

NASMHPD

*Taking Integration to the Next Level:
The Role of New Service Delivery Models
in Behavioral Health*

SECOND REPORT

in the

**Cornerstones for Behavioral
Healthcare Resource Series**

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Program Directors (NASMHPD)**

Alexandria, Virginia
August 2012

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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 mental illnesses.

About the Author

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Prior to his role at NASMHPD, Mr. Miller served as Senior Vice President at the National Coalition on Health Care, where he oversaw communications and public relations, and the evaluation, preparation and dissemination of innovative research and policy analysis about the nation's healthcare system.

At the National Alliance on Mental Illness (NAMI), Mr. Miller led NAMI's State Policy team, dedicated to improving the financing and delivery of mental health services at the state level for people with mental illness, and addressing mental illness issues across the lifespan.

He has published over 50 articles and reports on behavioral health and healthcare delivery and financing, the healthcare workforce, cost management, medical practice assessment, quality improvement, insurance exchanges, and public/private health insurance programs.

Acknowledgements

The author is indebted to Stephanie Sadowski, NASMHPD Administrative Program Associate, who provided the outstanding graphics in the report and the overall design of the document. She provided invaluable insights in the development of the report. Shanice Beasley, who served as an intern at NASMHPD during the development of the report, also provided graphic design support.

PREFACE

This white paper on service delivery reform models, with a focus on health homes and accountable care organizations (ACOs), is the second in a series of 12 reports under the auspices of the “*NASMHPD Cornerstones for Behavioral Healthcare Resource Series*” initiative. (**Appendix 1**) The series provides a strategic roadmap for State Behavioral Health Agencies (SBHAs) in implementing the behavioral mental health and substance use dimensions in the rapidly changing healthcare landscape.

NASMHPD is the only member organization representing state executives responsible for the \$37 billion public mental health service delivery system serving nearly 7 million people annually in all 50 states, 4 territories, and the District of Columbia.

The *NASMHPD Cornerstones Series* initiative – introduced earlier this year -- has been developed to assist SBHAs to navigate the changing landscape of healthcare and behavioral healthcare, provide background on key issues, spotlight SBHA initiatives at the state level, and focus on key action steps.

The initial set of Cornerstones’ reports concentrate on improving the integration of behavioral healthcare services with primary care and related programs. For this report, we have spotlighted recent efforts associated with the start-up of health homes and ACOs, and implications of these delivery models for SBHAs and for integrating services across the continuum of care.

Changes in the way behavioral healthcare services are delivered – whether through ACOs or health homes -- will require SBHAs to acquire new knowledge and expertise in many disciplines and fields. We believe this report will provide important technical assistance for SBHAs in meeting those new challenges, with the goal of addressing the needs of behavioral health clients in the new service delivery environment.

We hope this new report will address the needs of State Behavioral Health Agencies and help promote your interests as you embark on introducing new models to improve and integrate various services across the behavioral healthcare spectrum.

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 supportive programs have the expertise in care coordination and service delivery, and should play an important role in the implementation of these new models of care and other emerging strategies as they play out both in the public and private sectors.

These new models have the potential to unleash new powerful incentives to better coordinate and integrate behavioral health and primary care services. A new model called the "Coordination Care Organization" is a further example of new enhanced integration efforts in the field that encompass and merge large insurance companies and accountable care organizations.

Health Homes

Our current medical system is very good at treating serious disease – cancer, heart attacks, and especially "rare" illnesses. We have some of the best physicians and scientists in the world. Where we need to greatly improve is the care of common ailments – chronic illnesses such as depression, asthma, arthritis, obesity, high blood pressure, and diabetes. Chronic illness is expensive, and if we can find a better way to deal with it, we will have a healthier, more productive country and spend less money on health care.

Enter the Health Home strategy or the "Patient-Centered Medical (or Health) Home." The health home construct is a service delivery model that is being tested by several public and private sector health insurance and provider organizations to better coordinate services and programs for people with chronic illnesses.

Health homes are collaborative care models that offer the opportunity to improve coordination and integration of behavioral healthcare and primary care systems. Health homes are a promising strategy for 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 healthcare. The models of integration outlined in the recently released NASMHPD report on "*Reclaiming Lost Decades*" can be used within comprehensive service delivery reforms such as health homes and ACOs.

A state plan option under Medicaid has been created to provide health homes for persons with multiple chronic conditions. Under this strategy, the federal government will provide a 90 percent funding match for the first two years of these new initiatives. Importantly, two of the six chronic conditions defined are a serious mental health condition and a substance use disorder. The concept of a single point of clinical responsibility – similar to the health home model – has long been a foundation of sound community behavioral healthcare systems, although the execution has been challenging given the fragmentation in financing for care. Under the health home option, states can reimburse a patient-designated health home caregiver, who agrees to provide care management services, makes necessary referrals to specialists, provides support services as needed, and uses electronic health records and health information technology to monitor and coordinate several services and programs on behalf of the client.

Under the state plan option, individual states 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 provision of health home services.

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 clients, even when there are several caregivers and agencies involved in the patient's care.



Health Homes are collaborative care models that offer several opportunities to improve coordination of behavioral healthcare and primary care services.

In a Technical Report on *Measurement of Health Status for People with Mental Illness*, NASMHPD recommended that as the mental health system adopts strategies that reduce mortality and morbidity from chronic health conditions, they should be aligned with the healthcare delivery system. Moreover, implementation of chronic care models for individuals living with mental illness requires a health home as these individuals so often have co-morbid substance use and other serious medical conditions. As part of this delivery dynamic, SBHAs should assure that financing mechanisms align with, and promote, a single, integrated point of clinical responsibility for the individual, moving away from fragmented, fee-for-service reimbursement.

SBHAs should begin to promote connections between behavioral health specialists and primary care physicians who provide care within a health home. Once health teams are established through the grant program, SBHAs should also consider ways to collaborate with health home teams to foster integration of community-based behavioral health resources within disease prevention and disease management efforts.

