The Role of Integrated Service Delivery Models in Addressing the Needs of Adults and Children with Behavioral Health Conditions

By:

Joel E. Miller, M.S. Ed.
Executive Director and Chief Executive Officer
American Mental Health Counselors Association

Stuart Yael Gordon
Director of Policy and Healthcare Reform
National Association of State Mental Health Program Directors

March 2014
Alexandria, Virginia

Second in a Series of Eight on ACA Implementation

This issue brief was sponsored by NASMHPD and the Substance Abuse and Mental Health Services Administration (SAMHSA)
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About NASMHPD

The National Association of State Mental Health Program Directors (NASMHPD) is home to the only member organization representing state executives responsible for the $37 billion public behavioral health service delivery system serving nearly 7 million people annually in all 50 states, 4 territories, and the District of Columbia.

NASMHPD serves as the national representative and advocate for state behavioral health agencies and their directors and supports effective stewardship of state mental health systems. NASMHPD informs its members on current and emerging public policy issues, educates on research findings and best practices, provides consultation and technical assistance, collaborates with key stakeholders and facilitates state-to-state sharing of new approaches and information on improving care for people with serious mental illnesses.

Preface

This issue paper on the potential role of health homes and accountable care organizations (ACOs) in facilitating the integration of behavioral health into health care generally is the second in a series of eight briefs under the auspices of the NASMHPD on implementation issues associated with the Affordable Care Act.

We hope this report will provide further guidance to SAMHSA and State Behavioral Health Authorities (SBHAs) on the roles that state agencies can play in integrating behavioral health through the use of these new care models promoted by and made possible under the Affordable Care Act in the rapidly changing health care service delivery environment.

Robert W. Glover, Ph.D.
Executive Director
NASMHPD
Executive Summary

The Centers for Medicare and Medicaid Services (CMS) Innovation Center is implementing “health homes” under Medicaid, and “accountable care organizations (ACOs)” under Medicare, in order to improve quality of care and reduce healthcare costs. Behavioral health service providers and providers of supportive programs have expertise in care coordination and service delivery, and should play an important role in the implementation and delivery of these two new models of care and other emerging strategies as they play out both in the public and private sectors. These new models offer powerful incentives—shared savings in the case of ACOs and an enhanced federal match for the first two years of operation for health homes—to better coordinate and integrate behavioral health and primary care services and thereby improve care.

Health Homes: Primary Care and Behavioral Health at a Single Site

Health homes are collaborative care models that offer the opportunity to improve coordination and integration of behavioral healthcare and primary care systems, while revitalizing and redefining the primary care system. Highly functioning and responsive health homes can enhance efficiency and quality while improving access to needed health care and support services, including appropriate referral and linkage with specialty services such as community behavioral health care. The concept of a single point of clinical responsibility – similar to the health home model – has long been a foundation of sound community behavioral health care systems, although the execution has been challenging given the fragmentation in financing for care.

One trending approach to addressing chronic disease in a holistic manner is the health home or “patient-centered medical home (PCMH)” strategy. The health home/PCMH construct is a service delivery model used by public and private sector health insurance and provider organizations to better coordinate services and programs for people with chronic illnesses. In 2008, NASMHPD called for the creation of patient-centered medical homes (the more generic description for health homes not required to meet the federal criteria) for individuals who have a mental illness, as these individuals so often have co-morbid substance use and other serious medical conditions.

A state plan option under Medicaid has been created—under which the federal government provides implementing states a 90 percent funding match for the first two years—to provide health homes for persons with multiple chronic conditions. Under the health home option, states can reimburse a patient-designated health home provider or team of providers who agree to provide care management services, make necessary referrals to specialists, provide support services as needed, and use electronic health records and health information technology to monitor and coordinate several services and programs on behalf of the consumer. The state must meet certain defined standards, consult with SAMHSA about addressing behavioral health issues, monitor and report on performance and outcomes, and develop and implement a proposal for using health information technology in the provision of health home services.

A health home may qualify for the enhanced federal funding by addressing a serious and persistent mental health condition, two of six statutorily specified chronic conditions, or one of those specified chronic conditions and the risk of incurring a second of the specified conditions. Two of the chronic conditions that qualify a health home for the enhanced federal funding are a serious mental health condition and a substance use disorder. Health homes developed and implemented for people with serious mental illnesses make it possible for community behavioral health centers and agencies to coordinate and manage the integration of services over the full range of needs of consumers, even when there are several caregivers and agencies involved in the patient’s care.
Health homes help to ensure connections between the behavioral health specialists and primary care physicians who provide care within the health home, and foster integration of community-based behavioral health resources with the disease prevention and disease management efforts the health home team. To be able to effectively incorporate health homes into their Medicaid strategies, State Behavioral Health Agencies (SBHAs) should ensure that financing mechanisms align with, and promote, a single, integrated point of clinical responsibility, moving away from fragmented, fee-for-service (FFS) reimbursement.

People with serious mental illness treated in the specialty mental health sector often face many challenges in accessing appropriate primary medical care. This gap or poor quality of care contributes to higher rates of mortality among people with serious mental illnesses. For these vulnerable populations “specialty health homes” located in community mental health settings, provide a strategy for delivering integrated and comprehensive high-quality care.

Founded in 2006 by several large national employers and four primary care physician associations, the Patient-Centered Primary Care Collaborative (PCPCC) is dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-center medical home (PCMH). The PCPCC achieves its mission through the work of five Stakeholder Centers, dedicated to transforming the U.S. health care system through care integration and delivery reform, payment reform, patient and family engagement, advocacy and public policy, and employee benefit redesign. Today, PCPCC’s membership represents more than 1,000 medical home stakeholders and supporters throughout the U.S.1

**Health Homes for Children with Serious Emotional Disorders – A Wraparound Approach**

Nearly one in 10 children in the United States has a serious emotional disorder, and mental health conditions are the most costly conditions among children and youth. These children often need a variety of services and supports, which makes care coordination imperative.

The Affordable Care Act (ACA) and CMS recognize that the service utilization patterns and costs of children with serious emotional disorders render them an appropriate population for health homes. However, the health home language of “chronicity” and “long-term care” applied to adults with serious mental illness (SMI) does not resonate well with respect to child and youth populations. While children with mental health conditions do not have the same high rate of co-occurring physical health conditions as adults with SMI, it is important to note that these children use more physical health care than Medicaid-enrolled children in general.

A “wraparound” is a type of intensive, individualized care coordination involving a team process that wraps services, supports and resources around a child or youth with a severe emotional or behavioral disorder to meet goals set by the team. Wraparound focuses on collaboratively serving children and youth with complicated issues who are involved with multiple service systems and often at risk of out-of-home placement. In Missouri and Milwaukee Wisconsin, intensive care coordination approaches ensure that children have a designated primary care provider, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens and well-child visits are conducted, there is appropriate metabolic monitoring for children on psychiatric medications, and there is coordination between medical and behavioral health providers.

Under a wraparound approach:

- The child and family are at the center of the team and actively involved in planning and setting goals that build on the child’s strengths and meet the child’s needs.
The team consists of formal service providers and informal community supports closely connected, professionally and personally, to the child’s care and concerns. The team meets as necessary to creatively work together to solve problems and attain the goals in the child’s plan of care. The team tracks progress toward the plan’s goals and updates the plan as necessary to respond to the child’s changing needs. A team member serves as the facilitator to engage the family, convene the team, and keep everyone informed and involved in their role in realizing the goals of the plan.

**Accountable Care Organizations (ACOs): Coordination Across the Practice Continuum and Practice Settings**

ACOs are comprehensive, vertically, and horizontally integrated care systems designed to manage and coordinate care. Access to effective behavioral health services is as critical to the effectiveness of ACOs as to health homes. The focus of the ACO model is on arranging a comprehensive, integrated, team-based care involving all caregivers along the delivery continuum and across all practice settings for multiple patients. While health homes take the approach of having a single provider (usually a primary care physician) lead the care delivery team for a single patient, an ACO (often but not always a hospital system) coordinates care among multiple providers serving multiple patients. That means behavioral health providers currently in solo or small group practices could find it easier to plug into the ACO structure.

