works and what might work better. Members maintained that these initiatives and their components can serve as valuable building blocks for a statewide system. For example, the State Innovation Model (SIM) Grant proposal to Integrate the Primary Care and Behavioral Health System in Rhode Island lays out a vision for a value-driven, community-based, and patient-centered system that reflected considerable stakeholder contributions. Commercial payers in Rhode Island, as well as the state's Department of Behavioral Health, Developmental Disabilities, and Hospitals, have mounted pilot programs that strive to facilitate more integrated health. Initiatives in neighboring Massachusetts – such as Duffy Medical Center's integrated care model that was presented by Dr. Roanne Osborne-Gaskin – as well as Minnesota's Diamond Model – which features consistent methods for assessment/monitoring, a well-defined tracking system, and a stepped care approach, and relapse prevention – also offer insights that can shed light on Rhode Island's continued work.[20] As it moves forward in planning a statewide integrated system, attention should be especially focused on large-scale initiatives inside and outside of Rhode Island that yield robust information, providing decision-makers with a clear understanding of limitations and impact.

11) Explore collaboration compacts between behavioral health providers and practices that are organized as coordinated, co-located, and/or integrated, across settings and medical practices of different sizes.

As the Joint Commission studied different collaborative care models – including coordinated, co-located, and integrated models – members noted that Rhode Island has entered a transition phase as it pursues a more integrated healthcare system.[21] The transition period has brought and continues to present new demands to and refashion the roles of primary care providers, behavioral health providers, and a host of other professionals contributing to Rhode Island's healthcare system. Facing similar situations, a number of healthcare organizations have put into place collaboration compacts (sometimes known as care coordination agreements) that allow groups of healthcare professionals to articulate their commitments and contributions to a shared endeavor. To pave the way to a new integrated system and new services in Rhode Island, it may make sense to develop collaboration compacts among providers as a means to identify mutual expectations regarding clinical practices, accountability, professional norms and training, communication, and use of technology. Often what emerges from the extensive

[20] Unützer, Jürgen, Schoenbaum, Michael and Benjamin Druss (2013). "The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes." Centers for Medicare & Medicaid Services. May 2013.

[21] A full discussion of these models can be found in Collins , C., D.L. Hewson, R. Munger, & T. Wade (2010). *Evolving Models of Behavioral Health Integration Into Primary Care*. New York: Milbank Memorial Fund. Retrieved online January 16, 2014, from http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf.

planning and negotiation that go into creating such documents are stronger relationships that, in turn, support more effective care coordination.[22]

12) The Department of Health and the Office of the Health Insurance Commissioner should spearhead initiatives that focus on improving record sharing, capturing accurate, comprehensive data on health care system resources, and supporting population management.

Commission members heard on multiple occasions how the state lacks the capacity to collect, share, and act on data. For high quality integrated care to benefit all Rhode Islanders, a more robust data system and consistent standards for capturing and using common information need to be in place. Better data, as well as a cadre of people who are prepared to analyze them, will lead to better decisions among policy makers, providers, and payers. For example, analyses of common data can result in a clearer understanding of provider capacity at all levels of care, the identification of unmet health care needs, and clinical profiles of the highest risk populations. In addition, an inventory and assessment of existing resources and services could permit informed decisions to be made regarding which new or expanded services should be added.

> "Decisions of the appropriateness of adding new behavioral health services to this market should be data-driven, which cannot happen without an inventory of existing services in the state." (Dr. Augustine Manocchia, Chief Medical Officer, Blue Cross & Blue Shield of Rhode Island)
>
> "Start and implement an integrated care system with a focus on developing patient registries. We need to identify and manage those patient types, who with successful integrated interventions, show a reduction in inappropriate ER, labs, and office visits to help offset the future cost of a generalized screening and early intervention/preventive care approach." (Stephen J. Farrell, CEO, UnitedHealthcare)

[22] Mathematica Policy Research (2011). *Coordinating care in the medical neighborhood: Critical components and available mechanisms*. Contract No. HHSA290200900019I TO2. Washington, DC: US Department of Health & Human Services. Pages 16-18. Retrieved online January 20, 2014, from http://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20in%20the%20Medical%20Neighborhood.pdf

Appendices

Appendix A: GLOSSARY

Adapted from The Rhode Island State Healthcare Innovation Plan[23]

Accountable Care Organization (ACO): A health care organization that ties doctor and/or hospital payments to quality outcomes and cost of care for a population that has been assigned to them. The ACO contracts with a group or groups of providers to deliver highly efficient and effective care to its patients. The organization is accountable to the population it cares for and the payers that pay it money to provide care. If care is provided at a lower cost, the providers may share in a portion of the savings but only if quality targets are also met.

ACO-like structures: The title "Accountable Care Organization" or ACO refers to an organization that is recognized by the federal government (the Centers for Medicare and Medicaid Services or CMS) as one that meets the definition described above and as such are eligible to treat Medicare or Medicaid recipients. There are other types of organizations that are similar in structure and goals and may mirror the ACO exactly, but they may not be recognized by the federal government. These organizations may be referred to in a variety of ways, such as collaborative care, accountable care, or coordinated care businesses. Their requirements for business operations fall under state laws as opposed to a combination of state and federal regulations for the ACO.

Behavioral health: According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the term "behavioral health" is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.

Bundled Payments: There are a number of terms that may be used to describe a bundled payment: episode-based payment, case rate, global or packaged pricing, and so forth. Essentially, it refers to payment to a provider or group of providers for the expected cost for a clinically-defined episode of care for certain conditions or diagnoses. This may include inpatient, outpatient or any other services rendered to treat the condition of the patient. The team of providers involved in the episode of care receive one lump sum for all needed care while individually they are paid fee-for-service for the care they deliver. As such, they are responsible for coordinating treatment within the prescribed budget while meeting or exceeding quality metrics.

[23] The Rhode Island State Healthcare Innovation Plan (2014) (pp. 132-134). Available online at http://www.healthcare.ri.gov/healthyri/resources/SHIPwithAppendix.pdf.

Clinical integration: A network of doctors working (most often) in collaboration with hospitals. It includes a program of initiatives to improve the quality and efficiency of patient care, developed and managed by physicians, and supported by a performance management infrastructure. Clinical integration provides a legal basis for collective negotiation by independent physicians for improved reimbursement based on achieving better clinical outcomes and efficiency.

Community Health Teams (CHT): A coordinated team of often non-traditional care providers that interact or are integrated with traditional care teams like doctors, hospitals and long term care organizations. The CHT may include a nurse coordinator, social workers, dieticians, community health workers and care coordinators, or public health prevention specialists. As such, social determinants of health like housing, a person's sense of security, access to education, availability of healthy foods, and so forth can also be addressed in addition to more traditional physical and mental health. Operations are often supported by centralized technology systems that can "talk to each other" and share critical health information among the team such as electronic medical records, provider directories, and tools for predictive modeling of the health of the population served. CHTs work well when integrated with patient centered medical homes, provider groups, and accountable care-type organizations.

CSI-RI: CSI-RI is Rhode Island's Chronic Care Sustainability Initiative. CSI-RI's mission is to lead the transformation of primary care in Rhode Island by bringing together critical stakeholders to implement, evaluate and spread effective models to deliver, pay for and sustain high quality, comprehensive, accountable care for patients with chronic illnesses through the patient-centered medical home (PCMH) model. CSI-RI was launched in 2008 by the Office of the Health Insurance Commissioner. Currently, over 260,000 Rhode Islanders receive their care from CSI-RI practices.

Integration: Integrated care is a team-based healthcare model, in which medical and mental health providers' partner to facilitate the detection, treatment, and follow-up of psychiatric disorders in the primary care setting. Alexander Blount EdD. of University of Massachusetts Medical School explains that integrated care extends beyond just the co-location of providers and includes cooperative, flexible scheduling, enhanced communication, and coordinated patient interactions, among other aspects.