New health home demonstration projects explicitly include mental health and substance use conditions. People with serious mental illness treated in the specialty mental health sector face many challenges in accessing appropriate primary medical care. This gap or poor quality of care could contribute to excess rates of mortality among people with serious mental illnesses. For these vulnerable populations “specialty health homes” located in community mental health settings, could potentially provide a strategy for delivering integrated and comprehensive high-quality care.

The Patient-Centered Primary Care Collaborative supported by the several primary care associations, includes 14 state health home projects with solid results:

Studies indicate that the **North Carolina** health home program saved the state \$60 million in Medicaid costs in 2003 and savings increased to \$154 million in 2007.

Key results from the **Missouri** Community Mental Health Center (CMHC) Health Home initiative include:

- 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.
- Key outcomes for behavioral health clients included:
 - *Independent Living* for clients increased by 33 percent;
 - *Vocational Activity* increased by 44 percent;
 - *Legal Involvement* decreased by 68 percent;
 - *Psychiatric Hospitalization* decreased by 52 percent;
 - *Illegal Substance Use* decreased by 52 percent; and
 - *CMHCs Services* substantially decreased overall medical costs.

Accountable Care Organizations (ACOs)

The ACO model is a reaction to the failure of both fee-for-service payment arrangements, which offers incentives to provide excessive services but not devote resources to managing chronic disease or coordinating care, and capitated payment, which offers healthcare providers potentially perverse incentives to restrict necessary care and take on more financial risk than many can handle.

ACOs are comprehensive, vertically and horizontally integrated care systems designed to manage and coordinate care to Medicare fee-for-service beneficiaries only, with strong parallels to public mental health system constructs for a single point of clinical and financial accountability, and comprehensive home- and community-based services systems.

ACOs will be eligible for enhanced payments from the federal government 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 be full partners in ACOs. NASMHPD has urged the full inclusion of behavioral health in ACOs, including behavioral health records integration.

With their focus on effective, coordinated care for the whole person, ACOs hold the potential for significantly improving the health of those clients they serve, including people with behavioral health conditions. Access to effective behavioral care services will be critical to the effectiveness of both ACOs as well as health homes.

The ACO model is similar to health homes but its focus is on arranging a comprehensive, integrated, team-based care involving all caregivers along the delivery continuum. That means ACOs could be more accessible to behavioral health providers currently in solo practices or in small group practices.

Health homes are similar to Accountable Care Organizations in that they consolidate multiple levels of care for patients. However, health homes take the approach of having the primary physician lead the care delivery “team.” Simplistically, an ACO consists of many coordinated practices while a health home is a single practice.

SBHAs should advocate that specialty behavioral healthcare providers be included as ACO participants. SBHAs may also want to encourage certain behavioral healthcare providers to establish their own ACOs for patients whose primary diagnoses are behavioral health-related.

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, contribute to achieving cost and quality targets, and share in new payment methods such as episode or case rates.

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.

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.

The Congressional Budget Office has estimated that potential savings to Medicare from promoting ACOs could amount to \$5.3 billion between 2010 and 2019, although net savings would not begin to be realized until 2013. The savings would be realized as providers reduce the volume and intensity of services delivered to their patients.

A 2008 Massachusetts law required creation of a Special Commission on the Health Care Payment System. A 2009 commission report recommended that the state make the transition from the current fee-for-service payment system to global payments over a period of five years. It also recommended creating an agency to guide implementation of the new payment system. Among other things, the entity would be responsible for defining and establishing risk parameters for ACOs, which will receive and distribute global payments. ACOs will assume risk for clinical and cost performance.

Programs in at least two states—Colorado and North Carolina—use networks of providers that, while not true ACOs, have the potential to develop into formal ACOs and health homes. The programs focus on primary care for Medicaid enrollees and rely on provider-led local networks that are responsible for improving care, quality and efficiency for the patients served.

Other related delivery-financing strategies include **bundling and capitation**. **Bundling** payment for services that patients receive across a single episode of care is one way to encourage healthcare 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 focus on keeping the member healthy, thus relying less heavily on costly specialists.

Coordinated Care Organizations (CCOs)

Oregon has embarked on a dynamic experiment that could fundamentally redefine healthcare in coverage, delivery, and payment. The new organization created by legislation is called a Coordinated Care Organization. A CCO is envisioned as a community-based organization that will be a hybrid of insurance companies and accountable care organizations. CCOs will include behavioral health, medical, dental, public health, and most likely other services that are necessary for health, including social services, housing, employment, transportation, and more. CCOs are already being designed around innovative service delivery models. These include patient-centered primary care health homes; team-based care; behavioral health/primary care integration; care coordination; community health workers; proactive treatment of chronic health conditions such as obesity, hypertension, asthma and diabetes; and robust prevention and health promotion efforts.

Key Actions State Behavioral Health Agencies Should Take Include:

Action. Services provided in health homes must be coordinated, including patient and family support, transition from the hospital, use of health information technology and provision of referral to community and social services. The full inclusion of behavioral health prevention and treatment services must be an essential part of all health homes. SBHAs should begin to promote connections between behavioral health specialists and primary care physicians who provide care within a health home. Once health home teams are established through Medicaid initiatives, for example, SBHAs should also consider ways to collaborate with health home teams to foster integration of community-based behavioral health resources within disease prevention and disease management efforts.

Action. SBHAs should advocate that specialty behavioral healthcare providers be included as ACO participants. SBHAs should also encourage certain behavioral healthcare providers to establish their own ACOs for patients whose primary diagnoses are behavioral health-related.

Action. SBHAs should help behavioral healthcare providers decide to potentially merge with an ACO or health home, or partner with them on a contract basis, placing providers in the health home. A behavioral healthcare provider may function as a specialty provider receiving referrals from the health home or ACO, with a business agreement that facilitates the referrals. It may also become a health home for people with severe conditions – obtaining recognition as a health home or partnering with an entity (e.g., a federally qualified health center) that has health home status.