The ACO model has strong parallels to public mental health system constructs, with a single point of clinical and financial accountability and comprehensive home- and community-based services systems. The ACO model is a response to criticisms of both FFS payment arrangements and capitated payment models. Critics contend that FFS offers incentives to provide excess services without devoting resources to managing chronic disease or coordinating care. Those critical of capitated payments argue that those payments offer healthcare providers perverse incentives to restrict necessary care and take on more financial risk than many can handle. In contrast, the ACO and its participating providers share savings and costs with the public program in which the ACO is a participant, providing both a positive incentive for those providers to achieve savings through positive health outcomes and negative incentives against building patient service volume as a means to increase provider income.

Federal law specifically authorizes federal payments only to ACOs serving Medicare FFS beneficiaries, although CMS has encouraged the use of similar structures in Medicaid as well through guidance issued to the states. Medicare ACOs are eligible for enhanced payments from the federal government based on “shared savings” if they meet quality performance standards that include the adoption of electronic prescribing and health records. The standards underscore the importance of a behavioral health records integration to enable behavioral health providers and care networks to play as full partners in ACOs. NASMHPD has urged the full inclusion of behavioral health in ACOs, as well as the integration of behavioral health records with records for physical health.

Although there has been some skepticism by behavioral health caregivers about participating in ACOs, participation could provide new opportunities for behavioral health providers to integrate vertically with other components of the healthcare system, contributing to achieving cost and quality targets, and sharing in new payment models. SBHAs should advocate that specialty behavioral healthcare providers be included as ACO participants and encourage behavioral healthcare providers to establish their own ACOs for patients whose primary diagnoses are behavioral health-related. Health homes and ACOs will likely be foundational elements of the future healthcare system, and behavioral health providers must immediately begin positioning themselves to be recognized as qualified partners.
In September 2014, CMS released data stating that ACOs had generated $386 million in total savings for the Medicare Trust Fund in the second year of ACO performance. At the same time, ACOs qualified for shared savings payments of $445 million. The Congressional Budget Office had earlier projected that potential savings to Medicare from promoting ACOs could amount to $5.3 billion over the first 10 years, with the savings realized as providers reduced the volume and intensity of services delivered to their patients.

**Financing-Related Strategies for Integrating Service Delivery**

Financing-related strategies for integrating service delivery include bundling payments for post-acute services with hospital payments and capitation of reimbursement. Bundling payment for services that patients receive across a single episode of care is intended to encourage health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Under capitation, physicians are paid a monthly fee for each patient under their care to cover a set of services, regardless of the amount of services provided. Capitation in behavioral health and primary care settings should motivate caregivers to provide preventive care to members and help them focus on keeping the member healthy in order to keep costs down and rely less heavily on costly specialists.

**Some Key Actions for State Behavioral Health Agencies**

**Action.** Services provided in health homes must be coordinated and should include patient and family support, transition from the hospital, use of health information technology, and referrals to community and social services. The full inclusion of behavioral health prevention and treatment services leading to recovery should be an essential part of all health homes. SBHAs should promote connections between behavioral health specialists and primary care physicians that can lead to further health home partnerships.

**Action.** SBHAs should encourage the inclusion of specialty behavioral healthcare providers as ACO participants. SBHAs may also want to encourage certain behavioral healthcare providers to consider merging or contracting with an ACO or health home provider. Behavior health providers should also be encouraged to establish their own ACOs for patients whose primary diagnoses are behavioral health-related. At the very least, behavioral healthcare providers should be encouraged to sign business agreements to act as specialty providers, receiving referrals from the health homes or ACOs.
I. Introduction

The Centers for Medicare and Medicaid Services’ (CMS) Innovation Center is implementing Health Homes under Medicaid, and Accountable Care Organizations (ACOs) under Medicare, in order to improve quality of care and reduce healthcare costs. Behavioral health service providers and supportive programs have significant expertise in care coordination and service delivery, and should play an important role in the implementation of these new models of care.

While we also include a discussion of other initiatives to improve coordination of care through mechanisms such as “bundling” and “capitation,” this report focuses primarily on health homes and ACOs, as they are garnering more attention from public and private healthcare stakeholders.

In this report we:

- define health homes (and the broader category of medical homes);
- define different types of ACOs;
- discuss what services are provided, the types of providers who are eligible to apply for payment under health homes and ACO models, how these initiatives are reimbursed, and existing best practices that relate to these models; and
- identify the roles that State Behavioral Health Agencies (SBHAs) can play to interface with new service delivery models.

Health homes and ACOs can be mutually beneficial, synergistic models, although ACOs can function without a health home and health homes can exist outside an accountable care organization. We hope this document provides a roadmap on how new service delivery models can improve behavioral healthcare and financing.

II. Health Homes

While the definition of a medical home varies by source, the ACA lays out some very specific conditions for the enhanced federal assistance available to a subset of medical homes known as “health homes” implemented pursuant to that law. However, the general construct remains consistent. The medical home/health home model promotes a team-based approach to care of a patient through the spectrum of disease states and across the various stages of life. Overall coordination of care is led by a personal physician, with the patient serving as the focal point of all medical activity.

In 2007, under the leadership and the coordination of the American Academy of Family Physicians, four physician organizations developed seven joint principles to describe the characteristics of a “patient-centered health home.” Under that definition, the goal of the health home model is for a team of providers to care for a patient, seamlessly and efficiently, while managing costs. See Exhibit 1. In a health home, the primary care physician assists patients who need specialty care, maintains electronic records of all patient/provider interactions, communicates with all of the patient’s clinical caregivers, and tracks the patient’s progress.
Exhibit 1

- **Personal physician** — each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
- **Physician directed medical practice** — the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** — the personal physician is responsible for providing for all the patient’s health care needs, or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services, and end-of-life care.
- **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services).
- **Care is facilitated by registries, information technology, health information exchange** and other means to assure that patients get the indicated care when and where they need and want it, and in a culturally and linguistically appropriate manner.
- **Quality and safety** are hallmarks of the medical home.
- **Enhanced access** to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.
- **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

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**Health Homes for Persons with Chronic Conditions: An Opportunity for States**

In 2008, NASMHPD called for the creation of a "patient-centered medical home" for individuals who have mental illnesses, as these consumers often have co-morbid substance use and other serious medical conditions such as diabetes and heart conditions. The recommendation is contained in the report “Measurement of Health Status for People with Serious Mental Illnesses.” The report describes the health home as a platform for bringing together a primary care/physical health provider and specialty behavioral health services practitioners to provide collaborative care using disease management strategies based on a chronic care model.9

As states look for ways to improve healthcare for people with chronic conditions in order to enhance outcomes and contain long-term costs, the changing healthcare landscape offers an important opportunity. A state plan option under Medicaid was created under the ACA to provide health homes for persons with multiple chronic conditions. Enhanced federal funding—a 90 percent federal match—is available under that option for the first two years of state implementation of health homes serving Medicaid beneficiaries with multiple chronic conditions.10

A health home may qualify for the enhanced federal funding by addressing a serious and persistent mental health condition, two of six statutorily specified chronic conditions, or one of those specified chronic conditions and the risk of incurring a second of the specified conditions or have one serious and
consistent mental health condition. Two of the chronic conditions that qualify a health home for the enhanced federal funding are a serious mental health condition and a substance use disorder.¹¹

According to CMS, the goal of health homes is to:

“Expand traditional models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral healthcare, in keeping with the needs of persons with multiple chronic illnesses. Consistent with the intent of the statute, it is expected that states provide this optional benefit, and Health Home providers with which the state collaborates, to operate under a “whole-person” philosophy – caring not just for an individual’s physical condition, but providing linkages to long-term community care services and supports, social services, and family services”.¹²

Some argue that health homes should be permitted to be established in primary care settings or specialty care settings, depending on the resources available in those settings, the consumers’ needs, and established relationships with caregivers.¹³ Critics of that approach are concerned that specialty behavioral health settings have been unable to deliver primary and specialty healthcare and could find it a challenge to do so effectively in the future.¹⁴ NASMHPD has recommended that health homes be established to align with consumer needs and consumer preferences. Financing mechanisms must align with these objectives and promote a single, integrated point of clinical responsibility for the individual, moving away from fragmented, FFS reimbursement.

This concept of a single point of clinical responsibility has long been a foundation of sound community mental health care systems developed by state behavioral health agencies, although execution has frequently been challenging given the fragmentation in financing for care. Services provided in health homes must be coordinated, and include patient and family support, transition from the hospital, use of health information technology and referrals to community and social services. The full inclusion of behavioral health prevention and treatment services must be an essential part of all health homes.