Patient Centered Medical Home!(PCMH) or Medical Home: A model of care that emphasizes care coordination and communication among providers. There are five functions of a PCMH: 1) it is patient centered meaning care is individualized and reflective of patient needs, culture, values and preferences; 2) care is comprehensive which means the organization is accountable to deliver a large portion of what its population needs like physical and mental health care needs, including prevention and wellness, acute care, and chronic care; 3) coordinated care means that the PCMH is responsible to the patient to ensure all aspects of their care and their providers are working toward the same goal, the patient's health. This may include hospital, outpatient or community services; 4) access to care means that patients are able to be seen when needed, experience shorter waiting times for urgent needs, around-the-clock

telephone or electronic access to the care team; and 5) quality and safety are assured through the use of medicine and treatment that is "evidence-based" meaning there is clinical evidence for its effectiveness. PCMHs use systems-based tools to help in the measurement and reporting of the effectiveness of care including patient experience and satisfaction.

Shared Savings: At least part of a provider's income is directly linked to quality and the financial performance of a health plan. If costs for a specific population are lower than projected and quality is at the same level or better, a percentage of the savings is paid to the providers.

SIM (State Innovation Model): The State Innovation Models (SIM) initiative is an initiative launched by the Center for Medicare and Medicaid Services (CMS) Innovation Center (CMS Innovation Center) The purpose of the State Innovation Models (SIM) initiative is to test whether new payment and service delivery models will produce superior results when implemented in the context of a state-sponsored State Health Care Innovation Plan. These Plans must improve health, improve health care, and lower costs for a state's citizens through a sustainable model of multi-payer payment and delivery reform, and must be dedicated to delivering the right care at the right time in the right setting.

Transparency: In health care, this term refers to the sharing, publicly, of cost and quality information. It is meant to 1) provide doctors and hospitals with benchmarks for improving their performance, 2) encourage consumers and payers to reward quality and efficiency by purchasing from those organizations with the highest quality and lowest cost, and 3) to help consumers make informed decisions about their health care purchases. It is NOT the sharing of individual or personal patient information but rather an aggregation of severity-adjusted cost and quality information of a treatment or condition by provider, geographic area, or by other demographic data. For "value-based purchasing," both quality and price information are essential to know in order to compare and make decisions. Transparency of cost and quality information has become more important as the cost burden has begun to shift to the consumer in the form of high deductibles, co-insurance or full fee-for-service in the case of the uninsured.

Value based care or purchasing: In contrast to the prevalent "fee-for-service" system of provider payment, value-based purchasing and care rewards the provider for delivering high quality, efficient care that is safe and at a low cost. Rewards, bonus payments, or shared savings to providers are conditional on achieving pre-determined goals for quality and cost. The financial incentives are designed to discourage inappropriate, unnecessary, or costly care when other equally acceptable alternatives are available.

Appendix B: RESPONSES FROM STAKEHOLDERS

Special Joint Legislative Commission to Study the Integration of Primary Care and Behavioral Health

Rhode Island Department of Health Public Comments

January 22, 2014

The Rhode Island Department of Health appreciates the opportunity it has been afforded to join with other key stakeholders throughout the study commission process. Under the leadership of co-chairs Senator Miller and Representative Bennett, the process has been open and positive throughout, for which the Rhode Island Department of Health is most grateful. In the course of its work, the materials presented, viewpoints expressed and discussions engaged in at the commission have all been of real value. The department further appreciates the opportunity to respond to the commission's draft report, and add its comments for the record

---

These comments relate most directly to draft finding number 3:

"Primary care and behavioral health integration need to have a strong financing component to achieve success."

This finding is well established; achieving genuine integration of primary care and behavioral health requires a payment system that itself is integrated, and that works to support a truly collaborative practice model. The Primary Care Trust is designed to do exactly that.

The commission's charge to "consider the advisability of creating a Primary Care Trust or other mechanism to fund and otherwise support a comprehensive integrated primary care and behavioral health system for all Rhode Islanders[.]" begins by recognizing that the Primary Care Trust, as presented by Dr. Fine to the full commission on September 25, 2013, and as further considered at the subcommittee meeting of October 30, 2013, is envisioned to: (1) fund, and (2) otherwise support an integrated delivery system.

The Primary Care Trust is conceptualized to be the focal point and aggregator of dollars that are attributable to primary care, behavioral health care, and other allied services costs that are currently in the health care payment system. To the extent that it can aggregate funds and simplify payment systems (by, for example, moving rapidly away from fee-for-service payments), it will function to reduce administrative costs for both and providers alike. The cost savings of doing so can be a source of support for enhanced services.

As presented by Dr. Fine, the Primary Care Trust was shown to be the payor for an improved delivery system model termed "Neighborhood Health Stations." These are envisioned as community-based, multi-disciplinary team practices of professional providers that will provide ninety percent (90%) of all medical care needs to ninety percent (90%) of the whole population of its service area or neighborhood. They will be supported and rewarded through the Primary

Care Trust to achieve improved outcomes on a population basis, population understood as everyone, not just the active patient population.

To achieve this end, each Neighborhood Health Stations will develop its own multi-disciplinary team, one configured to best provide for positive outcomes in its neighborhood. Primary care and behavioral health will thus be integrated by both the payment model and the practice architecture. The professional teams can include not only physicians (including pediatricians, internists, and family physicians) and psychologists and social workers, but also dentists, nurses and nurse practitioners, home health workers and others: whomever effective, population-based practice requires.

These comments relate most directly to draft recommendation number 3:

"Examine opportunities to create a robust legislative pilot for an integrated primary care and behavioral care and health promotion model, working with the Department of Health's Health Care Planning Advisory Council to identify the state's existing behavioral health care capacity and to target unmet needs. The pilot should be conducted in a specific geographic location(s), feature a capitated fee structure to assess the impact of interventions aimed at population-based health outcomes, and be large enough to generate enough information about outcomes and impact to justify or dismiss statewide expansion."

The Department of Health strongly agrees with this recommendation, The comments above relating to finding number 3 provide a more detailed description of what this pilot will be. We would note, however, that one concept presented to the commission, the Community Health Team approach, is not at all the same, and is likely to be less effective in achieving the triple aim and population outcome improvements as is the Neighborhood Health Station pilot.

Community Health Teams have been tested in places such as Vermont where the population is less dense than Rhode Island's, but it is not clear whether these Community Health Teams will be effective in an urban environment. Rhode Island has a unique opportunity to take advantage of its population density to support neighborhood-focused integrated practices to achieve both improved patient – and population – outcomes, and lower global medical costs.

Focused care-coordination of people at highest risk has been used effectively in places like Camden, New Jersey, but its use has not been integrated well into patient centered medical homes. It is not clear how a segregated approach applied to the highest risk patients will impact the primary care ecology, but there is concern that the Community Health Team structure will, by separating subsets of patients from integrated multi-disciplinary practices, undermine both the breadth and depth of primary care services necessary for maximizing the efficacy of the primary care "home."

As delineated in the Rhode Island State Healthcare Innovation Plan, the Community Health Teams model is expensive. The dollar amount suggested in presentations about the financial model is approximately $12 per member per month. That number, which is very significant

compared to the current full spend on primary care in Rhode Island, would be used to create another service delivery model, and create more complexity in an already overcomplicated delivery system array of market actors. More importantly, this innovation diverts funds that could be used to directly support primary care practices.

In the last twenty years, primary care practices have lost income once earned from attending patients in the hospital. They have lost income as immunizations have moved to mass immunizers and pharmacies. They have lost income from urgent care. They have lost income from the provision of laboratory services. They are likely to lose volume and income from routine sick visits, as retail pharmacy clinics gain a foothold in Rhode Island. They have lost income to electronic medical record providers while their practices and lives have been made exceedingly complex by requiring electronic medical record use.

The Department of Health suggests that resources that would be required to create and sustain Community Health Teams will be better targeted to directly strengthen primary care practices and their architecture, in this case through piloting a Neighborhood Health Station as described in the draft recommendation and in these comments.