Conclusion

The development of health homes and ACOs has taken center-stage in the movement toward improving the coordination and integration of care. NASMHPD recommends that health homes and ACOs 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, fee-for-service reimbursement. This concept of a single point of clinical responsibility has long been a foundation of sound community mental health care systems, although the execution has been challenging given the fragmentation in financing for care. Services provided in new service delivery programs must be coordinated, including patient and family support, transition from the hospital, use of health information technology and provision of referral to community and social services.

The full inclusion of behavioral health prevention and treatment services must be an essential part of all health homes and ACOs.

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.

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

In this report we:

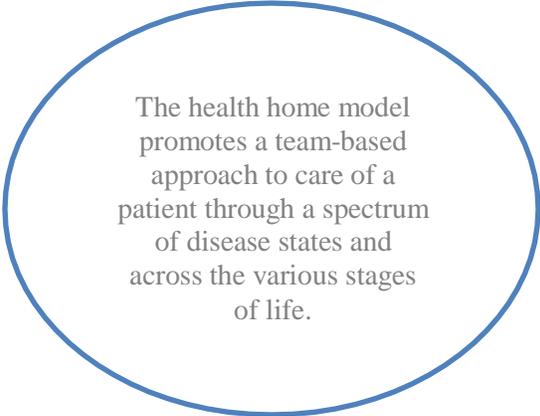
- Define Health Homes (also called Medical Homes by some stakeholders),
- Define different types of ACOs,
- Discuss what services are provided, the types of providers who are eligible to apply for payment under health homes and ACO models, how these initiatives are reimbursed, and existing best practices 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 are mutually beneficial, synergistic models, although ACOs can function without a health home and health homes can exist without an accountable care model. With so many new organizational models and acronyms – HMOs, PPOs POS (health maintenance organizations, preferred provider organizations and point-of-service plans) – it’s easy to lose sight of the differences between proposed solutions for making healthcare more efficient and effective. We hope this document provides a roadmap on how new service delivery models can improve behavioral healthcare and financing.

HEALTH HOMES

While the definition of a health home varies by source, the general construct remains consistent. The health home model promotes a team-based approach to care of a patient through a 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).¹



The health home model promotes a team-based approach to care of a patient through a spectrum of disease states and across the various stages of life.

The goal in the health home model is for a team of providers to care for a patient, seamlessly and efficiently, while managing costs. **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 a patient's clinical caregivers, and tracks the patient's progress.²

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.

Rather than tackling payment reform in isolation in the care delivery process, health homes and Accountable Care Organizations offer a consolidated approach to both issues. While the models are still developing, various pilot programs are being implemented around the country.

Health homes are similar to Accountable Care Organizations in that they consolidate multiple levels of care for patients. However, health homes take the approach of having the primary physician lead the care delivery "team." Simplistically, an ACO consists of many coordinated practices while a health home is a single practice.

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

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. Enhanced federal funding is available for two years for health homes serving Medicaid beneficiaries with chronic conditions.

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”.*³

NASMHPD has recommended that health homes be established to align with consumer needs and consumer preferences. (NASMHPD Policy Brief on Financing and the Public Mental Health System)

A state plan option (discussed further below) under Medicaid has been created to provide health homes for persons with multiple chronic conditions. Importantly, two of the six chronic conditions defined in the law are a serious mental health condition and a substance use disorder. Some argue that health homes may 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.⁴ Others are concerned that specialty behavioral health settings have been unable to deliver primary and specialty healthcare and may find it a challenge to do so effectively in the future.⁵

NASMHPD recommends 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, fee-for-service 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 the execution has been challenging given the fragmentation in financing for care. Services provided in health homes must be coordinated, including patient and family support, transition from the hospital, use of health information technology and provision of referral 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 recommends that state behavioral health authorities work closely with state Medicaid offices to ensure that behavioral health is included in health homes created under the changing healthcare environment for all chronic conditions and to carefully evaluate the potential for health homes for individuals with serious and persistent mental health conditions.

The 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 the execution has been challenging given the fragmentation in financing for care.

Target Population

A state may amend its “State plan” to provide health home services to Medicaid beneficiaries with any of the defined chronic conditions, or it may target individuals with particular chronic conditions or specific combinations that meet the minimum criteria described above.⁶

For example, states may target a population based on a minimum number of chronic conditions or on the severity of chronic/mental health conditions. Although states may target

by health condition, they do not have the flexibility to limit services by eligibility category, and therefore must include those who are eligible for both Medicare and Medicaid – known as dual eligibles, as well as those eligible for home- and community-based services waivers.

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.⁷

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.”⁸

Exhibit 2 describes three distinct types of provider arrangements that may deliver health home services under the changing healthcare environment.

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, Missouri implemented an integrated mental health/medical care coordination program for individuals with severe mental illness based in community mental health centers.

Exhibit 2

Health Home Provider Arrangements: Three Options

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).
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.
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.

Services Provided

There has been some confusion among states about which services are eligible for the 90 percent federal match under the changing healthcare landscape.

Enhanced payment applies to six key health home services listed in **Exhibit 3** (including care management, care coordination, and transitional care). 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 they can explain how these definitions contribute to the health home model.

Health homes are intended to foster greater integration, which CMS considers critical to the achievement of enhanced health outcomes.

Payment Methodology and Managed Care

CMS has envisioned a health home model of service delivery with either a per-member/per month (PMPM) or risk-capitated payment structure, but the agency has considered other payment methods or strategies.⁹

Exhibit 3

Services Coordinated by Health Homes

- High-quality health care services informed by evidence-based clinical practice guidelines;
- Preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Mental health and substance abuse services;
- Comprehensive care management and care coordination;
- 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;
- Chronic disease management, including self-management support to individuals and their families;
- Individual and family supports, including referral to community, social support, and recovery services; and
- Long-term care supports and services the state must be able to distinguish and quantify the health home services eligible for the 90 percent match.