NASMHPD has recommended that state behavioral health authorities work closely with state Medicaid offices to ensure that behavioral health is included in health homes created for all chronic conditions and to carefully evaluate the potential for health homes for individuals with serious and persistent mental health conditions.

### Target Populations

Under the health homes option, a state may amend its Medicaid State Plan to provide health home services to Medicaid beneficiaries with combinations of the specifically defined chronic conditions, or one defined chronic condition and a risk of developing a second. It may also target individuals with one serious and persistent mental health condition.¹⁵

Although states may target by health condition, they do not have the flexibility to limit services by eligibility category, and therefore must include those individuals with the targeted conditions who are eligible for both Medicare and Medicaid – known as dual eligibles—as well as those eligible for home- and community-based services. Studies of disease management programs, targeted case management, and community mental health case
management indicate that different populations are affected differently by these interventions, evidenced by a range of changes in utilization of health care services and returns on investment.16

The Health Home Provider

The health home’s main function is to coordinate—not provide—the array of medical and behavioral health services needed to treat the “whole person.”17 Exhibit 2 describes three distinct types of provider arrangements that may deliver health home services under a health home structure. In selecting the optimal health home provider arrangement(s), states should consider their target population. To the extent possible, the designated provider type should include entities that are local, accessible, and familiar to the target population. For example, in January 2012, the Missouri Medicaid program implemented an integrated mental health/medical care coordination program for individuals with severe mental illness, based in community mental health centers.

Exhibit 2

<table>
<thead>
<tr>
<th>Health Home Provider Arrangements: Three Options</th>
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</thead>
<tbody>
<tr>
<td>1. A designated provider – may be physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, another entity or provider (including pediatricians, gynecologists, and obstetricians, as well as other agencies that offer behavioral health services).</td>
</tr>
<tr>
<td>2. A team of health care professionals that links to a designated provider – such as physicians and other professionals that may include a nurse care coordinator, nutritionist, social worker, behavioral health professional, or other professionals. The team could operate in a variety of ways, including on its own, virtually, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate.</td>
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<tr>
<td>3. An interdisciplinary, inter-professional health team – must include: medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers (including mental health providers as well as substance use disorder prevention and treatment providers), chiropractors, licensed complementary and alternative medicine practitioners.</td>
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</table>

Services Provided

Under the ACA’s health home provisions and implementing CMS guidance18, enhanced payment is available for six key health home services listed in Exhibit 3 (including care management, care coordination, and transitional care). Health homes are intended to foster greater integration, which CMS considers critical to the achievement of enhanced health outcomes. All of the behavioral health, medical, and other services needed for addressing the “whole person” are reimbursed at each state’s regular Medicaid rate; states have had the flexibility in defining health home services such as care coordination and in doing so may include additional, specific activities. CMS has given states flexibility in defining the six core health home services delineated in the statute if the state can explain how these definitions contribute to the health home model.
Payment Methodology and Managed Care

The ACA requires that the state include a methodology for paying providers in its State Plan Amendment implementing the home health structure, but permits considerable flexibility, including expressly authorizing a tiered payment methodology that risk adjusts based on the individual’s chronic conditions and the capabilities of the designated provider or health team. CMS has envisioned a health home model of service delivery with a per-member/per month (PMPM) structure, but the ACA requires that the agency be open to other payment methods or strategies proposed by a state.\(^\text{19}\) The state must be able to distinguish, quantify, and report to CMS the health home services eligible for the 90 percent match.\(^\text{20}\)

Exhibit 3

<table>
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<tr>
<th>Services Coordinated by Health Homes</th>
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<tr>
<td>• High-quality health care services that address all of the clinical and non-clinical needs of the individual, informed by evidence-based clinical practice guidelines and developed using a person-centered planning approach to identify needed services and supports</td>
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<tr>
<td>• Preventive and health promotion services, including prevention of mental illness and substance use disorders</td>
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<td>• Mental health and substance abuse services</td>
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<tr>
<td>• Comprehensive care management and care coordination</td>
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<td>• Transitional care across settings including appropriate follow-up from inpatient to other settings, such as participating in discharge planning and facilitating transfer from a pediatric to an adult system of health care</td>
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<tr>
<td>• Chronic disease management, including self-management support to individuals and their families</td>
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<tr>
<td>• Individual and family supports, including referral to community, social support, and recovery services</td>
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<tr>
<td>• Use of health information technology to link services, facilitated communication among team members and between the health team and individual and family caregivers, and provide feedback to practices</td>
</tr>
<tr>
<td>• Use of a continuous quality improvement program that includes collection and report of data that permits an evaluation of increased care coordination and chronic disease management and their impact on health outcomes</td>
</tr>
<tr>
<td>• Long-term care supports and services, where needed</td>
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</table>

The ACA’s health home provisions offer critical financial support to states to implement a healthcare delivery model that has shown much promise in early pilots and programs. It has the potential to bring significant relief to the 19 states that have already implemented Medicaid health home programs and at least 24 additional states\(^\text{21}\) currently planning some form of medical/health home in their Medicaid programs, providing the incentive for other states to test the model as well.

NASMHPD has recently released a report on the need to accelerate access to behavioral healthcare services in the primary care site, while also working to make primary care available in behavioral health specialty settings. The models of integration outlined in NASMHPD’s report on “Reclaiming Lost Decades” can be used within comprehensive service delivery reform models such as health homes and ACOs.\(^\text{22}\)

In addition to linking behavioral health and primary care services, new comprehensive service delivery models should encompass all services including hospital and acute care services. For example,
accountable care organizations should be seen as a set of providers associated with a defined population of patients, accountable for the quality and cost of all care delivered to that population. SBHAs need to be vigilant to ensure that all indicated providers are included in models for integration. It is particularly important to ensure that behavioral health screening and treatment services are included, given the costs that result from a lack of treatment prior to an individual with SMI’s first episode.23

The following are key reasons that “bi-directional integration”—integration between primary care providers and behavioral health providers—makes good sense:

- Many people served in specialty substance use treatment have no primary care provider.
- Health evaluations and linkages to primary care can improve behavioral health status.
- Behavioral health interventions can reduce healthcare utilization and cost.
- Symptoms of mental illness and substance use disorders often go unrecognized by primary care providers, and can lead to and exacerbate other chronic (and acute) health conditions.
- Like other physical and behavioral health problems, substance use disorders are chronic conditions that progress slowly, so that the primary care setting is ideal for screening emerging problems and monitoring status.

**States Lead the Way in Promoting Health Homes**

The Patient-Centered Primary Care Collaborative (PCPCC), sponsored by several primary care associations, includes 14 state health home projects, including Community Care of North Carolina, which produced reduced emergency room admission rates in State Fiscal Year 2013 that were 40 to 50 percent lower than rates for non-CCNC North Carolina patients.24 Overall, these initiatives showed that improvements in preventive, coordinated care yielded reduced cost from hospital and emergency department utilization, as well as stronger evidence that investments in primary care can bend the cost curve.25

**Community Care of North Carolina**

North Carolina’s medical home program, Community Care of North Carolina, is the oldest and probably the most successful health home initiative in the country. It started as a small pilot program aimed at lowering emergency room use for patients with asthma. It now includes 14 community networks and more than 3,500 physicians, and serves more than 950,000 enrollees (more than two-thirds of Medicaid beneficiaries in the state). Every network provides local care managers (600), pharmacists (26), psychiatrists (14) and medical directors (20) to improve local health care delivery. Studies indicate the program saved the state of North Carolina more than $1 billion over a recent four-year period. (2007-2010).26

CCNC works holistically. It recognizes the social and environmental factors that affect population health, requiring network providers, with care management support, to attend not only to the delivery of physical health service, but also to social, mental health, and community issues that may affect mental health and medical care. As part of its care management approach, the North Carolina health home works to increase beneficiary access to appropriate community and social support services and resources. Care managers share their knowledge about local agencies and resources with network providers by providing resource manuals with contact information for an array of community and social support services.
Missouri Community Mental Health Center Health Home Program

Missouri was the first state, in 2011, to receive approval from CMS for a State Plan health home option. The state implemented the CMHC Health Home initiative on January 1, 2012, as a partnership between the Missouri Departments of Mental Health, MO HealthNet (Missouri’s Medicaid agency), and the Missouri Coalition of Community Mental Health Centers, the initiative has pioneered a program for Medicaid beneficiaries with SMI that is based in community mental health centers (CMHCs). Those CMHCs provide care coordination and disease management to address the “whole person,” including both mental illness and chronic medical conditions.

