the DELTA CENTER for a thriving safety net

# Towards a Thriving Safety Net

## The Delta Center's First Three Years

NOVEMBER 2020

The ultimate goal of the Delta Center for a Thriving Safety Net is to cultivate health policy and a care system that are more equitable and better meet the needs of individuals and families. The Delta Center has taken a novel approach to advancing this mission through collaboration with national and state primary care and behavioral health associations (PCAs and BHSAs), which reach thousands of safety net providers. Since 2017, the Delta Center for a Thriving Safety Net has catalyzed relationships and collective action between primary care and behavioral health at the national, state, and local levels.

The Delta Center funded 12 state teams for its first cohort: Colorado, Iowa, Maine, Massachusetts, Michigan, Missouri, New Mexico, New York, North Carolina, Oregon, Texas, and Washington. State association teams came together in four in-person and two virtual convenings to learn from experts and each other. Grantees also participated in coaching and virtual learning opportunities throughout. The advent of COVID-19 deeply impacted Delta Center grantees and changed the course of the initiative, but the relationships built through the Delta Center helped support the safety net's initial response and will continue to contribute to greater alignment between primary care and behavioral health in future policy and practice changes. For state perspectives on essential changes due to COVID-19, see a summary of the May 2020 Delta Center virtual convening.

In 2021, the Delta Center will welcome a new cohort of grantees to participate in the State Learning & Action Collaborative. The program structure and activities will be co-designed with these new grantees and will also draw on the experience of the first three years. Below are four key outcomes of the first phase of the Delta Center:

### #1|Stronger National Partnerships

Strong partnerships are the foundation to improving policy and care. The Delta Center was the first time the National Association of Community Health Centers (NACHC) and the National Council for Behavioral Health (National Council) partnered in a long-term, regular working relationship. Through the Delta Center, they have deepened their understanding of each other's priorities and opportunities for collective action, and they now collaborate regularly both on the Delta Center and other joint activities.

### #2|Stronger Relationships and Aligned Strategies for Policy Change in 12 States

Partnership building, a focus of Delta Center's training and technical assistance (TTA) to associations, resulted in new collaborative processes, such as joint staff and board meetings. For many PCAs and BHSAs, the Delta Center was their first experience working together in any substantive way. The Maine team commented, "We've developed a culture of true partnership."

The Missouri team described their communication as more expedient and frequent compared to their prior more protracted, formal style. The Oregon Primary Care Association and the Association of Oregon Community Mental Health Programs developed their first-ever joint policy agenda: being mutually responsible for improved care for vulnerable Oregonians; prioritizing support for the behavioral health workforce; prioritizing bi-directional primary care and behavioral health (PC-BH) integrations; and promoting a "Treat First" model to accelerate access to care. Strengthening relationships was essential for PCAs and BHSAs to clarify and align their strategies, which directed action on mutually beneficial opportunities, such as those described next.

## #3|Local Provider-Level Learning and Partnership

To help support implementation at the provider level at scale, the Delta Center developed and curated resources for PCAs and BHSAs to deliver TTA to their provider members, preferably jointly. More than half of the state associations reported having engaged in increased levels of joint TTA to convene provider members for peer learning, relationship building, and collective action at the local level. Examples include Missouri's Value-Based Payment Academy and Joint Care Management Training, Washington's joint TA through its Value-based Payment Academy, and Michigan's Value-Based Payment Learning Collaborative and Practice Transformation Academy, which involves a learning collaborative of 28 organizations that for the first time includes tracks for both providers and payers. The Delta Center has also fostered new action in states where health centers and behavioral health organizations have a history of working together. For instance, the Oregon state associations supported new regional partnerships between local community health centers and new certified community behavioral health clinics in Portland, Deschutes, and Wallowa to improve integrated care for medically and socially complex consumers while also coordinating with their Medicaid accountable care organizations (Coordinated Care Organizations in Oregon).

## #4|State Policy Actions to Advance Improved Access & Care

State associations have worked together and on their own to effect changes in state policy to advance value-based payment and care (VBP/C) with greater speed, skill, and collaboration through their Delta Center participation. For instance, Missouri successfully established a first-of-its-kind patient engagement payment reform that incentivizes health centers to get "assigned but not seen" Medicaid members into care. Multiple states, including Colorado and Iowa, are pursuing FQHC Alternative Payment Methodologies, and Missouri has begun exploring an independent practice association (IPA) that includes both community-based primary care and behavioral health providers (CHCs and CBOs). Such an arrangement would provide opportunities to coordinate care, combine data, present a united safety-net provider voice with payers, and potentially share in savings associated with improved care. A "joint" IPA is particularly advantageous to BHSA members who typically lack negotiating clout with Medicaid managed care plans and ways to have members assigned to them, despite operating as Health Homes for individuals with mental illness. Further, more than half of the associations reported that their participation in the Delta Center helped them to remove regulatory barriers, such as barriers related to same-day billing and telehealth, and 9 of 21 reported Delta Center helped them advance payment and partnership models promoting PC-BH integration.

The Delta Center has had a particularly significant impact in behavioral health policy, where low payment rates have deeply curtailed access to care. For example, in New Mexico, the two associations leveraged a collective safety net voice to promote reimbursement parity for behavioral health services by creating an identical minimum rate for primary care and behavioral health visits in health centers. This shift in financial incentives is a critical step to advancing parity in access and care, as health centers are no longer losing money on behavioral health due to insufficient rates. The two associations continue to further a payment parity agenda together.

Most notable in the policy arena related to behavioral health, the Texas Council for Community Centers advanced a comprehensive delivery system and payment reform change for individuals with serious mental illness. One unique aspect was the establishment of state-sponsored Certified Community Behavioral Health Clinics (CCBHCs) independent of the federal demonstration. CCBHCs are important because they deliver a comprehensive array of behavioral health, physical health, and social services while meeting specific standards, high levels of accountability, and receiving commensurate funding to expand access and sustain care. A second unique aspect is that the Texas Council helped providers to establish a capitated CCBHC payment model and advanced a policy through the renewal of its 1115 Medicaid waiver to achieve a Medicaid coverage expansion for hundreds of thousands of persons with serious mental illnesses. According to the leadership of the Texas Council, these dramatic innovations in state behavioral health policy would not have been possible without Delta Center support.

The Delta Center also continues to further the national discourse on VBP/C. The Delta Center's thought leadership is exemplified in the development of the Model for Advancing High Performance in Primary Care and Behavioral Health (MAHP 2.0), which has guided policy and technical assistance work with Delta Center state associations. Other works from the Delta Center include an environmental scan highlighting rural-specific challenges and potential solutions to implementing VBP/C, recommendations for states to advance access to high-quality behavioral health services within their Medicaid programs, and a brief on the financial stability of the safety net during the COVID-19 crisis and beyond.

For more information on the second phase of the Delta Center, including the Call for Proposals for new states and a curated library of resources, please visit the Delta Center website at: deltacenter.jsi.com.