The health home provision offers 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 several states already implementing or planning some form of medical/health home in their Medicaid programs, and may provide incentives for other states to test the model as well.

Though states are required to contribute a 10 percent share toward health home services for the first two years, and a larger portion thereafter, health homes that facilitate, coordinate, and integrate medical care, behavioral healthcare, long-term care, and community-based social services and supports for those with chronic conditions will likely yield better health outcomes and produce savings in the long run.

New Service Delivery Models and the Integration Imperative

NASMHPD recently released a report on the need to accelerate behavioral healthcare services in the primary care site, but also that primary care should be available in the behavioral health specialty settings. The models of integration outlined in NASMHPD’s report on “*Reclaiming Lost Decades*” can be used within overall and comprehensive service delivery reforms such as health homes and ACOs.

In addition to linking behavioral health and primary care services, new comprehensive service delivery models encompass all services including hospital and acute care services. For example, accountable care organizations can be seen as a set of providers associated with a defined population of clients, accountable for the quality and cost of care delivered to that population.

Dedicated vigilance is needed to ensure all indicated providers are included in models for integration, and that there is attention to include needed behavioral health screening and treatment services.

Given the costs related to behavioral health – including costs of providing treatment and costs resulting from a lack of treatment – it is imperative that behavioral health be included as models for service integration continue to develop and take root.¹⁰ The following are key reasons that “bi-directional integration” make 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;
- Behavioral health conditions are prevalent in primary care, often go unrecognized, and can lead to and exacerbate other chronic (and acute) health conditions; and
- Like other physical and behavioral health problems, substance use disorders are chronic conditions that progress slowly, so primary care physicians are in an ideal position to screen for emerging problems and monitor status.

Health homes that facilitate, coordinate, and integrate medical care, behavioral health care, long-term care, and community-based social services and supports for those with chronic conditions will likely yield better health outcomes and produce savings in the long run.

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 and the Colorado Department of Health Care Policy and Financing, which resulted in positive outcomes in pediatric care. Overall, these initiatives showed that improvements in preventive, coordinated care yielded reduced costs from hospital and emergency department utilization, as well as stronger evidence that investments in primary care can bend the cost curve.¹¹

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. And has expanded that includes 14 community networks and more than 3500 physicians, and serves more than 950,000 enrollees (more than two-thirds of Medicaid recipients). Studies indicate that the program saved the state \$60 million in Medicaid costs in 2003 and increased to \$154 million in 2007.

“The Mental Health and Medical Health Care Program in Community Mental Health Centers” in **Missouri** pioneered a program for Medicaid beneficiaries with severe mental illness that is based in community mental health centers (CMHCs) and provided care coordination and disease management to address the “whole person,” including both mental illness and chronic medical conditions.

The initiative is a partnership among Missouri’s Departments of Mental Health, MO HealthNet (Missouri’s Medicaid agency), and the Missouri Coalition of Community Mental Health Centers.

Missouri’s CMHC-based health home model leverages an 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 without 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 and train case managers in recognizing and managing chronic medical conditions and coordinating and integrating mental health disease management with Medicaid disease management programs.

Key results from the Missouri CMHC Health Home initiative include:

- For each client who enrolled in the initiative, savings on a per-member/per-month basis were \$300 for a total savings to the state of \$21 million.
- 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.
- Key outcomes for behavioral health clients included:
 - Independent Living** for clients increased by 33 percent;
 - Vocational Activity** increased by 44 percent;
 - Legal Involvement** decreased by 68 percent;
 - Psychiatric Hospitalization** decreased by 52 percent;
 - Illegal Substance** use decreased by 52 percent; and
 - CMHCs services** substantially decreased overall medical costs.

Under a related program that targeted people with serious mental illness who had chronic medical conditions –35 percent with COPD; 34 percent with asthma; 32 percent with diabetes and 11 percent with CHF, and incurred at a minimum \$25,000 in care outside of the public behavioral health system - the health home effort saved the state of Missouri nearly \$10 million on an annualized basis.

For each client who enrolled in Missouri’s Mental Health and Medical Health Care Program in CMHCs, savings on a per-member, per-month basis were \$300, for a total savings to the state of \$21 million. Rx costs were reduced by 23.4%.

Missouri was the first state to receive approval for a Health Home state plan option in 2011. Services for people with chronic conditions will be provided in the state’s community mental health centers to improve quality of care and reduce

costs. The services became effective January 1, 2012. The initiative will be used to:

- Enhance the amount of primary care nurse liaison staffing available at the CMHCs;
- Add primary care physician consultation/support;
- Enhance the State’s ability to provide transitional care between institutions and the community; and
- Enable the state to provide incentive payments to the CMHCs for reducing ER visits and inpatient hospitalization.

Recently, Rhode Island’s health home application has been approved and will initially target individuals with serious mental illness meeting the State’s criteria for designation as a “community support client”. Enrollment in a health home will be mandatory for all eligible clients with payment for team activity being rolled into a single monthly “case rate” for each active client.

NASMHPD Policies

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 a 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 the chronic care model.¹²

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.

SBHAs should assure that financing mechanisms align with, and promote, a single, integrated point of clinical responsibility for the individual, moving away from fragmented, fee-for-service reimbursement.

ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

ACOs are envisioned as large primary care-based partnerships that integrate other provider groups – e.g. hospitals, primary care physicians, behavioral health and other specialists (some gathered in health homes) – who are tasked with shared and coordinated responsibility for a patient's care from beginning to end.

Background

The ACO model is built on the principle that in placing the responsibility for a population's entire care continuum within a single entity with aligned clinical and financial incentives, healthcare quality and patient experience will improve and costs will go down.