The Missouri CMHC-based health home model leverages the existing mental health system, with added training for providers on chronic conditions as well as the use of data and analytic tools. CMHCs are designated as the central care coordination site for patients who lack a regular primary care provider. All Missouri CMHCs have a primary care nurse liaison on site to educate the behavioral health staff about physical health issues, train case managers in recognizing and managing chronic medical conditions, and coordinating and integrating mental health disease management with Medicaid disease management programs.

Under the Missouri program, individual and family support services activities include advocating for individuals and families and assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. There is also a primary focus on increasing health literacy, the ability to self-manage care, and beneficiary participation in the ongoing revision of treatment plans. For individuals with developmental disorders, the health team refers to and coordinates with an approved developmental disorders case management entity for services more directly related to habilitation. The initiative enhances the state’s ability to provide transitional care between institutions and the community. The CMHCs receive incentive payments for reducing emergency room visits and hospitalizations.

Key early results from the Missouri CMHC Health Home initiative revealed:

- For each client who enrolled in the initiative, savings on a PMPM basis after 18 months were $51.75, for a total savings to the state of $23.1 million.\(^{27}\)
- Pharmacy costs were reduced by 23.4 percent, general hospital costs were reduced by 6.9 percent, and included with other changes, resulted in reduced costs overall of 16 percent.\(^{28}\)
- Hospital admissions have been reduced by 12.8 percent and emergency room use by 8.2 percent, creating a PM/PM reduction in hospital and emergency room costs of $127.55.\(^{29}\)
- More than 70 percent had a primary care visit within the first 12-month period.\(^{30}\)
New York Health Home Program

Implementation of Health Homes for New York Medicaid enrollees with chronic conditions was recommended by the Governor Cuomo's Medicaid Redesign Team as a means to integrate care. As a result, this initiative was included in the Governor's SFY11/12 Budget and was adopted into law, effective April 1, 2011. The health home initiative was rolled out in three phases. A State Plan Amendment to provide health homes, beginning January 1, 2012, for Medicaid enrollees with behavioral health and chronic conditions was approved by CMS in February 2012 for retroactive implementation in ten New York counties.

The behavioral health categories of enrollees approved for participation included:

**Alcohol and Substance Abuse**
1. Alcohol Liver Disease
2. Chronic Alcohol Abuse
3. Cocaine Abuse
4. Drug Abuse – Cannabis/NOS/NEC
5. Substance Abuse
6. Opioid Abuse
7. Other Significant Drug Abuse

**Mental Health**
1. Bi-Polar Disorder
2. Conduct, Impulse Control, and Other Disruptive Behavior Disorders
3. Dementing Disease
4. Depressive and Other Psychoses
5. Eating Disorder
6. Major Personality Disorders
7. Psychiatric Disease (Except Schizophrenia)
8. Schizophrenia

The state developed a comprehensive individualized patient-centered care plan, required for all health home enrollees. The care plan is based on the information obtained from a comprehensive health risk assessment used to identify the enrollee’s physical, mental health, chemical dependency, and social service needs. The individualized care plan includes and integrates the individual’s medical and behavioral health services, rehabilitative, long-term care, and social service needs, as applicable.

The care plan identifies the primary care provider/nurse practitioner, specialist(s), behavioral health care provider(s), care manager, and other providers directly involved in the individual’s care. The individual’s care plan identifies community networks and supports that will be utilized to address their needs. Goals and timeframes for improving the patient’s health, their overall health care status, and necessary interventions are included in the plan of care.

The care plan must include outreach and engagement activities which support engaging the patient in their own care and promote continuity of care. In addition, the plan of care must include a periodic reassessment of the individual’s needs and goals and clearly identify the patient’s progress in meeting those goals. Changes in the plan of care are made based on the patient’s needs change.

Comprehensive transitional care is provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility) and to
ensure proper and timely follow up care. To accomplish this, the health home provider is required to develop and have a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home care manager prompt notification of an enrollee’s admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

The health home provider must also have policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to ensure coordinated, and safe transition in care for its patients who require transfer to/from sites of care. The health home provider must develop and maintain a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers.31

A December 2012 evaluation of the New York health home option by the Urban Institute on behalf of the HHS Assistant Secretary for Planning and Evaluation (ASPE) did not include an evaluation of outcomes.

**Ohio Community-Based Health Center**

Phase 1 of Ohio’s Medicaid Health Home Project for individuals with serious and persistent mental illness (SPMI)—designed to provide personal mental health and physical health assistance, as well as assistance with social service needs—went live in five counties October 1, 2012 after being approved by CMS earlier that year. A second phase was implemented in 2013.

An Ohio Community-Based Health Center (CBHC) health home is responsible for identifying individuals with SPMI who are currently affiliated with the health home site. Individuals living with SPMI without a community behavioral health center affiliation or a routine source of health care are identified through an administrative review or by referral by another provider (e.g. a hospital emergency department, a specialty provider, a primary care provider), a managed care plan, or a community service provider. CBHC health homes are responsible for notifying other treatment providers about the goals and types of health home services as well as encouraging participation in care coordination efforts.32

The CBHC engages the eligible individual and his/her family by explaining the benefits of health home services and the right to opt-out of those services. The CBHC completes a comprehensive assessment of the individual’s physical health, behavioral health (i.e., mental health, substance use disorder, long-term care, and social needs). The assessment accounts for the cultural and linguistic needs of the individual and uses relevant comprehensive data from a variety of sources, including the individual/family, caregivers, medical records, and the team of health professionals.

The impact of the program on participating enrollees has not yet been evaluated.

**Rhode Island Community Mental Health Organization Health Home**

In Rhode Island, comprehensive care management services are conducted with “high-cost, high need” individuals, their families, and supporters to develop and implement a whole person-oriented treatment plan and monitor the individual’s success in engaging in treatment and supports. Services are carried out through use of a bio-psychosocial assessment conducted at the time of admission to the community mental health organization. A psychiatrist, registered nurse or a licensed and/or Master’s prepared mental health professional conducts the assessment, which determines:

- the individual’s treatment needs and expectations;
• the type and level of treatment to be provided;
• the need for specialized medical or psychological evaluations;
• the need for participation of family or other support persons; and
• identification of the staff person(s) who will provide the treatment.

Rhode Island focuses on the transition of individuals from any medical, psychiatric, long-term care, or other out-of-home setting back into a community setting. Members of the health home team work closely with the individual to transition smoothly, sharing information with the discharging organization to prevent any gaps in treatment that could result in a re-admission. To facilitate timely and effective transitions from inpatient and long-term settings to the community, all health home providers maintain collaborative relationships with hospital emergency departments, psychiatric units of local hospitals, long-term care providers, and other applicable settings. In addition, all health home providers use hospital liaisons to assist in discharge planning of existing community mental health organization clients and new referrals. Any member of the community mental health organization health home team—including community support professionals—can provide comprehensive transitional care services, but hospital liaisons are the primary practitioners, providing comprehensive transitional care services.

Care coordination also is implemented when transitioning an individual from a jail/prison setting into the community.  

A December 2012 evaluation of the Rhode Island health home option by the Urban Institute on behalf of the HHS Assistant Secretary for Planning and Evaluation (ASPE) did not include an evaluation of outcomes.

**Oregon Patient-Centered Primary Care Health Home**

In Oregon, patients choose and are then assigned to a provider/clinic or team to ensure continuity of care and individual responsibility for coordination functions. A person-centered plan is developed based on the patient’s needs and preferences that include at least the following elements: options for accessing care, information on care planning and care coordination, names of Primary Care team members, and information on ways the patient is expected to participate in care.

Health home services occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors.

The Oregon health home provider promotes the use of evidence-based, culturally sensitive wellness and prevention services by linking the enrollee with resources for smoking cessation, diabetes, asthma, and self-help resources and, based on individual needs. Health promotion activities promote consumer/family education and self-management of the chronic conditions. Health home services are provided under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, professional counselors, community health workers, personal health navigators, or peer wellness specialists.  

A December 2012 evaluation of the Oregon health home option by the Urban Institute on behalf of the HHS Assistant Secretary for Planning and Evaluation (ASPE) did not include an evaluation of outcomes.
III. Use of Health Homes for Children with Serious Behavioral Health Conditions – Issues and Challenges

Nearly one in 10 children in the United States has a serious emotional disorder, and mental health conditions are the most costly conditions among children and youth. These children often need a variety of services and supports, which makes care coordination imperative. Although the ACA legislation does not allow states to use health homes to target a specific age group, states may want to consider the health home option as a way to improve the quality and cost-effectiveness of care provided in Medicaid to adults and children with behavioral health challenges.