Feedback from Blue Cross & Blue Shielf of Rhode Island

January 24, 204

The Honorable Joshua Miller
The Honorable David Bennet

VIA Email, hard copy to follow

Dear Senator Miller and Representative Bennet,

On behalf of Blue Cross & Blue Shield of Rhode Island, I want to thank you for the opportunity to participate in the Special Joint Committee to Study the Integration of Primary Care and Behavioral Health. The Committee provided a welcome forum to bring together key stakeholders to air concerns and share ideas addressing how to improve care in Rhode Island. At your invitation, we offer the following thoughts on the draft report. These comments beginning with what we think is your highest concern, the recommendations, then moves back into the body of the report.

Our comments focus on recommendation number 6. We suggest redrafting this recommendation to make it more actionable, to more fully reflect the importance of quality and affordability, and to acknowledge that most integration will happen outside of the co-location model.
From a drafting standpoint, we recommend making the word "interventions" be the end of what would then become the first sentence. The remaining text would be replaced with a second sentence recommending payers and providers build on existing practice guidelines to reach common acceptance of measurements to show adherence to best practices and other quality metrics. Additional elements could reflect the recognition that co-location will likely have a limited reach and that most coordination will happen within the broader framework of improving quality. Payers and providers should demonstrate their support for improving communication among and between providers and their patients, as well as other methods to educate and engage providers and patients that facilitate and encourage care coordination. Lastly, the recommendation could recognize that the transition from fee-for-service to other innovative payment models should help speed this integration.

An additional recommendation, whether as part of number 6 or on its own, would be on the issue of data on health care system resources. The state has a critical necessity to better know provider capacity at all levels of care and to build a fact-based estimate of its residents' needs. The Office of the Health Insurance Commissioner, the Department of Health, or some other appropriate entity or group, should be tasked with conducting that inventory and assessment. Decision of the appropriateness of adding new behavioral health services to this market should be data-driven, which cannot happen without an inventory of existing services in the state.

Moving back into the body of the report, we offer comments organized by page number.

- At page 9, the draft cites the finding reported in the State Healthcare Innovation Plan that behavioral health diagnoses appear in the top three highest volume diagnoses. My recollection is that many members of the Committee challenged the accuracy of this finding and I agree with their concerns

related to the method of grouping of services. It would be inappropriate to use that as foundational information.

- At pages 10-11, additional clarification of how the terms collaboration, co-location, coordination, and integration are used in the report would be helpful. Also helpful would be background information about the provider environment (for example, information on provider practice sizes in primary care and behavioral health).
- At page 12, it is not clear what is meant regarding the partial sentence. We recommend that on integration, the report recognize that however "integrated care" is defined, interim steps for both patients and providers will be necessary to achieve that ultimate goal. These could include educating the provider workforce and patients, standardizing certain communications, and implementing technology tools to facilitate those activities. The transition would include establishing quality standards supported by evidence based practices. Both behavioral health and primary care providers would need to be active in these efforts, while payers will need to reinforce and reward this behavior.
- At page 14, in the third paragraph, the report should replace the sentence about Blue Cross's experience on incentives for referrals, with this: "Blue Cross & Blue Shield of Rhode Island recognizes that the medical visit is likely the first touch point for many patients. Blue Cross supports the identification of behavioral health concerns in primary care by incentivizing the use of screening tools. For example, the use of screening tools for depression and anxiety is a quality metric for primary care medical homes (PCMHs)."
- At page 15, the report comments about system resources. In support of the proposed recommendation above, here the report could note that Dr. Recupero's broad comments point to the state's critical need to conduct an inventory of provider capacity at all levels of care and build fact-based estimates of its residents' needs.
- At pages 16-17, the section heading speaks to parity, but the body of the section focuses on Blue Cross & Blue Shield of Rhode Island's behavioral health experiences without mentioning parity (*appropriately, as that was not a focus of our comments*). If the final report is to include a reference to parity, then it could explain that federal law sets out requirements for parity and those requirements apply without need for any change to state law. BCBSRI, and presumably all other payers, follow those federal rules, as well as state law. In regard to the report's representation of the testimony and other comments, please consider the following clarification of the comments:
    - Our experience suggests that co-location is not an efficient way of meeting the **populations'** behavioral health needs. That is, on a population basis, it is not possible to have enough behavioral health providers in a co-location setting to meet the broad population needs, in terms of the range of services needed or based on access and volume within any one practice.
    - On page 17, the first bullet should be changed to more appropriately reflect the intent of the comment, which is that Blue Cross's goal is to move from fee for service payments to other financial models that better incentivize providers to meet an individual patient's overall health care needs and that of a population of patients. Copayments for two visits - medical and behavioral - on the same day may be a barrier for some, but those scenarios are the exception and multiple same-day services are not the common experience. Furthermore, on the medical side, patients frequently see a primary care practioner and medical specialists on the same day, in which case cost sharing applies without waivers. No evidence was presented that a behavioral health provider in this scenario should be treated differently than a medical provider.

- In the third bullet, we suggest the text reflect that practices should be reviewing their upcoming patient visits to determine which patients might benefit from a behavioral health consult or referral. Blue Cross currently provides financial support for nurse case managers and PCMHs to do this proactive care coordination.

Lastly, where the report suggests that financing being a barrier to care, it might more clearly articulate that this barrier differs between the uninsured, Medicaid, and commercially insured patients.

We look forward to working with you to determine if and how the work of the commission might lead to legislation or other next steps. Even absent legislation, we appreciate your creating this setting in which important issues were discussed and the foundation for future innovations was established.

Sincerely,
Dr. Augustine Manocchia,
Chief Medical Officer
Blue Cross & Blue Shield of Rhode Island

Feedback from the Rhode Island Health Center Association

Senator Joshua Miller, Co-Chair
Representative David Bennett, Co-Chair
Special Joint Legislative Commission
to Study the Integration of Primary Care and Behavioral Health
Rhode Island State House
82 Smith Street
Providence, RI 02903

Dear Chairmen Miller and Bennett:

Thank you for the opportunity to comment on the draft report of the Special Joint Legislative Commission to Study the Integration of Primary Care and Behavioral Health. I was grateful to be appointed to the Commission and to represent the Rhode Island Health Center Association (RIHCA). Integration of primary and behavioral health care is very important to RIHCA and our members. Together we have been learning about how to integrate care, discussing best practices, and then trying new things once again. We have also gathered significant experience regarding challenges facing integration efforts.

RIHCA represents Rhode Island's nine community health centers, including eight federally qualified health centers (FQHCs) and one island-based health center. In addition, one community mental health organization, the Providence Center, is an associate member of RIHCA. In 2012, the FQHCs provided care for nearly 135,000 Rhode Islanders who are uninsured, underinsured, publicly insured (*e.g.* Medicaid) and privately insured. The community health centers have a long history of providing high-quality, low-cost primary medical, dental and behavioral health care to Rhode Islanders. Community health centers are not-for-profit health care providers that serve patients who may otherwise confront financial, geographic, language and cultural barriers accessing health care services. All FQHCs provide some behavioral health care and dental care, and have examined various strategies to integrate these services with their medical care. Several employ behavioral health staff directly. The Providence Center and Providence Community Health Centers are bi-directionally co-located, with PCHC running a medical office at the Providence Center on North Main Street, and the
Providence Center running an office at PCHC-Prairie Ave.

In 2011, RIHCA engaged a consultant to prepare a paper to help foster more structured conversation regarding efforts and strategies to integrate behavioral health and primary medical care. I am attaching the resulting paper here. The time is ripe for Rhode Island to take the next steps towards truly integrating behavioral healthcare and primary medical care. RIHCA and our member community health centers and community mental health organization are looking forward to working with the General Assembly to develop possible legislative strategies to address the needs of Rhode Islanders.