ACOs are envisioned as large primary care based partnerships that integrate other provider groups – e.g. hospitals, primary care physicians, behavioral health and other specialists (some gathered in health homes) – who are tasked with shared and coordinated responsibility for a patient's care from beginning to end. ACOs (like health homes) also require robust health information technology (HIT) to track patients within and across primary and specialty care and to manage and mediate some new payment methods.

Outside of the Medicare program, over 100 healthcare provider organizations are already working with private health insurance companies and creating contracts containing the key elements of the ACO model: payment tied to improving patient care across the continuum and slowing down the rate of increase in healthcare spending.

The “Shared Savings Program”

Under the Medicare Shared Savings Program (MSSP) at the federal level, the accountable care organization has been touted as a model for service care reforms by providers, researchers and policy analysts, yet its initial success has been limited to a handful of healthcare systems across the country. However, the ACO model has recently taken on far greater significance as one of Medicare’s pilot programs to improve healthcare delivery, quality of care and efficiency.

MSSP is in place at the Federal level to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. The Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by:

- Promoting accountability for the care of Medicare fee-for-service beneficiaries;
- Requiring coordinated care for all services provided under Medicare Fee-For-Service; and
- Encouraging investment in infrastructure and redesigned care processes.

To test the ACO structure and requirements for pilot sites, at least one hospital should be included in the project, a minimum of 50 physicians (a mix of primary care and specialists), and a commitment to operate for 3-5 years and serve at least 5,000 patients.

The Genesis of the ACO Concept

The phrase “Accountable Care Organization” is attributed to Dr. Elliot Fisher of Dartmouth Medical School. Dr. Fisher has led the Dartmouth Atlas Project — a project that has, for the last 30 years, painstakingly documented the variation in care across the United States.¹³

Dr. Fisher’s purpose in identifying ACOs was to help identify the proper “locus for shared accountability” for a patient’s health care. HMO’s and other health insurers are obvious candidates, but as Dr. Fisher has noted, HMOs only comprise a small percentage of the current market, and health plans in general have focused on negotiating favorable prices within relatively open networks of providers.¹⁴

Dr. Fisher noted that a better option already exists: “virtual” organizations consisting of the various physicians that are associated with local acute care hospitals.¹⁵

In a recent Urban Institute paper on ACOs, the authors pointed to three essential characteristics of ACOs:

1. The ability to provide, and manage with patients, the continuum of care across different institutional settings, including at least ambulatory and inpatient hospital care and possibly 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.¹⁶

In exchange for investing in this reformed healthcare provider structure, the ACO members would share in the savings that results from their cooperation and coordination. Thus, ACOs can – theoretically – act

as a reform tool by incentivizing more efficient and effective care. This would help to combat the current perverse incentives of overutilization and overbuilding of health care facilities and technology.

Since Dr. Fisher’s introduction of the ACO concept, the idea has continued 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.¹⁷ The Medicare Payment Advisory Commission (MedPAC) has also 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.¹⁸

For a comparison of core capabilities of ACOs, health homes and other service delivery models, adapted by Dr. Fisher in collaboration with the Brookings Institution, please see **Exhibit 4**.

Exhibit 4 (Brookings Institution Side-by-Side Comparison)

| | Accountable Care Organization (Shared Savings) | Primary Care Health Home | Bundled Payments | Partial Capitation | Full Capitation |
|--|--|---|--|---|--|
| General strengths or weaknesses | Providers are accountable for total per-capita costs. Does not require patient “lock-in”. Reinforced by other reforms that promote coordinated, lower-cost care. | Supports new efforts of primary care physicians to coordinate care, but does not provide accountability for total per-capita costs. | Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs. | 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. | 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. |
| Strengthens primary care directly or indirectly | Yes- provides incentive to focus on disease management. Can be strengthened by adding medical home or partial capitation payments to | Yes- changes care delivery model for primary care physicians, allowing for better care coordination and disease management. | Yes/No – only for bundled payments that result in greater support for primary care physicians. | 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. | Yes – it gives providers “upfront” payments and changes the care delivery model for primary care physicians. |

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

| | Accountable Care Organization (Shared Savings) | Primary Care Health Home | Bundled Payments | Partial Capitation | Full Capitation |
|--|---|--|--|--|--|
| Removes payment incentives to increase volume | Yes – incentives are based on value, no volume. | No – there is no incentive in the health home to decrease volume. | No – for payments outside the bundle. There are strong incentives to increase the number of bundles and to shift costs outside the bundle. | Yes – strong efficiency incentive to the degree that prospective fixed payment is weighted in overall payment. | Yes – very strong efficiency incentive. |
| Fosters accountability for total per-capita costs | Yes- in the form of shared savings based on total per-capita costs. | No- incentives are not aligned across providers. No global accountability. | No – for payments outside of the bundle. No accountability for per-capita cost. | Yes – strong efficiency incentive to the degree that prospective fixed payment is weighted in overall payment. | Yes – very strong accountability for per-capita cost. |
| Requires providers to bear risks for excess costs | Limited risk – while there might be risk-sharing in some models, the model does not require | No – no risks for providers who continue to increase volume and intensity. | Yes, within the episode – providers are given a fixed payment per episode and bear the risk of costs | Yes – to the degree that prospective fixed payment is weighted in overall payment. | Yes – providers are responsible for costs that are greater than the payment. |

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| | providers to take risks. | | within the episode being higher than the payment. | | |
| Requires “lock-in” of patients to specific providers | No – patients are assigned based on previous care patterns. There are incentives to provide services within participating providers. | Yes – in order to give providers a PMPM payment, patients must be assigned. | No – bundled payments are for a specific duration or procedure and do not require patient “lock-in”. | Likely – depending on the model, patients might need to be assigned to a primary-care physician. | Yes – to calculate appropriate payments, patients must be assigned. |

ACOs are trying to provide incentives to manage utilization, improve quality, and haress cost growth using a shared-savings model (see Exhibit 5).