Customizing Health Homes for Children with Serious Behavioral Health Challenges a new resource paper produced by Sheila Pires, managing partner of the Human Services Collaborative--can serve as a tool to help states think through how to develop a health home approach that can meet the needs of children with SMI. This new resource provides a rationale for why health homes under ACA should be customized for children and youth with serious behavioral health challenges. The report offers practical and financial approaches to health home customization based on intensive care coordination models using the “wraparound approach” that has emerged from systems of care in children’s behavioral health care.

Wraparound is a type of intensive, individualized care coordination involving a team that wraps services, supports, and resources around a child or youth with a severe emotional or behavioral disorder to meet goals set by the team. Wraparound focuses on collaboratively serving those children and youth with complicated issues who are involved with multiple service systems and often at risk of out-of-home placement. Under the wraparound approach:

- The child and family are at the center of the team, actively involved in planning and setting goals that build strengths, culture, and needs in the child’s life.
- The team consists of formal service providers and informal community supports closely connected, professionally and personally, to the child’s care and concerns.
- The team meets as necessary to creatively work together to solve problems and attain the goals in the child’s plan of care.
- The team tracks progress toward the plan’s goals and updates the plan in response to the child’s changing needs.
- Someone on the team usually serves as the facilitator to engage the family, convene the team and keep everyone informed and involved in their role in realizing the goals of the plan.

The ACA and CMS recognize that the service utilization patterns and costs of children with serious behavioral health conditions render them an appropriate population for health homes. However, the health home language of “chronicity” and “long-term care” applied to adults with SMI does not resonate well with respect to child and youth populations. While children with mental health conditions do not have the same high rate of co-occurring physical health conditions as adults with SMI, it is important to note that these children use more physical health care than Medicaid-enrolled children in general.

Intensive care coordination approaches using the “wraparound” approach employed in Missouri and Milwaukee, Wisconsin ensure these children have a designated primary care provider, that EPSDT screenings and well-child visits are conducted, there is appropriate metabolic monitoring for children on psychiatric medications, and there is coordination between medical and behavioral health providers.
IV. Accountable Care Organizations (ACOs)

Background

The ACO model is built on the principle that by placing responsibility for a population's entire care continuum on a single entity with aligned clinical and financial incentives, healthcare quality and patient experience will improve and costs will go down. The Medicare Payment Advisory Commission (MedPAC), an appointed advisory body charged with reporting to Congress, has defined accountable care organizations as a set of providers associated with a defined population of patients, accountable for the quality and cost of care delivered to that population.\textsuperscript{36}

ACOs can take a variety of forms. Chief principles and prerequisites of the model include:

- Payment reform that promotes value, including a shared-savings model based on targeted savings using a global, prospective budget;
- Performance measurement using timely and accurate data that allows organizations to be accountable for quality and cost for a defined population; and
- Delivery system changes that promote integrated, organized processes for improving quality and controlling costs.

ACOs are envisioned as large primary care-based partnerships that integrate other provider groups – e.g., hospitals, primary care physicians, and behavioral health and other specialists – tasked with shared and coordinated responsibility for a patient's entire care continuum. ACOs are similar to health homes, in that they consolidate multiple levels of care for patients. Rather than tackling payment reform in isolation in the care delivery process, health homes and ACOs offer a consolidated approach to both issues. However, an ACO consists of many coordinated practices, while a health home is a single practice. ACOs (like health homes) require robust information technology (IT) to track patients within and across primary and specialty care and to manage and mediate new payment methods.

Separately from the Medicare “Shared Savings” Program (MSSP) discussed below, over 100 healthcare provider organizations are contracting with private health insurance companies in relationships that include the key elements and goals of the ACO model: payment tied to improving patient care across the care continuum and reducing the rate of increase in healthcare spending.

The ACO Concept: Shared Savings in a Continuum of Care

A recent Urban Institute paper on ACOs singled out three essential characteristics of ACOs:

1. The ability to provide patients a continuum of care, managed across various institutional settings, including at least ambulatory and inpatient hospital care and often post-acute care;
2. The capability of prospectively planning budgets and resource needs; and
3. Sufficient size to support comprehensive, valid, and reliable performance measurement.\textsuperscript{37}

In exchange for investing in this reformed healthcare provider structure, ACO members are expected to share in the savings that results from their cooperation and coordination. ACOs thereby theoretically act
as a reform tool by incentivizing more efficient and effective care. This serves to combat the current perverse incentives of overutilization and overbuilding of health care facilities and technology.

The creation of the term “accountable care organization” is attributed to Dr. Elliot Fisher of Dartmouth Medical School. Dr. Fisher’s purpose in developing ACOs was to help identify the proper “locus for shared accountability” for a patient’s health care. The concept of the ACO continues to be refined. Dr. Stephen Shortell and Dr. Lawrence Casalino envision a broad range of ACOs in addition to the “extended medical staff” originally described by Dr. Fisher.³⁸

Dr. Fisher, in collaboration with the Brookings Institution, has developed the comparison of core capabilities of ACOs, health homes, and other service delivery models shown in Exhibit 4.

**Exhibit 4**

<table>
<thead>
<tr>
<th>Accountable Care Organization (Shared Savings)</th>
<th>Primary Care Health Home</th>
<th>Bundled Payments</th>
<th>Partial Capitation</th>
<th>Full Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General strengths or weaknesses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providers are accountable for total per-capita costs. Does not require patient “lock-in”. Reinforced by other reforms that promote coordinated, lower-cost care.</td>
<td>Supports new efforts of primary care physicians to coordinate care, but does not provide accountability for total per-capita costs.</td>
<td>Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs.</td>
<td>By combining FFS and prospective fixed payment, it provides “upfront” payments that can be used to improve infrastructure and process, but provides accountability only for services/providers. May be viewed as risky by many providers.</td>
<td>Provides “upfront” payments for infrastructure and process improvement and makes providers accountable for per-capita costs. Requires patient “lock-in”. May be viewed as risky by many providers.</td>
</tr>
<tr>
<td><strong>Strengthens primary care directly or indirectly</strong></td>
<td>Yes—provides incentive to focus on disease management. Can be strengthened by adding medical home or partial capitation payments to</td>
<td>Yes—changes care delivery model for primary care physicians, allowing for better care coordination and disease management.</td>
<td>Yes/No – only for bundled payments that result in greater support for primary care physicians.</td>
<td>Yes – when primary care services are included in a partial capitation model, it can allow for infrastructure and process improvement, and a new model for care delivery.</td>
</tr>
</tbody>
</table>

³⁸
primary care physicians.

<table>
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<tr>
<th>Fosters coordination among all participating providers</th>
<th>Yes – significant incentive to coordinate among participating providers.</th>
<th>No – specialist hospitals and other providers are not incentivized to participate in coordination.</th>
<th>Yes – Depending on how the payment is structured, it can improve care coordination.</th>
<th>Yes – strong incentive to coordinate and take other steps to reduce overall costs.</th>
</tr>
</thead>
</table>

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<tr>
<th>Accountable Care Organization (Shared Savings)</th>
<th>No – there is no incentive in the health home to decrease volume.</th>
<th>No – for payments outside the bundle. There are strong incentives to increase the number of bundles and to shift costs outside the bundle.</th>
<th>Yes – very strong efficiency incentive.</th>
<th>Yes – strong efficiency incentive to the degree that prospective fixed payment is weighted in overall payment.</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Removes payment incentives to increase volume</th>
<th>Yes – incentives are based on value, no volume.</th>
<th>No – incentives are not aligned across providers. No global accountability.</th>
<th>No – for payments outside of the bundle. No accountability for per-capita cost.</th>
<th>Yes – very strong accountability for per-capita cost.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Fosters accountability for total per-capita costs</th>
<th>Yes- in the form of shared savings based on total per-capita costs.</th>
<th>No – incentives are not aligned across providers. No global accountability.</th>
<th>No – for payments outside of the bundle. No accountability for per-capita cost.</th>
<th>Yes – to the degree that prospective fixed payment is weighted in overall payment.</th>
</tr>
</thead>
</table>

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<tr>
<th>Requires providers to bear risks for excess costs</th>
<th>Limited risk – while there might be risk-sharing in some models, the model does not require providers to take risks.</th>
<th>No – no risks for providers who continue to increase volume and intensity.</th>
<th>Yes, within the episode – providers are given a fixed payment per episode and bear the risk of costs within the episode being</th>
<th>Yes – providers are responsible for costs that are greater than the payment.</th>
</tr>
</thead>
</table>
The Medicare “Shared Savings” Program

Section 3022 of the ACA\textsuperscript{39} created required the Secretary of HHS to establish a Medicare Shared Savings Program (MSSP) intended to encourage the development of Accountable Care Organizations (ACOs) in Medicare. With implementation of the MSSP, the ACO model has taken on great significance in efforts to improve healthcare delivery, quality of care, and efficiency.