RIHCA offers the following comments regarding specific findings and recommendations:

Finding 1. We concur that leadership is critical to developing strategies to successfully achieve full integration of behavioral health care, substance abuse treatment and primary medical care. The Joint Commission should continue with a charge to coordinate ongoing efforts, or join efforts with the Health Care Planning and Accountability Advisory Council (HCPAAC)

Finding 2. Rhode Island has reached consensus regarding the importance of integrating primary medical and behavioral health care. It is critical to look at the financial incentives for providing care across different systems. The analysis commissioned by the HCPAAC will provide important information the state can use when determining policy changes that would be advisable to promote integration of care. If the state has the opportunity to integrate Medicaid financing for all Medicaid services, including behavioral health and medical care, this might be a place to look for opportunities to innovate and integrate care.

Finding 3. Achieving meaningful clinical integration requires a carefully designed change process that helps providers communicate across disciplines, and helps systems develop that facilitate the integration. All of this should be designed to maximize patient access in a meaningful way – the patient should be at the center of the patient-centered design including the planning and implementation process.

Finding 4. RIHCA concurs that, without strong, well thought-out financing strategies, integration cannot succeed, or will not be sustainable. While there is stigma associated with accessing behavioral health care, and this should not be ignored, a larger problem remains that even with the attached stigma there is inadequate access for individuals currently, actively seeking care. We recommend prioritizing the access issues at this point in time. Access is a crucial issue in Rhode Island, and its importance cannot be underestimated. We also need to be aware, as we work to redesign the healthcare delivery system, that we often address one piece of the problem when what we really need is an extensive overhaul of the whole system at the same time. We need to be very aware of the danger of piecemeal solutions that might unintentionally move one problem down the road, to another part of the system. A prime example, in Rhode Island and nationally, is the changes in prescribing patterns of pain medication. As prescribers began to prescribe less pain medication, or stop prescribing for addicted patients, some of these patients moved to diverted prescription drugs or street drugs like heroin. The recent publicity around the multitude of overdoses in Rhode Island so far this year highlights the need for more access to services, and also for increased attention to possible unintentional consequences.

Finding 6. RIHCA believes that the Affordable Care Act may provide the opportunity to increase access to behavioral health services. With the addition of a projected 70,000 or more additional insured individuals (50,000 in the Medicaid program), there may be an unparalleled opportunity to form an organized system of care, integrating behavioral health and primary medical care. The newly eligible Medicaid beneficiaries, low-income adults without dependent average. The expansion population also comes with a 100% federal match for several years. We should use this financing to truly integrate services for Medicaid populations across departments, and create a meaningfully integrated, organized system of behavioral health and primary medical care.

Recommendation 1. We agree that it is important to connect, coordinate and support the delivery of integrated healthcare. However, we do not think any single state agency is the right place for this effort. Instead, we recommend either that the work of the Joint Commission continue, or that this work be moved to the Health Care Planning and Accountability Advisory Council (HCPAAC).

Recommendation 2. We recommend that the locus of activity, whether the Joint Commission or HCPAAC, be charged with investigating opportunities to ensure that access to integrated primary medical and behavioral health care is maximized, and that patients seeking care are able to access it. Additional tasks might be to investigate whether to streamline funding for services and how best to use the opportunities created by the Affordable Care Act, including expanded access to Medicaid and private health insurance.

Recommendation 5. ACOs are one possible services delivery model that may help foster a move toward more integrated care. However, we recommend that a wider net be cast, and as described above, multiple opportunities for streamlined funding for integrated care should be explored.

Recommendation 6. We agree that payment for meeting quality standards is a good incentive for payers to use. There was, however, much discussion by the taskforce that co-location is a desirable model for some practices, but not all. Multiple strategies will work best in Rhode Island, and these will surely include co-location, particularly at community health centers and some other larger medical practices. However, co-location is not and should not be the goal – it is one of several possible strategies that can help achieve the goal of meaningfully integrated care.

Additional possible recommendation: We believe that in order to meet our stated goal of integration of behavioral health and primary medical care, it is important to look at not only the financing for healthcare services, but also the statutory framework for licensing provider and facilities, the framework for departmental operations and the "mental hygiene laws." We believe the time is right to revisit and modernize the statutory framework under which we operate, with an eye to making it more supportive of the integrated system we hope to create.

RIHCA and our members are committed to working together with the General Assembly as we move toward a more integrated system of care. It is our hope that through the work of this commission and other ongoing efforts, Rhode Island can take the next steps towards realizing our goal of integrated behavioral health and primary medical care.

Sincerely,
Jane A. Hayward
President & CEO
Rhode Island Health Center Association

Feedback from The Providence Center

January 21, 2014

To:
From: Garry Bliss, Director of Government & External Relations
The Providence Center
Re: Draft Report, *Special Joint Commission to Study the Integration of Primary Care and Behavioral Health*

Thank you very much for this opportunity to provide comments on the Commission's report. These comments represent the input of several key leaders of The Providence Center, a full-service community mental health center located in Providence, serving more than

Findings

1) We concur with this finding and agree that clearly defined leadership is essential in order to continue to make progress building a comprehensive system of Integrated Care. This will be all the more critical given the challenges ahead that must be resolved and moved forward.

   Given the scope and scale of work to be done, we believe it might be productive to convene a second Joint Commission to explore some issues such as leadership in greater detail and produce a specific recommendation on where long-term leadership would be most effectively placed.

2) We believe consensus already exists around the value and benefits of integrating primary care and behavioral health. As noted in the report, and as described at meetings of the Commission, the state has several examples of integrated care currently under way across Rhode Island.

   Given our experience and the current landscape for integrated care, we believe this finding could be more robust and call for moving forward with implementing integrated care. Rhode Island is fortunate to have some successful integrated care models. These initiatives can and should form the foundation for future steps to expand beyond current activity.

3) Training and education will be critical to the success of any efforts to fully implement integrated care. The state has a strong healthcare education and workforce development infrastructure that can be a strong foundation for this work. The principles and practices of integrated care should be fully embraced by all entities involved in the education, training, and professional development of healthcare workers at all professional levels.

4) Financing is the most significant barrier to fully realizing the benefits of integrated care. As stated in our comments to the first Finding, we believe a follow up Commission with are more narrowed charge is in order. This second Commission could explore and make specific recommendations on how to address the financial barriers in place now and the ways to achieve

greater alignment between primary and behavioral health and streamlined administration of state healthcare resources.

5) At the last meeting of the Commission there was extensive discussion about the need for greater clarity in this Finding and the fact the Finding as currently written combines two different, and somewhat separate, observations.

   We will not repeat those, but we do agree that parity and payment issues must be resolved in order for behavioral healthcare to be fully incorporated into a holistic, whole person, health strategy.

6) The Affordable Care Act will, undoubtedly, have a profound impact on the healthcare landscape of Rhode Island, particularly for low income Rhode Islanders who will now have access to quality service, including preventive, primary, and behavioral care. A collaborative approach, like that used by the Commission, is probably the best way to identify and build broad support for specific changes to Rhode Island laws.

   As was noted at the Commission meetings current high copay requirements and high deductibles for behavioral health are very real barriers to service.

General

In addition to the notes above relating individual findings, we offer the following points which we believe merit attention in the final report by the Commission:

- At several Commission meetings the issue was raised about the need to be clear about the breadth of services which fall under the general umbrella of "mental health." In order to avoid any confusion, in order to ensure that future steps are as broadly inclusive as the Commission members intended, the report should include a statement clarifying that true integrated care also incorporates behavioral health and addictive disorders. And, in terms of addictive disorders, the reports should specify that both treatment and recovery are critical to long-term success. Recovery Support Services, are essential immediately after treatment or as a stand-alone "on ramp" for an individual seeking break an addiction. Additionally, long-term Recovery Support Services are the lynchpin of maintaining the sobriety. Just as those with diabetes or asthma are provided on-going care after an acute episode, so to do those with addictive disorders need support after treatment.
- In order to achieve wide-spread adoption of integrated care, payment systems will need to reimburse for the time doctors participate in team meetings. Current payment practices present a real barrier to doctors being fully engaged and active members of integrated care teams. This jeopardizes the gains made through coordination of all of the other medical and support professionals. This can be done while still respecting the premium on time from doctors.
- Peer Mentors are an extremely valuable component of the integrated care practice at The Providence Center. They should be central part of any future pilots or programs advancing integrated care. However, in order for Peer Mentors to be a standard part of a robust integrated care system, they need to be fully integrated into the payment system.