Beginning in 2012, CMS provided for piloting and evaluating 32 Accountable Care Organizations through Medicare for adults and seniors, and a pediatric ACO demonstration under Medicaid.¹⁹ (Please see Appendix 2)

Exhibit 5

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.

CMS has issued regulations for how ACOs should be formed and evaluated for participation in the Medicare Shared Savings plan. CMS has built its regulations in part on the lessons learned from ACO projects underway around the country.²⁰ ACOs will be eligible for enhanced payments based on shared savings if they meet quality performance standards including the adoption of electronic prescribing and heath records. This provision underscores the importance of behavioral health records integration, enabling behavioral health providers and care networks to be full partners in ACOs. NASMHPD has urged the full inclusion of behavioral health in ACOs, including behavioral health records integration.^{21/22}

How Should Behavioral Health Providers Position Their Groups to Become Qualified Partners?

The National Council for Community Behavioral Healthcare has developed a roadmap for providers to become qualified ACOs.²³ For many behavioral healthcare providers, partnering with health homes and ACOs will mean honing significant new skills and capacities. According to the National Council, it is critically important that behavioral health providers assess their current ability to qualify for participation in these efforts and address the gaps they find. 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 HIT 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.

Looking Ahead: The "Healthcare Neighborhood" Construct

Behavioral health providers should be looking to where healthcare will be heading next – beyond health homes and ACOs as currently construed. As these models are put in place, it will become 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.²⁴

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

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 medical conditions.

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.

The following recommendations have been adapted from the work of *The Commonwealth Fund*.²⁵

- **Technical Support for Behavioral Health Providers** – Behavioral healthcare treatment providers have a long history of serving populations from the margins where profits are slim. Most behavioral healthcare provided is financed by Medicare, Medicaid, Federal block grants, State general funds and other government grants.
- **Integrated Care** – truly effective ACOs will ensure that a foundation of integrated primary and behavioral health care is available for their members.
- **Accountability for Behavioral Health** – the most accurate measures of quality care, patient care experiences, population outcomes, and total costs must include mental health and substance use disorders.
- **Informed Patients** – ACOs must inform, engage and educate patients and their families. Nowhere is the need greatest than among those members and patients with behavioral health conditions.
- **Commitment to Communities** – serving the entire community has long been the mission of behavioral health providers – many of whom also serve social service functions. Linkages between community assets, case management and social work are vitally important to the most vulnerable populations like people with serious mental illness, those suffering from disabilities and those suffering from multiple chronic conditions.
- **Reward High Performance in Behavioral Health** – as much as ACOs represent a gold rush among business interests, it will be critically important that behavioral health providers be included in models that involve shared savings.
- **Innovative Payment Mechanisms for Behavioral Health** – behavioral health providers are eager to look for new and creative ways to be reimbursed. They are uniquely positioned to offer services on case rates and the basis of episodes of care.
- **Timely Monitoring** - data collection, aggregation, analysis and feedback must include and address behavioral health needs.

CMS Guidance on ACO Regulations and Provider Concerns

On March 31, 2011, CMS provided guidance to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations. These rules were later amended to make it easier for provider organizations to participate in the effort through three key provisions:

Pioneer ACOs:

The first initiative was the creation of the “Pioneer ACO,” designed to allow up to 30 integrated organizations that have already begun coordinating patient care to move forward with the ACO process.²⁶ The Pioneer ACO is an abridged version of the overall ACO model. However, the Pioneer ACO model did not address the main criticisms of the initial regulations – namely the data collection requirements, governance mandates, start-up costs, financial risks, expensive IT capabilities, compliance dictates, infrastructure needs, performance metrics and expenditure baseline calculations that favor high cost/low quality providers.

Advance Payment – ACOs:

A second new initiative under the additional rules allowed for an “Advance Payment ACO.” CMS sought comments on how to provide cash-strapped providers up-front financial assistance to lessen the burden of the estimated \$1.7 million in start-up costs that ACOs were expected to face.

Accelerated Development Learning Lessons:

In another 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.

Role of Behavioral Health under Federal ACOs

New federal regulations provide CMS with the discretion to define which healthcare providers are eligible to form and manage an ACO.²⁷ Rather than exercise this authority, the rules adhered to the categories explicitly designated by Congress. Therefore behavioral healthcare service providers were excluded from the regulatory definition of “ACO professional.”²⁸ The regulations would require an assessment of “psychosocial needs” as part of individualized care planning for high-risk individuals targeted for case management.²⁹ But when ACOs evaluate their population’s health needs, they are not obligated to assess behavioral healthcare needs.³⁰ If ACOs are not aware of their population’s behavioral health needs, they may not provide targeted case management to address such concerns.³¹

If ACOs are not aware of their population’s behavioral health needs, they may not provide targeted case management to address such concerns. SBHAs should inform ACO designers of this potential problem.

Among the 65 quality measures for ACOs proposed by CMS in the proposed rules, just one measure acknowledged a prevalent behavioral health need of Medicare beneficiaries: depression. As drafted, the regulations would require that ACOs screen for depression and document a follow-up plan. Similar to other proposed criteria, this will measure a procedure rather than a treatment outcome. Among the changes to the rules was CMS’ decision to slash the number of quality measures that ACO’s must meet from 65 to 33.

On October 20, 2011, CMS issued their final rule on the implementation of ACO’s. Based on NASMHPD’s comments and as well as other behavioral health groups, the final ACO rules promote both psychiatric participation in ACOs and the needs of mental health consumers.

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 also competing with ACOs and health homes as attractive alternatives. One such effort is “bundling” healthcare services.

Bundling Payments

Bundling payment for services that patients receive across a single episode of care, such as 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.