Final regulations implementing the program were published in November 2011, and took effect January 3, 2012. The intent of the MSSP is to promote accountability for Medicare beneficiaries, improve the coordination of FFS items and services, encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery, and incent higher value care.

CMS built its program in part based on the lessons learned from ACO projects already underway around the country.\textsuperscript{40} The MSSP shares a percentage of the achieved savings with the ACO, but only if they meet both the quality performance standards specified in regulations and generate a specified threshold of savings. If there are losses, those losses must be repaid by the program participant.

MSSP is intended to facilitate coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries, improve beneficiary outcomes, and reduce unnecessary costs. The MSSP is designed to:

- promote accountability for the care of Medicare FFS beneficiaries;
- require coordinated care for all services provided under Medicare FFS;
- encourage investment in infrastructure and redesigned care processes; and
- meet performance standards that include the adoption of electronic prescribing and health records.\textsuperscript{41}

Under the regulations, an ACO must have a sufficient number of primary care providers to serve at least 5,000 patients, and be committed to operating at least three years.\textsuperscript{42}
Of the 220 ACOs in the Medicare Shared Savings Program, only 53 exceeded their targets sufficiently in the first year of program operation to share in $300 million in savings. Another 52 reduced costs but didn't meet the threshold for shared savings. One overspent its target by $10 million.  

**CMS Guidance on ACO Regulations and Provider Concerns**

After CMS proposed the MSSP regulations in April 2011, there was a public outcry among doctors, hospitals, and other health care providers that the proposal was too complex. The final regulations abandoned a number of provisions to reduce the administrative burden of participation, but because concerns remained about whether there would be uptake, the program was later modified to make it easier for provider organizations to participate in the effort, through three key pilot programs:

**Pioneer ACOs:** The first initiative was the creation of the “Pioneer ACO,” designed to allow up to 30 integrated organizations that had already begun coordinating patient care to move forward with the ACO process. The Pioneer ACO is a slimmed-down version of the ACO model. However, the Pioneer ACO model does not address the main criticisms of the initial regulations—that the significant data collection requirements, governance mandates, start-up costs, financial risks, expensive IT capabilities, compliance dictates, infrastructure needs, performance metrics and expenditure baseline calculations all favor larger, established providers such as hospital systems.

The Pioneer program initially enlisted 32 participants, but by late September 2014, only 19 participants remained. Thirteen of the Pioneer participants left the program in 2013, after failing to meet their performance targets, and at least two additional participants left in 2014. CMS said the Pioneers generated total savings for the Medicare program of over $96 million and qualified for shared savings of $68 million last year. But only 11 of the Pioneers qualified for those savings; three generated losses and three elected to defer reconciliation until next year. One of the Pioneer participants who left the program complained that it had failed to receive any shared savings—despite exceeding its assigned savings targets by $2.5 million in each of the two years—because of the way the targets for the savings measures were structured. CMS said the Pioneer ACOs improved in 28 of 33 quality measures, including screening for fall risk and tobacco use and controlling high blood pressure.

**Advance Payment – ACOs:** The second new initiative, announced in July 2012, allowed for an “Advance Payment ACO” designed for physician-based and rural providers to receive upfront and monthly advance payments, which they can use to make investments in care coordination infrastructure. CMS recoups the advance payments from shared savings. Only two types of organizations are qualified to participate:

- ACOs that do not include any inpatient facilities and have less than $50 million in total annual revenue; and
- ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals and have less than $80 million in total annual revenue.

At last count, there were 35 participants in the Advance Payment model.

**Accelerated Development Learning Lessons:** In its final post-rule initiative, CMS sponsored training sessions, called “Accelerated Development Learning Lessons,” to teach providers how to improve care delivery and develop an action plan toward providing better coordinated care.
How Should Behavioral Health Providers Position Their Groups to Become Qualified Partners?

Federal regulations provided CMS with the discretion to designate additional healthcare providers as eligible to form and manage an ACO. Rather than exercise this authority, the rules adhered to the categories explicitly designated in the ACA. Therefore, behavioral healthcare service providers were excluded from the regulatory definition of “ACO professional, qualified to form an ACO.”

However, this does not prevent behavioral health providers from participating actively within ACOs. The ACO rules promote both psychiatric participation in ACOs and the needs of mental health consumers. The regulations require an assessment of “psychosocial needs” as part of individualized care planning for high-risk individuals targeted for case management. But when ACOs evaluate their population’s health needs, they are not obligated to assess behavioral healthcare needs. The regulations require that ACOs screen for depression and document a follow-up plan; this measures a procedure rather than a treatment outcome. If ACOs are not aware of their population’s behavioral health needs, they cannot provide targeted case management to address such concerns.

NASMHPD has urged the full inclusion of behavioral health in ACOs, including behavioral health records integration. The following recommendations for including behavioral health providers in Medicaid ACOs are adapted from the work of the Center for Health Care Strategies, funded by The Commonwealth Fund. Those recommendations are based on a table of models for integrating levels of service and payment integration developed by the SAMHSA-HRSA Center for Integrated Solutions.

- **Align with Existing Behavioral Health Initiatives** – States can use existing behavioral health initiatives building blocks to foster behavioral health integration within ACO programs. States can leverage the data infrastructure, operational process flows, and working relationships that have developed across providers to serve these targeted populations when designing program elements for Medicaid ACOs.

- **Leverage Federal Grant Opportunities** – Both the Center for Medicare and Medicaid Innovation and SAMHSA have been awarding grants for innovative approaches to care integration. States should consider partnering with grant awardees to leverage grant moneys in creating or enhancing existing integrated ACOs. In addition, The Innovation Center is also supporting states, through the SIM program, in testing innovative approaches to integrate existing siloed services and achieve former CMS Administrator Donald Berwick’s famed Triple Aim of improved population health, enhanced patient care, and reduced costs.

- **Reward High Performance in Behavioral Health** – States should be encouraged to maintain flexibility in ACO payment methodologies to ensure that financial incentives support the level of service integration being pursued. It will be critically important that behavioral health providers be included in models that involve shared savings. States can either require ACOs to share savings with behavioral health providers, or leave it up to the ACOs to determine the appropriate financial incentives to encourage the full participation of behavioral health providers. In some cases, a shared savings payment tied to a set of cost and quality measures may be sufficient to propel providers to coordinate physical and behavioral health services.

- **Approach Payers About Working Out Payment Mechanisms** – Behavioral health providers transitioning to integrated care models will need to enhance their relationships with physical health providers and payers. They will also have to build the administrative infrastructure to support scheduling, billing, and medical record functionality. Behavioral health providers should
be eager to participate in new and creative reimbursement methodologies. They are uniquely positioned due to their experience in providing on the basis of episodes of care.

- **Timely Monitoring** - Data collection, aggregation, analysis, and feedback must include and address behavioral health needs and providers. To support seamless data exchange across these providers, additional fields – including medical disorders, screenings, health risks and expanded medication lists – need to be incorporated into health software programs.

- **Quality Measures** – Quality measures must include metrics for behavioral health. While specific measures may vary from state to state, most Medicaid ACO programs are beginning to make shared savings payments contingent on meeting specific behavioral health-related process and outcome measure targets. A number of states are beginning to utilize measures related to social outcomes, including housing, employment, incarceration, and social connectedness.

- **Review regulatory barriers to integration.** Revise licensure and other regulatory frameworks— such as state laws barring billing for primary care and behavioral health services in the same day—that currently serve as barriers to provider-level integration and establish the integration of physical and behavioral health services as a core component of cross-cutting policy strategy.