- Integrated care is a more sophisticated and demanding method of providing care. Those who are best positioned to work effectively within an integrated care model are often professionals based within larger organizations. However, payers do not always reimburse for such service when not provided by an individually licensed professional.
- While much progress has been in recent years to improve record sharing through compatible, uniform, and harmonious information systems and practices, there remain large gaps. A clear directive to define common information sharing standards to facilitate integrated care would provide critical support to expanding high-quality integrated care.

Recommendations

1) The leadership required to realize these changes needs to be broader than just the Office of the Health Insurance Commissioner in order to ensure all healthcare payment streams – notably Medicaid – are incorporated. Additionally, licensure issues will need to be explored and addressed. An integrated, multi-agency task force of state agencies may be the most productive way to proceed, and given the level of integrated planning conducted to prepare for and implement the Affordable Care Act, the timing for this is quite opportune.

2) We agree wholeheartedly with the "no wrong door" approach, believing that is the philosophy that will best serve clients, putting their needs first. This recommendation might be strengthened by highlighting the area where changes are needed in order to realize this goal, such as parity between behavioral health and primary care and the need for more providers to be trained in integrated care.

6) Implementing this recommendation is critical to the success of integrated care. In our experience, we have found cross-team consultation and care coordination to be essential. And yet this is singularly difficult to achieve under current reimbursement and management systems. Without a comprehensive way to address this, the benefits of the various models for integrating care will not be realized. Additionally, it is important to ensure payers reimburse for activities such as case management and education. These investments – of time and money – should not be seen as secondary. They are central to improving patient well-being.

9) This recommendation could be strengthened by also stating that the scope and scale of CSI-RI trainings could be broadened to include a broader array of healthcare professionals and more activities.

Feedback from CSI-RI

January 20, 2014

The Honorable Senator Joshua Miller
The Honorable David Bennett
Co-Chairs, Joint Commission to Study the Integration of Primary and Behavioral Health
Rhode Island General Assembly
82 Smith Street
Providence, RI 02903

Dear Co-Chairs Miller and Bennett:

We are writing on behalf of the Chronic Care Sustainability Initiative of Rhode Island (CSI-RI). CSI-RI was pleased to serve as a member of the Joint Commission. Our Executive Committee appreciates the opportunity to submit recommendations to the Joint Commission as you consider how to advance the integration of primary physical and behavioral health care in Rhode Island.

CSI-RI is a statewide multi-payer, patient-centered medical home initiative (PCMI) involving 48 adult primary care practice sites in the state of Rhode Island. Participating practices represent 303 primary care providers who care for nearly 220,000 Rhode Islanders (over 20% of the population).

- CSI-RI's Vision: Rhode Islanders enjoy excellent health and quality of life. They are engaged in an affordable, integrated healthcare system that promotes active participation, wellness, and delivers high quality comprehensive health care.
- Our Mission: To lead the transformation of primary care in Rhode Island. CSI-RI brings together critical stakeholders to implement, evaluate and spread effective models to deliver, pay for and sustain high quality, comprehensive accountable primary care.

In addition to achieving the triple AIM, our forth strategic goal is to expand the number participating practices so that 500,000 (or approximately half the people in our state) will have access to high functioning PCMHs by 2018. Through CSI-RI, participating practices receive supplemental per member per month (PMPM) payments to transform their practices into PCMH's that improve quality and patient experience, reduce costs, and improve population health outcomes. CSI-RI has recently created a broad-based Integrated Behavioral Health Committee consisting of representatives from behavioral health providers, primary care providers, health plans, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), Rhode Island Quality Institute, and EOHHS staff. The mission for this committee is to lead the transformation of primary care in Rhode Island in the context of an integrated health care system. The committee will likely expand the scope of work to include the pediatric population as funding has recently been secured to launch PCMH-Kids.

CSI-RI practices have a working knowledge of population needs and have a demonstrated track record of improving quality outcomes and patient experience. In addition to offering recommendations to the Joint Commission, CSI-RI would be interested in working with the State to plan, implement, and evaluate strategies for advancing payment models that achieve primary care and behavioral health integration.

Recommendations

CSI-RI recommendations are based on our vision for a sustainable system approach for improving health outcomes base on our experience in providing coordinated, co-located, and integrated behavioral health services. The recommendations are also based on a review of the literature, with particular emphasis on the Milbank Memorial Fund Report (2010): *Evolving models of behavioral health integration in primary care*. C. Collins, D.L. Hewson, R. Munger, T. Wade.

Outlined below are key areas for your consideration:

1. Endorsement of Rhode Island Health Care Reform Act of 2014: CSI-RI supports the Rhode Island Health Care Reform Act of 2014 as it seeks to improve affordability and effectiveness of all health care, works to more completely implement health care parity, ensures that behavioral health is managed with the same standards as all health care, and acts on national priorities that are widely recognized, but not presently addressed.

2. Calculate Total Cost of Care: There is a priority need for understanding total cost of care, including knowing the cost of the highest cost patients. Payers need to work together to obtain integrated financial data (inclusive of systems that "carve out" behavioral health and substance abuse services and expenses). As strategies are selected and evaluated, it will be important to ensure that there are shared primary care and behavioral health objectives with total cost reduction.

3. Understand Gaps in Care: There is a need to conduct an environmental scan to better understand risk areas and shortage areas so that priority can be given to developing systems and supports that will address critical areas of need. Analysis could include such things as review of adverse event reports, work force competencies (behavioral health and medical) for delivering integrated services, and access to care barriers related to meeting patient needs based on insurance status and/or out of pocket expenses.

4. Statewide Initiatives to Address Service Gaps: The Commission is urged to explore examples of statewide initiatives that have been created to successfully address service gaps. For instance, the University of Massachusetts established a Child Psychiatry Access Project to provide primacy care practices with real-time telephone consultation from a child psychiatrist or nurse specialist. The primary care provider may also refer the patient for psychiatric evaluation and assistance with treatment planning. Additionally, a team consisting of a case manager, social worker and psychiatrist provides support within a geographic region, offers consultation and training for primary care providers, and helps families that are placed on waiting lists access to specialty care and direct services. The program is expanding to include similar services for parents with post-partum mood disorders identified by pediatric, obstetric, or primary care providers. Rhode Island Primary Care Physician Corporation has recently established a web-based referral network for behavioral health providers as primary care providers often cite knowing who to call as a barrier to care. The State might want to consider creating a state-wide web-based information and referral system so that primary care providers

could have ready access to information on behavioral health providers (with information such as areas of specialty, languages spoken, credentials and insurance plans accepted).

5. Payment System Reform: CSI-RI has as a core requirement that each practice site must provide all patients with access to a nurse care manager whose services are paid for through the supplemental PMPM payment, a key feature of the multi-payer model. Such a system allows a practice to provide all patients with access to nurse care manager services and eliminates barriers such as patient co-pays and complex authorization procedures. A similar system could be created within primary care practices to support patients with behavioral health and drug dependency needs. Other states (Minnesota and Massachusetts) have created bundled case rates to fund care management and psychiatric services that are worthy of the Joint Commission's examination.

   In the short term, the Commission may want to consider a tiered approach to support integrated behavioral health such as activating medical and behavioral health codes by all payers and paying both behavioral health and medical providers for telephonic consultation and case conferencing. Additionally we recommend that consideration be given to how team based care can be financially supported. Presently practices must rely on separate face to face encounters. There is no payment mechanism for consultation, and no ability to bill for both behavioral health and primary care providers if both see the patient at the same time and limited ability to bill if both providers see the patient on the same day.