CMS is working in partnership with providers to develop models of bundling payments through the “Bundled Payments” initiative. On August 23, 2011, CMS 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.³²

Bundling payments like ACOs is another way that doctors, hospitals and other health care providers can work together to better coordinate care for patients, which can help improve health, improve the quality of care, and lower healthcare 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. Under the Bundled Payment and ACO initiatives, CMS would link payments for multiple services patients receive during an episode of care. 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.

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.

Models of Care to Bundle Payments

The Bundled Payments initiative sought applications for four broadly defined models of care. Three models involve a retrospective bundled payment arrangement, and one model would pay providers on a prospective basis. By giving providers the flexibility to determine which model of bundled payments works best for them, it may be easier for providers of different sizes and readiness to participate.

Retrospective Payment Bundling

NASMHPD has collaborated with the state Medicaid directors to promote broader adoption of evidence-based practices. Moreover, integrated and adequate reimbursement is essential to ensuring widespread adoption of such practices.

In these models, providers would set a target payment amount for a defined episode of care. Applicants would propose the target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models would be paid for their services under the original Medicare fee-for-service (FFS) system, but at a negotiated discount. After the conclusion of the episode, the total payments would be compared with the target price. Participating providers may then be able to share in those savings.

Prospective Payment Bundling

Under another model, CMS would make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians and other practitioners. Physicians and other practitioners would submit “no-pay” claims to Medicare and would be paid by the hospital out of the bundled payment.

Bundling and Evidence-based Practices

NASMHPD has urged CMS to examine the role of financing mechanisms such as bundled services in expanding the use of evidence-based practices (EBPs) in the core services provided in the rehabilitation and clinic options.

Several evidence-based practices 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.

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.

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NASMHPD has collaborated with the state Medicaid directors to promote broader adoption of evidence-based practices, 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. 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.

Other Reforms -- Capitation Rates

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. Blended models where capitation is combined with pay-for-performance programs aim to address some of the weaknesses of current payment methods, such as fee-for-service, by rewarding physicians with additional payment for providing high-quality care.³³

Many 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. However, generalizing about these arrangements is difficult due to the variation in compensation across managed care plans.³⁴

Blended models are widely used by physician groups in California that reimburse specialists and primary care physicians using blends of capitation and fee-for-service.³⁵

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.³⁶ The second type of capitation is simply capitated payment contracted to a specific provider group: a physician group, or a hospital, individually.³⁷

Coordinated Care Organizations (CCOs) – The Future is Now

Oregon has embarked on a bold experiment that may fundamentally redefine health coverage, delivery, and payment. The new organization created by the legislation is called a Coordinated Care Organization. A CCO is envisioned as a community-based organization that will be a hybrid of insurance companies and accountable care organizations (large organized groups of healthcare providers.) CCOs will include behavioral health, medical dental, public health, and most likely other services that are necessary for health — social services, housing, employment transportation, and more.³⁸

Key elements of the Coordinated Care Organization include:

>> *Focus on the Triple Aim:* The Institute for Healthcare Improvement, a leading healthcare quality organization, coined the term the *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 process will have a better chance of success.

>> *Organization and Governance:* A CCO will 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 will have one or more Community Advisory Councils that include local governments, community members, and consumers/patients.

>> *Service Delivery Models:* These include patient-centered primary care homes; team-based care; primary care/behavioral health integration; care coordination; proactive treatment of chronic health conditions such as obesity, asthma and diabetes; and robust prevention efforts. The delivery system of the near future could see itself as a dynamic hospital and institutional prevention organization that helps enrollees move toward lifelong health and wellness. Behavioral health leaders have become embedded in the CCO design efforts as they succeed in advocating the business case for integrated and specialty behavioral health. Additionally, 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.³⁹

These new organizations will operate under a risk-adjusted global budget that reimburses set rates for each patient's care rather than per service and that grows at a fixed rate. Physicians and other caregivers not only will need to keep total costs under that amount but also will be assessed based on measures of access, clinical outcomes, and population health. As of May 2012, 14 entities had applied to become a CCO, which will cover up to 95 percent of patients in Oregon's Medicaid program. Participating Oregon healthcare professionals can share in any savings associated with measured improvements in quality and efficiency, an incentive that many believe will lead to better care management.⁴⁰

If patients move in and out of the Medicaid program it could severely disrupt the process, and it may be difficult at first to encourage physicians – who are participating in managed care arrangements – to take on further risk through the CCO.

OPPORTUNITIES 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. Beginning January 1, 2011, states had the option to amend the state Medicaid plan and to assign Medicaid enrollees with chronic conditions to a “health home” selected by the beneficiary. Health home services are provided by a designated provider, a team of health care professionals, or a health team, and include:

- (i) Comprehensive care management;
- (ii) Care coordination and health promotion;
- (iii) Comprehensive transitional care;
- (iv) Patient and family support;
- (v) Referral to community and social support services;
- and (vi) Use of health information technology to link services.

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); or (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. 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 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. SBHAs should begin to promote connections between behavioral health specialists and primary care physicians who provide care within a health home. Once health teams are established, SBHAs could also consider ways to collaborate with health teams to foster integration of community-based behavioral health resources within disease management efforts.

Accountable Care Organizations

Action. SBHAs should advocate that specialty behavioral healthcare providers be included as ACO participants. SBHAs may also want to encourage certain behavioral healthcare providers to establish their own ACOs for patients whose primary diagnoses are behavioral health-related.

Action. SBHAs should help behavioral healthcare providers merge, as appropriate, with an ACO or health home, or partner with them on a contract basis. A behavioral healthcare provider would function as a specialty provider receiving referrals from the health home or ACO, with a business agreement that facilitates the referrals. It may also become a health home for people with severe conditions – 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.

The full inclusion of behavioral health prevention and treatment services must be an essential part of all health.

Action. ACOs will be 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. SBHAs with their special knowledge on public systems should provide needed expertise which results in the full inclusion of behavioral health in ACOs, including behavioral health records integration.