The National Council for Community Behavioral Healthcare has developed a roadmap for behavioral health providers to become qualified ACOs. For many behavioral health providers, partnering with health homes and ACOs will mean honing significant new skills and capacities. Behavioral health providers need to address the gaps they find in these efforts and assess their ability to qualify for participation. To ensure their readiness to participate in health homes and ACOs, behavioral health providers could undertake the following action steps:

1. **Prepare now for participation in the larger healthcare field:**
   a. Identify community partners and build relationships, especially with primary care; and
   b. Develop competency in team-based care and health homes in particular.

2. **Establish credentials as a high performer:**
   a. Adopt quality tools and train staff in using them to track performance; and
   b. Assess clients’ experience of care (including its patient-centeredness and cultural/linguistic competence) and address gaps.

3. **Ensure information technology readiness:**
   a. Institute IT systems that are able to support:
      i. Exchange of data within and outside the organization; and
      ii. Use of data as a routine part of clinical work.

4. **Plan for an extended period of change:**
   a. Implement a change management plan;
   b. Identify key resources and support network for staying current around new and emerging practice and financing models.
V. Other Service Delivery Reforms

Health homes and ACOs are garnering significant attention as providers try to develop initiatives that will qualify for new and increased payments for the care they deliver, and position their organizations as new delivery models are developed. But other delivery and payment initiatives are competing with ACOs and health homes as attractive alternatives. One such approach is the “bundling” of payments for healthcare services across a single episode of care. Bundling payment for post-acute care services that patients receive across a single episode of care, such as for a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients both when they are in the hospital and after they are discharged. Like ACOs, such initiatives can help improve health, improve the quality of care, and lower costs.

Medicare currently makes separate payments to providers for the services they furnish to beneficiaries for a single medical condition or course of treatment, leading to fragmented care with minimal coordination across providers and healthcare settings. Payments are based on how much a provider does, not how well the provider does in treating the patient.

Research has shown that bundled payments can align incentives for providers – hospitals, post-acute care providers, doctors, and other practitioners – to partner closely across all medical specialties and settings that a patient may encounter to improve the patient’s experience of care during a hospital stay in an acute care hospital, and during post-discharge recovery. CMS is working in partnership with Medicare providers to develop models of bundling payments through its “Bundled Payments” initiative. CMS has invited providers to apply to help test and develop four different models of bundling payments. Through the Bundled Payments initiative, providers have great flexibility in selecting conditions to bundle, developing the healthcare delivery structure, and determining how payments will be allocated among participating providers.58 For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire healthcare team is compensated with a “bundled” payment that provides incentives to deliver services more efficiently while maintaining or improving quality of care.

Models of Care to Bundle Payments

The CMS Bundled Payments for Care Improvement Initiative (BPCIi) began seeking applicants in January 2013 for four broadly defined models of care, all centered around post-acute care episodes. Three models involve a retrospective bundled payment arrangement, and one model pays providers on a prospective basis. Giving providers the flexibility to determine which model of bundled payments works best for them and which episodes of care to work with was intended to make it easier for providers of different sizes and readiness to participate. However, none of the 48 episodes of care designated by CMS for inclusion in the initiative involved behavioral health complications from acute care stays or post-acute recovery.

Under the retrospective payment bundling model, providers set a target payment amount for a defined episode of care. Applicants proposed the target price, set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models are being paid for their services under the original Medicare FFS system, but at a negotiated discount. After the conclusion of an episode of care, total payments are compared with the target price. Participating providers then share in those savings.
Under the second, prospective payment, model, CMS makes a single, prospectively determined bundled payment to the hospital intended to reimburse for all services furnished during the inpatient stay by the hospital, physicians, and other practitioners. Physicians and other practitioners submit “no-pay” claims to Medicare and are paid by the hospital out of the bundled payment.

**NASMHPD Role on Bundling and Evidence-Based Practices**

Several Evidence-Based Practices (EBPs) in the behavioral health field are complex, multiple component interventions. In some state Medicaid programs, reimbursement is structured around separate components, while in others a more comprehensive bundled payment has been established. For example, a number of states now employ bundled payments for Assertive Community Treatment (ACT), and others cover supported housing.

NASMHPD has urged CMS to examine the role of financing mechanisms such as bundled services in expanding the use of EBPs in the core services provided in the rehabilitation and clinic options. NASMHPD has collaborated with the National Association of Medicaid Directors to promote broader adoption of EBPs, recognizing that integrated and adequate reimbursement is essential to ensuring not only widespread adoption, but also implementation of practices with fidelity to the evidence standards.

**Other Reforms -- Capitation Rates**

Under a capitated rate structure, physicians are paid a monthly fee for each patient under their care to cover a set of services, regardless of the amount or number of services provided. Blended models, where capitation is combined with pay-for-performance programs, aim to address some of the weaknesses of current payment methods, such as FFS, by rewarding physicians with additional payment for providing high-quality care.\(^{59}\) Blended models are widely used by physician groups in California that reimburse specialists and primary care physicians using blends of capitation and FFS.\(^{60}\)

Many managed care health plans also offer physicians bonuses for efficiency—either for following “utilization management” guidelines (which try to keep the use of health care services within certain parameters on the part of patients and doctors), or through some other mechanism.\(^{60}\) However, generalizing about these arrangements is difficult due to the variation in compensation across plans.\(^{61}\)

There are essentially two kinds of capitation, with many variations.

The first is called 'global capitation,' in which whole networks of hospitals and physicians band together to receive single fixed monthly payments for enrolled health plan members. Under global capitation, the physicians sign a single contract with a health plan to cover the total cost of care of groups of members, and then must determine a method of dividing up the total capitation payment among themselves.\(^{52}\) The second type of capitation is simply capitated payment contracted to a specific provider group: a physician group, or a hospital, individually.\(^{63}\)

A key provision of Medicaid health homes is the ability to pay for services using per member/per month (PM/PM) capitation or other alternative payment methodologies. States and providers favor PM/PM and monthly case rates over reimbursements based on 15-minute unit or other partial-hour billing, and states can set a non-actuarially set PMPM amount. Providers commonly cite 15-minute unit billing as one barrier to effectively integrating physical and behavioral health care due to the burden of documenting each service rather than receiving payment for a bundle of services. And although the health home payment can be a PM/PM payment, it must be made in connection to the rendering of a Medicaid allowed health home service.
A second barrier is that some health home service components (i.e., care coordination and referral to community and social support services) were previously non-reimbursable unless a state covered the services, such as targeted case management services, separately under its Medicaid state plan. As a result, there is little data to guide rate-setting.

VI. Looking Ahead: The “Healthcare Neighborhood” Construct

Given that the ACO model appears to have its weaknesses, as demonstrated by the mixed results reported by HHS, behavioral health providers should be looking to where healthcare will be heading next – beyond health homes and ACOs as currently conceived. As these models are put in place, it is becoming increasingly clear that their goals will be fully met only by broadening their framework to include the larger community. As the Robert Wood Johnson Foundation’s Commission to Build a Healthier America concluded, good health is not achieved primarily in the healthcare provider’s office but through early childhood education, good nutrition, and healthy communities. The “healthcare neighborhood” strategy of the future will connect the evolving health system with public health, social services, schools, and community groups to truly ensure people’s whole health across the lifespan.

While it’s true that all interested parties – behavioral health providers included – need to be able to carry their own weight in business terms, any ACO that fails to properly include behavioral health providers is destined to continue struggling with a significant share of otherwise unmitigated chronic care costs so the value proposition should be clear. In order to achieve a high performance health system that is organized to attain better health, better care, and lower costs, the behavioral health needs of patients and their families must be met with as much ingenuity, quality and precision as other conditions.

VII. Looking Ahead: Coordinated Care Organizations (CCOs)

The delivery system of the near future will see itself as a dynamic hospital and institutional prevention organization that helps enrollees and community members move toward lifelong health and wellness. In August 2012, Oregon embarked on a bold experiment that may fundamentally redefine health coverage, delivery, and payment. The new type of organization, created by state legislation, is called a Coordinated Care Organization. A CCO is as a community-based organization that is a hybrid of an insurance company and an accountable care organization. CCOs are to include mental health, substance use treatment, medical, and dental services, and a focus on chronic disease prevention and management designed to create partnerships with public health entities.

Key elements of the Coordinated Care Organization approach include:

• **A Focus on the Triple Aim:** Former CMS Administrator Donald Berwick popularized the term “Triple Aim” to describe efforts to simultaneously achieve better health for the population, better care for individuals, and reduced costs. CCOs that consider every design decision through this three-part prism have a better chance of success.