6. Promote Information Sharing: An important challenge to the integration of primary care and behavioral health services is the exchange of information between providers. Timely and effective information exchange is critical to team-based care, but is often hampered by privacy concerns, additional confidentiality rules related to the sharing of substance abuse treatment, barriers to interoperability between electronic health records (EHRs), and low adoption of EHRs among behavioral health providers. HIPAA is often cited as a barrier to information sharing. While federal regulation CFR 42 restricts information sharing regarding substance abuse services, sharing information between primary care and behavioral health practitioners for the purposes of care coordination is permitted under HIPAA. CSI-RI recommends state-wide training on what information sharing is permissible between behavioral health providers and medical providers.

   The state has addressed privacy, confidentiality, and interoperability challenges through CurrentCare, Rhode Island's Health Information Exchange, and should support increased use of CurrentCare for the exchange of information between primary care and behavioral health providers. Such increased use can be attained through additional data feeds from primary care and behavioral health providers' EHRs to CurrentCare, as well as through increased use of the CurrentCare Viewer by behavioral health and primary care providers. In particular, the CurrentCare Viewer, which providers can use to access patients' longitudinal health records, offers unique opportunities for improved information sharing with the behavioral health community, as it does not require

providers to have an EHR in order to view patients' health records. In addition, the State should support increased use of Direct HIPAA-compliant secure email for peer-to-peer electronic exchange of protected health information between behavioral health and primary care providers. As with the CurrentCare Viewer, Direct email does not require providers to have an EHR and could be especially beneficial for communicating with providers without an EHR.

7. Cost-reduction strategies: One area of frustration for primary care providers is that frequently patients who are at-risk and in need of inpatient care are required to be "medically cleared" at the emergency room. CSI-RI recommends that, when clinically appropriate, the present practice be reviewed of medically clearing patients at emergency rooms rather than through the primary care provider to see if there are opportunities for meeting medical clearance criteria in the primary care setting.

Thank you in advance for your consideration of these recommendations on advancing integration of primary care and behavioral health services. Please feel free to contact me if you need additional clarification on these recommendations.
Sincerely,

Debra Hurwitz, MBA, BSN, RN
CSI-RI Co-Director
debra.hurwitz@umassmed.edu
508-856-4270

Pano Yeracaris MD, MPH
CSI-RI Co-Director
pyeracaris@gmail.com
617-953-5501

Thomas Bledsoe, MD
CSI-RI Co-Chair CSI Executive and Steering Committees
Primary Care Internal Medicine
University Medicine
285 Governor Street
Providence, RI 02906
401-228-3480
Thomas_Bledsoe@brown.edu

Matthew J. Roman
Matthew J. Roman, LICSW, CPEHR
CSI RI Co-Chair Integrated Behavioral Health Committee
Health Center Director, Tri-Town Community Action Agency
1126 Hartford Avenue
Johnston, RI 02919

401-519-1945
mroman@tri-town.org

Comments on the Draft Report of the Special Joint Commission to Study the Integration of Primary Care and Behavioral Health

Lisa M. Rocchio, Ph.D.
Clinical and Forensic Psychologist,
Past-President, Rhode Island Psychological Association

Finding #2: Clarify that *multiple and varying models* of coordinated/integrated will be needed in order to meet the health needs of the population, and that *co-location is neither the only, nor the best model for all circumstances.*

Also in the third paragraph of that section, the sentence beginning with "Another payor…." should be revised to read: *A committee member (Dr. Lisa Rocchio) made a suggestion that existing CPT codes, such as those for collateral contacts between different providers or between providers and other supports such as schools and dieticians, should be reimbursed to facilitate coordination of care.*

Finding #3: add : including training primary care *and behavioral health* practitioners and staff

Finding #5: Revise for clarification purposes: "While access to behavioral and medical health services *in addition to case management and other support services is critical*….."

Finding #6: In explanatory paragraphs, specify that *additional barriers to access include high deductibles, high co-payments and restrictions on outpatient behavioral health practitioners providing services to Medicaid recipients.*

Recommendation #2: Clarification is needed on what is meant by "wrong door". Add the words "For example" to start of second sentence, and clarify what is meant by use of "evidence-based screening tools" and who will be using them.

Recommendation #3: The pilot should use an "*alternative or global fee structure*" rather than a "capitated fee structure"

Recommendation #4: *services to underserved populations such as children, adolescents and geriatric patients*

Recommendation #6: *Care-coordination* (instead of co-location) is encouraged

Recommendation #7: Payer's Utilization Review *and Case Management* policies should be reviewed. In addition, Case Management should be defined in state laws and regulations using the Utilization Review law as a model.

Recommendation #10: Use more general language with the emphasis on considering other states' models *such as* the Minnesota Diamond model.

Stephen J. Farrell
Chief Executive Officer
475 Kilvert Street
Warwick, RI 02886
Tel 401-732-7348
Fax 401-732-7536

January 22, 2014

The Honorable Senator Joshua Miller
The Honorable Representative David Bennett
Co-Chairs
Special Joint Commission to Study the Integration of Primary Care and Behavioral Health
Rhode Island General Assembly
82 Smith Street
Providence, RI 02903

Dear Co-Chairs Miller and Bennett:

UnitedHealthcare appreciates the opportunity to have participated in the meetings in connection with the Special Joint Commission to Study the Integration of Primary Care and Behavioral Health and would like to take this opportunity to provide comments on the draft report. We commend the work of the Special Joint Commission to identify and start to address the issues of medical and behavioral integration.

It is important that the framing for the work be:

a. Aligned with the triple aim for healthcare, (improving the patient experience, improving the overall population health, and reducing the per capita cost of care)

b. Promote uniformity among the payers and providers, like the Diamond Project, including:

   i. Defining the scope of services to be included as a part of integration services, (provider to provider consultation and case management)

   ii. Use of standard codes by payers and providers

   iii. Use of NQF and other acceptable performance measures

This is important to:

a. Reduce unnecessary administrative complexity for providers who manage populations from different payers
b. Promote the necessary office practice changes to provide integrated care
c. Set a foundation for uniform measurement of performance.

The Special Joint Commission in Recommendation 2,3,and 5 promote the adoption of wide spread screening of patients in a PCP practice for behavioral health conditions, use of capitation or ACO practices and payment for consultation and case management services. In setting policy for these proposed pilots which include all these elements, it is important that there is a progressive approach in the implementation of integrated care models to ensure effective and affordable care. Promoting broad based screening and capitation arrangements in a system or provider practice that is not experienced or trained could lead to excessive referrals to behavioral health, gaps in care, and unnecessary cost or practices operating in the negative.

We would recommend:

a. Voluntary trials and pilots where the process leaves room for variation as opposed to mandates which are largely inflexible

b. The use of performance measurement and pay for performance mechanism as the initial construct for integrated practices. The performance measures should be designed to promote cross accountability for medical and behavioral health providers who service the same patients to promote coordination of care, (e.g. both provider types are accountable for blood glucose test rates for patients on antipsychotic medications). The standardized performance measures should include clinical quality and cost-efficiency or appropriate use metrics.

c. Start and implement an integrated care system with a focus on developing patient registries. We need to identify and manage those patient types, who with successful integrated interventions, show a reduction in inappropriate ER, labs, and office visits to help offset the future cost of a generalized screening and early intervention/preventive care approach. Additionally, data subsets could be prioritized to include Admission, Transfer and Discharge reports from hospitals and EDs.

To present a value oriented perspective to these recommendations we would add focused recommendations related to:

- Multisystem data integration needs as it relates to medical behavioral management and population management
  - Necessary for ongoing management of integrated care plans
  - Necessary for identifying highest risk populations
- Shared risk/savings models among payers and providers such that integrated would be "incentivized"
  - Full Service Health Plans and MBHOs

- Medical and Specialist Providers

Relative to Recommendation #3, instead of specifically noting that the programs should "feature a capitated fee structure," we would recommend a more generic and broader statement such as: "feature alternative reimbursement models" that emphasize value (vs. volume: quantity-based structures like Fee-for-Service)

We would modify Recommendation #6 by omitting the statement about eliminating the potential of "multiple co-pays on a single day" to a phrase that highlights and incents the member to receive treatment for behavioral and medical conditions "including on the same day." It should be noted that eliminating multiple co-pays on a single day may be operationally challenging in a multi-payer environment.