Conclusion

The development of health homes and ACOs has taken center-stage in the movement toward improving the coordination and integration of care. NASMHPD recommends that health homes and ACOs 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, fee-for-service reimbursement. This concept of a single point of clinical responsibility has long been a foundation of sound community mental health care systems. Services provided in health homes must be coordinated, including patient and family support, transition from the hospital, use of health information technology and provision of referral to community and social services.

The full inclusion of behavioral health prevention and treatment services must be an essential part of all health homes and ACOs.

Appendix 1: Cornerstones for Behavioral Healthcare Today and Tomorrow

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|---|---------------|---|
| Cornerstone I Improve the Coordination of Behavioral Health Services with Primary Care and Supportive Services and Maximize the Use of Available Resources to Effectively Address Behavioral Healthcare Needs by Reducing Fragmentation and Ensuring a Full Spectrum of Care | ROLE 1 | Accelerate the necessary linkages between <u>physical health care and behavioral health services</u> to promote and achieve recovery for people with mental illnesses and/or substance abuse who also have chronic physical diseases. |
| | ROLE 2 | Provide content expertise in the development and implementation of behavioral health aspects of <u>service delivery</u> system reforms such as medical homes, health homes and accountable care organizations, and related payment initiatives such as bundling and capitation. |
| | ROLE 3 | Accelerate the necessary linkages between <u>behavioral healthcare services and the array of supportive services</u> (supported housing, employment, transportation, education and training, etc.) essential to promote and achieve recovery for persons with persistent mental illness and/or substance use. |
| Cornerstone II Leverage Mental Illness Prevention, Mental Health Promotion, and Public Health Resources – and Identify and Promote New Public Health Strategies and Practices to Reduce Risks for Behavioral Health Problems – with an Emphasis on Children and Youth | ROLE 4 | Develop and implement effective behavioral <u>health promotion</u> , wellness and prevention activities. |
| | ROLE 5 | Continue the development and expanded provision of services and supports, including <u>safety-net services that are provided by or under the control of SBHAs</u> , and ensure that proper linkages exist between these services and health and behavioral health services. |
| Cornerstone III Coordinate Measurement, Electronic Health | ROLE 6 | Provide content expertise on the development of and inclusion of <u>behavioral health quality measures</u> in specifications for electronic health records, in the development of <u>health information exchanges</u> , and in public and private sector initiatives to improve the quality of behavioral healthcare. |

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| Records' and Health Information Technology Initiatives as Essential Prerequisites to Improving Behavioral Health Quality in Tandem with a Stable Behavioral Health Workforce that Relies on Explicit Standards of Care and Using Best Practices to Deliver Quality Behavioral Health Care Services to Maximize Recovery for People with Behavioral Health Disorders | ROLE 7 | Provide leadership to health providers, federal and state policymakers and officials, national medical societies, including primary care organizations, to ensure the <u>adequacy of providers in the behavioral health workforce</u> to deliver quality behavioral health care services. |
| | ROLE 8 | Empower consumers to <u>maximize control of their recovery</u> through new and emerging ways to design, apply and organize existing treatments and by finding new platforms and avenues to deliver new treatments. |
| Cornerstone IV Work to Ensure that Public and Private Insurance Plans Operating in the State Adequately Address the Behavioral Health Interests of Eligible Enrollees Through Covered Benefits and Payment Systems | ROLE 9 | Serve as the state authority for <u>mental health/substance abuse benefits</u> including, where possible, serving as the contractor for and payer of services on behalf of other state agencies (e.g., state Medicaid program), or by <u>developing the scope</u> and requirements for behavioral health services if contracted for or paid directly by the state Medicaid authority, as well as develop innovative payment systems that recognize and reward performance. |
| | ROLE 10 | Provide content expertise on <u>benefits and scope and requirements for behavioral health services</u> – in partnership with state insurance authorities – <u>that are offered</u> in public and private health insurance plans operating in the state. |
| | ROLE 11 | Actively ensure the <u>outreach and enrollment</u> of individuals with mental and substance use disorders so they may receive and maintain <u>health coverage</u> based on their eligibility and are able to easily access care. |
| | ROLE 12 | Educate providers, insurance carriers, federal and state policymakers and officials, health care providers, consumer organizations and the general public on behavioral health parity within public and private insurance and monitor its implementation. |

Appendix 2: Accountable Care Organizations Selected

On July 9, 2012, the Centers for Medicare & Medicaid Services (CMS) announced the selection of 89 ACOs to participate in the Medicare Shared Savings Program. The selected organizations will take responsibility for coordinating care for nearly 1.2 million beneficiaries in 40 States and Washington, D.C. In total, there now are 154 organizations participating in Medicare shared savings initiatives, serving over 2.4 million Medicare patients across the country.

All ACOs that succeed in reducing the rate of growth in the cost of care while providing high quality care may share in the savings to Medicare. To ensure high quality of care, ACOs will report performance on 33 measures relating to care coordination and patient safety, use of appropriate preventive health services, improved care for at-risk populations, and patient and caregiver experience of care.

Participation in an ACO is purely voluntary for providers. Because the Shared Savings Program is part of the original Medicare fee-for-service program, beneficiaries served by these ACOs will continue to have free choice about the care they receive and from whom they seek care, without regard to whether a particular provider or supplier is participating in an ACO.

For a listing of the 89 ACOs selected, please go to the following HHS link:

<http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4405&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

ENDNOTES

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(http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.dat /022107medicalhome.pdf.)

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See U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations*, Proposed Rule, http://www.ofr.gov/OFRUpload/OFRData/2011-07880_PL.pdf

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²⁶ <http://innovations.cms.gov/wp-content/uploads/2011/05/Pioneer-ACO-RFA.pdf>

²⁷ 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).]

²⁸ 2 U.S.C. § 1899(b)(1)(E).

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³⁰ Proposed rule 42 C.F.R. § 425.5(d)(15)(ii)(B)(4).

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