• **Organization and Governance:** A CCO must be a legal entity with a governance structure that includes representatives from local health plans, the delivery system, and the community. In addition to a board of directors, each CCO must have one or more Community Advisory Councils that include local governments, community members, and consumers/patients. Together they have a fiduciary responsibility to systematically move toward a true health care system.
• **Service Delivery Models:** CCOs are being designed around innovative service delivery models. These include patient-centered primary care homes, team-based care, primary care/behavioral health integration, care coordination, community health workers, the proactive treatment of chronic health conditions such as obesity, asthma and diabetes, and robust prevention efforts. All throughout Oregon, behavioral health leaders have become embedded in the CCO design efforts as they succeed in pitching the business case for integrated and specialty behavioral health.

• **Patient Centeredness:** Healthcare innovations only work if the patient is at the center of the design whether it’s a health home, a hospital transition program, or a community health team.

• **Financing:** CCOs assume direct authority to administer Oregon Health Plan funds for mental health and addiction services, but must operate within a global budget.66

**VIII. A Word on Health Information Technology**

Health information technology (HIT), including electronic health records (EHRs), personal health records (PHRs), health information exchange (HIE), mobile health, and other technologies that support health and wellness, are key enablers of care coordination and integration. To make new service delivery models work well, the effective use of HIT must be a key element. If behavioral health organizations cannot adopt HIT at a rate comparable to the rate of adoption by primary care facilities, hospitals, and physicians, it becomes difficult to provide comprehensive and coordinated care, and for lagging organizations to compete in the marketplace. However, behavioral health clinicians have been slow in adopting interoperable information systems. In a June 2012 study by the National Council for Community Behavioral Healthcare, only 2 percent of 505 behavioral health organizations surveyed indicated were meeting federal meaningful use requirements, and only 21 percent were using EHRs at their sites.67

New York is using a community-based and provider-centric approach to behavioral health HIT. The Health Care Efficiency and Affordability Law (HEAL), enacted in N.Y. in 2004, supports projects to accelerate the adoption of HIT and interoperable EHRs. HEAL awarded $120 million to community-based HIT projects to build a more streamlined approach to sharing client information, with a focus on behavioral health and long-term care providers. One of HEAL’s initiatives allows the Regional Extension Adoption Center for Health (REACH) to create a new division of the extension center dedicated exclusively to behavioral health providers.

To get started, New York City hospital selected a panel of patients using the diagnosis codes that indicate bipolar disorder and schizophrenia. Partners defined several events that would trigger an alert for their selected panel of clients, including an inpatient admission. When the Brooklyn Health Information Exchange (BHIX), Maimonides, and six other participating hospital sites (including four teaching hospitals, a skilled nursing facility, and a long-term care facility, and a level one trauma center) were ready to launch, each site designated care coordinators to receive and monitor these alerts and to follow up with clients and clinicians as appropriate. Since the original HEAL project began, it has generated over 10,000 alerts to partner providers.

Similarly, the New York State Office of Mental Health uses the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) as a tool to support several statewide quality collaborative projects. Projects have focused on reducing:

- Psychotropic poly-pharmacy;
The use of higher metabolic impact antipsychotics among individuals with existing cardio-metabolic conditions, including obesity, hypertension, hyperlipidemia, diabetes and ischemic vascular disease;

- Higher than recommended dosages; and
- Youth psychotropic poly-pharmacy set (“too many, too much, too young”).

Planned projects will include reducing hospital re-admissions and health promotion.

IX. Taking Integration to the Next Level

The integration of behavioral health and primary care services has been the subject of considerable attention for almost a decade. Such work has been motivated by the prevalence of chronic health problems in persons with behavioral health conditions and correspondingly high rates of early death. Service integration efforts have typically included cross-referral or bidirectional efforts to add some features of primary care to specialty behavioral health care settings or the reverse.

The approach fostered under the ACA, based on full service and financial integration differing substantially from previous models, has the potential to bring much-needed behavioral services to persons served in primary care settings who have behavioral health conditions, while fostering integrated services in specialty settings for those with the most severe mental or substance use conditions.

To make this model a reality, behavioral health and medical professionals must develop an improved understanding of each other’s cultures and practices. Sustainable, integrated medical and behavioral health financing must be implemented that consolidates payment for medical and behavioral health benefits. And integrated care sites in primary, specialty medical, and specialty behavioral health settings should address all of the physical, behavioral, and social needs of the populations served.

X. Recommendations for State Behavioral Health Agencies (SBHAs)

This section provides a specific roadmap for SBHAs for participating in and coordinating initiatives in developing and implementing health homes and ACOs.

Health Homes

Action. Health home services must be provided by a designated provider, a team of health care professionals, or a health team. Medicaid enrollees eligible for these health home services must meet one of three categories: (1) have at least two chronic conditions (including mental health conditions and substance abuse disorders); (2) have one chronic condition and be at risk of developing a second chronic condition; or (3) have a serious and persistent mental health condition. Services must include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care;
- Patient and family support;
- Referral to community and social support services; and
- Use of health information technology to link services.

The changing healthcare landscape has great potential to help individuals who are experiencing behavioral health issues in addition to other chronic condition(s). SBHAs should provide their state Medicaid officials with information about how treatment in health homes can contain healthcare costs and better address the needs of those with behavioral health conditions.

**Action.** Services provided in health homes must be coordinated and should include patient and family support, transition from the hospital, use of health information technology, and referrals to community and social services. The full inclusion of behavioral health prevention and treatment services leading to recovery should be an essential part of all health homes. SBHAs should promote connections between behavioral health specialists and primary care physicians that can lead to further health home partnerships.

**Accountable Care Organizations**

The *Medicare Shared Savings Program* incentivizes groups of providers and suppliers to work together through ACOs. The goal of the program is to promote accountability, and thus better care coordination, for Medicare FFS patient populations. Professionals who organize into certified ACOs are eligible to receive additional payments for shared savings if the ACO: (1) meets the quality performance standards set by the HHS Secretary; and (2) spends below the established benchmark amount for a given year.

**Action.** SBHAs should encourage the inclusion of specialty behavioral healthcare providers as ACO participants. SBHAs may also want to encourage certain behavioral healthcare providers to consider merging or contracting with an ACO or health home provider. Behavior health providers should also be encouraged to establish their own ACOs for patients whose primary diagnoses are behavioral health-related. At the very least, behavioral healthcare providers should be encouraged to sign business agreements to act as specialty providers, receiving referrals from the health homes or ACOs.

Behavioral health providers can also become a health home for people with severe conditions within an ACO – obtaining recognition as a health home or partnering with an entity (e.g., a federally qualified health center) that has health home status. Which path the provider chooses to take will depend on the types of services it wishes to provide, how it wants to position itself in the larger health system, and the resources it has available. ACOs are eligible for enhanced payments based on shared savings if they meet quality performance standards, including the adoption of electronic prescribing and health records. This provision underscores the importance of behavioral health records integration, enabling behavioral health providers and care networks to play as full partners in ACOs.

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1. [http://www.pcpcc.org/about](http://www.pcpcc.org/about).
4. 76 Federal Register 67802, 67872-67904; 42 C.F.R. Part 425 Subpart F.
5. Department of Health and Human Services, “Fact Sheet: Medicare ACOs Continue to Succeed in Improving Care, Lowering Cost Growth” (September 16, 2014).


§ 2703 of the ACA; 42 U.S.C. § 1396w-4.

§ 2703(h) of the ACA; 42 U.S.C § 1396w-4(h).

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CMS, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations: Final Regulations, 76 Federal Register 67802 et seq. (November 2, 2011).

Ibid.

CMS Fact Sheet: Medicare ACOs Continue to Succeed in Improving Care, Lowering Cost Growth (September 16, 2014).


See 42 U.S.C. § 256a-1 [Under the PPACA section for “Establishing Community Health Teams to Support the Patient-Centered Medical Home” one requirement of health teams is that they “implement interdisciplinary, interprofessional care plans” § 256a-1(c)(4)] and 42 U.S.C. § 1396w-4 [Under PPACA’s “State Option to Provide Health Homes for Enrollees with Chronic Conditions”, the care team is comprised of “physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State.” § 1396w-4(h)(6).]


Proposed rule 42 C.F.R. § 425.4.


Ibid.


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