NASMHPD

National Association of State Mental Health Program Directors

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

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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 the expertise in care coordination and service delivery, and should play an important role in the implementation 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 have the potential to unleash powerful incentives to better coordinate and integrate behavioral health and primary care services, thus can be labeled "Taking Integration to the Next Level", since they contain several new elements to improve care. A new model called the "Coordination Care Organization" is a further example of enhanced integration that encompasses large insurance companies and accountable care organizations.

Health Homes

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.

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 health care. The models of integration outlined in NASMHPD's report on *"Reclaiming Lost Decades"* can be used within comprehensive service delivery reforms such as health homes and ACOs.

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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 consumer.

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

In a *Technical Report* series in 2008, NASMHPD recommended that implementation of new service delivery models for individuals with a mental illness, should require a health home, as these individuals so often have co-morbid substance use and other serious medical 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 that encourages over-utilization.

SBHAs could 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 could 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.

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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 increased to $154 million in 2007.

Key results from the **Missouri** Community Mental 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 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 play as full partners in ACOs. NASMHPD has urged the full inclusion of behavioral health in ACOs, including behavioral health records integration.

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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 practice and small groups.

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.

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 and small group.

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.

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 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 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 focus on keeping the member healthy, thus relying less on costly specialists.

Coordinated Care Organizations (CCOs)

Oregon has embarked on a dynamic experiment that could fundamentally redefine health in 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 providers in this case.) 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.

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 that 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 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 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. The concept of a single point of clinical responsibility has long been a foundation of sound community mental healthcare systems, 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 and ACOs.

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To access the complete "Taking Integration to the Next Level" report, please go to www.nasmhpd.org

The National Association of State Mental Health Program Directors (NASMHPD) represents 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. NASMHPD is the only national association to represent state mental health commissioners/directors and their agencies.