Thank you for the opportunity to review and comment on the Special Joint Commission's draft recommendations. We look forward to continued dialogue in this evolving space.

Sincerely,

Stephen J. Farrell
Chief Executive Officer

NASW RHODE ISLAND CHAPTER
National Association of Social Workers
220 West Exchange Street, Suite 007
Providence, Rhode Island 02903
Telephone ▪ 401-274-4940
Facsimile ▪ 401-274-4941
rhodeislandnasw@gmail
www.rinasw.info

Date: January 17, 2014
To: Senator Miller, Representative Bennett, Paula S. Dominguez and David Salvatore
From: Rick Harris, LICSW
Re: Comments regarding the Special Joint Commission to Study the Integration of Primary Care and Behavioral Health - Findings in Recommendations

First, I would like to thank Commission Co-Chairs, Senator Miller and Representative Bennett for facilitating an efficient, respectful and judicial set of Commission meetings. I thought the tone was set early on to allow for open communication and for all voices to be heard. I would also like to thank Paula S. Dominguez and David Salvatore for their diligent and effective work in support of this Commission.

Following are recommendations. These recommendations are guided by biases, assumptions and principles which are stated in each section.

I. Successful Therapeutic Intervention and Consumer Choice

It is our belief that, regardless of therapeutic methodology utilized, the most important factor for success in therapy practices is the relationship between the client and the service provider. Because of this factor, we believe consumers should direct the choice of both the therapeutic setting and therapist.

Recommendation: Ensure choice of mental health and substance use services and locations remains with the consumer whenever possible. Codify the concept of consumer choice in regulation.

II. Mental Health and Substance Use Healthcare Service Parity

True behavioral healthcare parity cannot be obtained until the issue of high co-pays and high deductibles is alleviated. Currently, behavioral healthcare is classified as a "specialty service" hence the high co-pays. Because of the frequency of service often required to provide effective therapeutic intervention, high co-pays is a major obstacle to many low to middle income individuals utilizing mental health and substance use services.

Recommendation: Change the categorization of mental health and substance use services from a "specialty " service, creating a new category if necessary, and lower required co-pays to more affordable fees. Where it makes sense, explore alternative payment methods that does not

necessarily rely on "fee-for-service" only. Eliminate "double co-pays" when more than two services are provided on the same day. Monitor reliance on high deductible insurance policies and provide mechanisms for individuals to receive health, mental health and substance use services when not affordable due to high deductible policies.

III. Stigma

Another obstacle to providing needed mental health and substance use services has been stigma that some professionals, the public and policy makes have historically attached to these disorders. It has been stated by a major health insurance company in the last couple of years that mental health service utilization is higher in Rhode Island than in most other states. I have not seen the actual studies or the methodology the studies rely on, but I would not necessary doubt that this could be true. If it is true, we do not view this as a negative outcome but a positive one. Rhode Island has been unique in its efforts to eliminate many of obstacles, both obvious and perceived, in relation to access for mental health services.

With the passage many years ago of the Zania Bill, we put in law limited mental health parity long before most other states and certainly long before the national parity law. We have also had a very active cadre of concerned professional organizations, a State sponsored Mental Health Advocates Office and several strong family and consumer advocacy organizations that have consistently and effectively battled stigma. Yet with all this effort, thousands of Rhode Islanders remain without needed mental health and substance use services due to stigma and other obstacles. (I also fear that due to the factors identified in this document and several others not identified, mental healthcare access in Rhode Island will continue to be negatively affected if action is not taken on several fronts. Factors that I believe will negatively affect access to mental health and substance use services in Rhode Island can be found at **www.rinasw.info** in a concept paper publish September of 2012. The paper is entitled: "*The End of Mental Healthcare Access as We Know it in Rhode Island*".)

Recommendation: Utilize the momentum that has risen through the establishment of this Commission to educate primary physicians, mental health/substance use providers and the general public about the relationship between good physical health and good mental health. If the premise underlying this Commission's existence that there is a strong relationship between these two factors is accurate, then attention to both will lower healthcare cost, promote economic growth and improve the health of all Rhode Islanders.

III. Co-location and Improving Networks

We believe that it is important to improve the connection between primary care physicians and behavioral healthcare providers in order to assist individuals who have significant issues due to mental health and/or substance use problems that interfere in daily life goals. However, we strongly believe that co-location, although a very viable strategy to address this issue, certainly is not the only strategy to be put in place. We need a wide variety of options including substantial professional and support networks, coordinated services, vehicles for improved communication and planning, and service paradigms we haven't even thought of yet.

Effective mental health and substance use services help struggling individuals improve in both daily living and vocational arenas. Regardless of therapeutic methodology or service location, a major outcome of assisting the individual is to help the person not to let **situations** control their behavior and attitudes and to assist the individual to develop strategies and techniques that allows him/her to take control over aspects of their lives which they can control. If the individual has targeted the problems that most negatively impact their lives, then money will be saved in both publically and privately funded health and mental health services. A healthy person makes better choices.

Recommendation: Develop a system of mental health and substance use services that provides a wide variety of solutions both in location and network mechanisms. One size never fits all!

IV. Settings and Intensity of Services

We believe that the type of setting for services available needs to meet the need of the individual at time of service need. It is critical for positive outcomes is that the individual should be in substantial control over the choice of service setting whenever possible.

I can categorize three broad and general service delivery systems.

1. Intense service support systems include: Intensive supports such as psychiatric hospitals, day therapeutic programs, wraparound services, and what Rhode Island has become so well known for - Community Support Programs.

These settings are required for voluntary or involuntary hospitalization and where intensive community based services are needed to maintain an individual in the least restrictive environment.

2. Medium to large entities providing counseling and therapeutic services which may be formalized or loosely associated.

These settings provide some consumers with conveniences associated with co-located disciplines. These facilitates can offer easy peer consultation and possible savings in business operations.

3. Very small to individual private practice settings.

The vast majority of mental health and substance use services is provided by category three professionals. Many individuals need a small, quiet and private setting to facilitate the therapeutic process.

Recommendation: Educate the public and policy makers about the distinction between types of service delivery systems. Fully engage all stake holders in developing a comprehensive state plan to pay for and deliver mental health and substance use services. It is important to make sure that the public and all interested parties understand that more intense services cost more money, but, also can realize the most savings to the healthcare system. Example: The daily cost of

assisting an individuals with serere and persistent mental illness in the community as oppose to the daily cost of hospital institutional care. This cost can be both measured in real dollars and the cost in the degradation and the human integrity of the individual when instutionalization is utilized.

January 15, 2014
The Honorable Joshua Miller
The Honorable David Bennett
Co-Chairs
Joint Commission to Study the Integration of Primary and Behavioral Health
Rhode Island General Assembly
82 Smith Street
Providence, RI 02903

Dear Co-Chairs Miller and Bennett:

I am writing on behalf of the American Psychological Association Practice Organization (APAPO) to express our belief that a proposal under consideration by your commission, tentatively entitled the "Behavioral Health Reform Act of 2014," can serve as the basis for concrete improvements in the availability and effectiveness of mental and behavioral health services in Rhode Island. The APAPO is dedicated to advancing the practice of psychology, and represents the interests of doctoral-trained psychologists, who are licensed health care professionals. The APAPO is affiliated with the American Psychological Association (APA), the largest membership association of psychologists, with more than 137,000 members and affiliates engaged in the practice, research, and teaching of psychology.

For far too long, lingering stigma and ignorance have resulted in discriminatory coverage practices and insufficient funding for needed mental and behavioral health treatment. Federal and state policies are now changing this situation, but more work is needed. The Behavioral Health Reform Act will help to improve access to mental and behavioral health care in Rhode Island.

We commend you and your colleagues on the Joint Commission to Study the Integration of Primary and Behavioral Health for developing policy solutions to normalize mental and behavioral health treatment and to integrate mental and behavioral health services into the primary and general medical care delivery system. By amending several state laws to explicitly incorporate these services into the fabric of the state's health care policies and programs, the proposed legislation should help achieve two vitally important policy objectives for Rhode Island: 1) ensuring that residents have adequate access to effective behavioral health services; and 2) improving patient outcomes and reducing health care costs for individuals with chronic and general medical conditions.

We ask your commission to work for the enactment of legislation to promote the establishment of an integrated, effective, and accessible behavioral health service delivery system in Rhode Island.

Sincerely,
Katherine C. Nordal, Ph.D.
Executive Director for Professional Practice
American Psychological Association Practice Organization

Appendix C: ENABLING LEGISLATION

2013 -- S 0834 SUBSTITUTE A

=======
LC00805/SUB A/2
=======

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2013

J O I N T R E S O L U T I O N

CREATING A SPECIAL JOINT COMMISSION TO STUDY THE INTEGRATION OF PRIMARY AND BEHAVIORAL HEALTH IN THE STATE OF RHODE ISLAND

Introduced By: Senators Miller, Sosnowski, Cool Rumsey, Sheehan, and Goldin

Date Introduced: April 04, 2013

Referred To: Senate Health & Human Services

WHEREAS, It is the long-standing policy of the State of Rhode Island to take cognizance of the interests of life and health among the peoples of the state, to make investigations into the causes of diseases, the prevalence of epidemics and endemics among the people, the sources of mortality, the effect of localities, employments, and all other conditions and circumstances on the public health, do all in its power to ascertain the causes and the best means for the prevention and control of diseases or conditions detrimental to the public health, and adopt proper and expedient measures to prevent and control diseases and conditions detrimental to the public health in the state; and

WHEREAS, Population health outcomes in Rhode Island, as in the nation as a whole, are persistently and significantly worse for factors such as infant mortality, prevalence of chronic disease, serious mental illness, and life expectancy than in other developed countries with similar socio-economic resources; and

WHEREAS, The federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Research and Services Administration (HRSA) established the Center for Integrated Health Solutions (CIHS) to promote the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions; and

WHEREAS, Despite these inferior health outcomes, the global cost of medical and other health care services in the State of Rhode Island, as in the nation as a whole, is among the highest in the world and imposes significant burdens on business, government, families, and individuals; and

WHEREAS, Rhode Island's Health Homes Project is working to integrate physical and mental health services, partly by requiring care providers to collaborate with community organizations and in-the-market resources; and

WHEREAS, The Rhode Island Chronic Care Sustainability Initiative (CSI-RI), is one of the first multi-payer patient-centered medical home (PCMH) demonstration projects in the country, with plans to expand the successful project; and

WHEREAS, In Rhode Island, as in the nation as a whole, global medical and other health care costs are projected to continue rising faster than the gross national product, than family income, and than the rate of inflation, and unless effectively addressed, will soon become unsustainable, threatening the economy, public budgets, and Rhode Islanders' access to affordable care; and

WHEREAS, There is a large body of data and other research that demonstrate the potential for improving the public health and population-based outcomes through improving the delivery of and access to primary care that is community-based and patient-centered; and

WHEREAS, Improving population-based health outcomes and integrating behavioral health and primary care will result in significant savings by averting the costs incurred by treating chronic diseases, premature death, and diminished productivity at work and school; now therefore, be it

RESOLVED, That a special joint commission be and the same hereby is created and shall consist of twenty-one (21) members: one of whom shall be a member of the Senate, to be appointed by the Senate President, who shall serve as co-chairman; one of whom shall be a member of the House, to be appointed

by the Speaker of the House, who shall serve as co-chairman; one of whom shall be the Director of the Department of Health or his/her designee; one of whom shall be the Director of the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals or his/her designee; one of whom shall be a representative of the Rhode Island AFL-CIO; one of whom shall be a representative of the UNAP; one of whom shall be the President of the Hospital Association of Rhode Island or his/her designee; one of whom shall be Family Physician who is a member of the Rhode Island Chronic Care Sustainability Initiative Committee or his/her designee; one of whom shall be the President of the American Academy of Pediatrics Rhode Island Chapter or his/her designee; one of whom shall be President of the Rhode Island Academy of Physician Assistants or his/her designee; one of whom shall be the Executive Director of the Rhode Island Medical Society or his/her designee; one of whom shall be the President of the Rhode Island Psychological Association or his/her designee; one of whom shall be the Executive Director of the Rhode Island State Nurses Association or his/her designee; one of whom shall be the Executive Director of the National Association of Social Workers Rhode Island Chapter or his/her designee; one of whom shall be the President/CEO of the Rhode Island Health Centers Association or his/her designee; one of whom shall be the President/CEO of Blue Cross and Blue Shield of Rhode Island or his/her designee; one of whom shall be the Associate Dean of Medicine for Brown University School of Public Health or his/her designee; one of whom shall be President of United Healthcare of Rhode Island or his/her designee; one of whom shall be the CEO of Neighborhood Health Plan of Rhode Island or his/her designee; one of whom shall be the President of the Rhode Island Council of Community Mental Health Organizations or his/her designee; and one of whom shall be the Executive Director of the Drug and Alcohol Treatment Association of Rhode Island or his/her designee.

In lieu of any appointment of a member of the legislature to this commission, the appointing authority may appoint a member of the general public to serve in lieu of a legislator, provided that the majority leader or minority leader of the political party which is entitled to the appointment consents to the appointment of the member of the general public and the public member is a resident of the State of Rhode Island.

The purpose of said commission shall be to make a comprehensive study of the current status of primary care and behavioral health in Rhode Island; of the available research, data and analyses of the impact of primary care and behavioral health service availability and delivery system architecture on population outcomes; and of the advisability of creating a Primary Care Trust or other mechanism to fund and otherwise support a comprehensive integrated primary care and behavioral health system for all Rhode Islanders. In studying this issue, the commission is encouraged to:

(1) Examine trends, current policies, and data pertaining to Rhode Island behavioral health and primary care utilization trends;

(2) Identify policy restrictions which currently prevent Rhode Island from integrating primary care and behavioral health systems;

(3) Identify and seek ways to remedy gaps in the system, specifically in the area of linkages and connections among providers and agencies in delivering comprehensive,
community-based healthcare services;

(4) Examine the role of multi payers within the market and potential innovative delivery systems and payment reforms.

(5) Examine potential funding and grant opportunities to advance the recommendations of the commission.

Forthwith upon passage of the resolution, the members of the commission shall meet at the call of the Speaker of the House and President of the Senate. The commission shall have the authority to organize and form subcommittees, when deemed appropriate by a majority of the members.

Vacancies in said commission shall be filled in the manner as the original appointment.

The membership of said commission shall receive no compensation for their services.

All departments and agencies of the state shall furnish such advice and information, documentary and otherwise, to said commission and its agents as is deemed necessary or desirable by the commission to facilitate the purposes of this resolution.

The Joint Committee on Legislative Services is hereby authorized and directed to provide suitable quarters for said commission; and be it further

RESOLVED, That the commission shall report its findings and recommendations to the Governor, the Secretary of the Executive Office of Health and Human Services, and the General Assembly no later than January 28, 2014, and said commission shall expire on June 13, 2016.

=======
LC00805/SUB A/2
========

EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

J O I N T R E S O L U T I O N

CREATING A SPECIAL JOINT COMMISSION TO STUDY THE INTEGRATION OF PRIMARY AND BEHAVIORAL HEALTH IN THE STATE OF RHODE ISLAND

***

This resolution would create a twenty-three (23) member special joint commission whose purpose would be to make a comprehensive study of the current status of primary care and behavioral health services in Rhode Island; of the available research, data and analyses of the impact of primary care and behavioral health service availability and delivery system architecture on population outcomes; and of the advisability of creating a Primary Care Trust or other mechanism to fund and otherwise support a comprehensive integrated primary care and behavioral health system for all Rhode Islanders, and who would report back to the general assembly no later than January 28, 2014, and whose life would expire on June 13, 2016.

=======
LC00805/SUB A/2