

State Approaches for Integrating Behavioral Health into Medicaid Accountable Care Organizations

States are developing accountable care organizations (ACOs) for their Medicaid populations to target health care costs and improve health care quality. States are designing ACOs with the goals of better coordinating care for high-need, high-cost patients and reducing inappropriate inpatient and emergency department visits. Many high-need, high-cost Medicaid patients have mental health and substance use issues and are often not well served in the current fragmented health care system.¹ In response, states, including those participating in The Commonwealth Fund-supported *Medicaid ACO Learning Collaborative*, are increasingly looking to integrate behavioral health into their Medicaid ACO programs to help move the needle on cost and quality.

Given the prevalence of behavioral health conditions and the related cost implications among the Medicaid population, integrating behavioral health services within Medicaid accountable care organizations (ACOs) may help states to improve quality of care and generate savings from avoidable utilization. This resource examines four broad strategies states can use to integrate behavioral health services into ACOs: (1) incorporating behavioral health into payment models; (2) requiring ACOs to report on behavioral health metrics; (3) encouraging ACOs to include behavioral health providers; and (4) providing integration supports. It explores how eight states have incorporated these strategies into their ACO approaches.

Four strategies that states have used to drive coordination of behavioral health and physical health services in Medicaid ACO models are: (1) including behavioral health services in ACO payment models; (2) requiring ACOs to report behavioral health quality metrics and tying some of these metrics to payment; (3) encouraging ACOs to include behavioral health providers in ACOs and/or ACO governance structures; and (4) providing support to ACOs to integrate behavioral health services into their models.

This technical assistance tool examines the eight Medicaid ACO programs that have integrated behavioral health into their Medicaid ACO models. These states have used the following four methods to achieve this goal.

1. Including Behavioral Health Services in ACO Payment Models

Four Medicaid ACO programs (IL, ME, MN, and OR) currently require ACOs to include behavioral health services in their programs, and one (VT) includes these services as optional. Since all of these models have shared savings payment approaches, these services are included in the ACO's total cost of care (TCOC) calculation, from which shared savings is based. This creates a powerful incentive for ACOs to effectively provide and coordinate physical and behavioral health services, since all costs for these services are accounted for when shared savings are calculated.

2. Utilizing Behavioral Health Quality Metrics

Six Medicaid ACO programs (IL, ME, MN, NJ, OR, and VT) include at least one behavioral health quality metric in their Medicaid ACO programs. These metrics assess the impact of the ACO delivery model on specific behavioral health issues and more effectively evaluate their patients' mental health or substance abuse treatment needs. These states also tie some of these metrics to payment by making the distribution of shared savings contingent on meeting or exceeding quality

thresholds. Other metrics are simply required to be reported, and not tied to payment, but ACOs are informed of their performance on these metrics, which is sometimes reported publicly.

3. Requiring or Encouraging Inclusion of Behavioral Health Providers

Eight states with Medicaid ACO programs (CO, IA, IL, ME, MN, NJ, OR, and VT) have specific requirements or incentives for integrating behavioral health into Medicaid ACOs. Examples of strategies include: (a) requiring behavioral health representation on the ACO’s executive board (IL, NJ, and VT); (b) requiring behavioral health providers be part of the ACO and share accountability for cost and outcomes (IL, ME, and NJ); (c) requiring ACOs to have a formal plan to address behavioral health concerns (IA); and (d) offering increased shared savings to ACOs that reallocate funds to behavioral health providers (MN). Maine requires ACO providers that contract with behavioral health homes to include these behavioral health homes in their ACO activities to better support mental health and substance abuse coordination for complex patients. These methods encourage physical and behavioral health providers to form partnerships with the goal of better serving patients. Requirements can also be designed to improve communication between physical health and behavioral health providers, such as developing common language among providers, aligning workflows, standardizing how cases are approached, and determining how treatment goals are prioritized between behavioral and physical health providers.²

4. Providing Integration Support

Five states (CO, ME, MN, OR, and VT) provide direct support to help ACOs integrate behavioral health. Four states (ME, MN, OR, and VT) have leveraged their State Innovation Model grants from the Center for Medicare and Medicaid Innovation to bolster behavioral health information technology and data-sharing capacity. In addition, three states (CO, ME, and OR) provide educational opportunities for physical health providers to learn more about behavioral health care practices.

The matrix on the following pages provides further detail regarding how Medicaid ACOs have undertaken the task of integrating physical and behavioral health in order to provide comprehensive care for their beneficiaries.

State Medicaid ACO Program Characteristics for Behavioral Health (BH) Integration

State	BH in Payment Models	BH Quality Metrics	BH Integration Requirements and Incentives	BH Integration Support
Colorado <i>Regional Care Coordination Organizations (RCCOs)</i>	<ul style="list-style-type: none"> No behavioral health services included in payment calculations. 	<ul style="list-style-type: none"> No behavioral health quality metrics are included. 	<ul style="list-style-type: none"> Primary care medical providers (PCMPs) enrolled in RCCOs are required to have interest and expertise in serving members with complex behavioral health needs.³ 	<ul style="list-style-type: none"> The state supports PCMPs through formal training classes and forums on integrating physical and behavioral health care.⁴
Illinois <i>Accountable Care Entities (ACEs)</i>	<ul style="list-style-type: none"> Behavioral health services included in TCOC calculations.⁵ 	<ul style="list-style-type: none"> Follow-up care for children prescribed ADHD medication (tied to payment). Inpatient hospital 30-day readmission rates with primary behavioral health diagnosis (reporting only). Antidepressant medication management (reporting only). Adherence to antipsychotic medication for individuals with schizophrenia (reporting only). Initiation and engagement of alcohol and other drug dependence treatment (reporting only).⁶ 	<ul style="list-style-type: none"> The ACE's provider network must include a behavioral health provider.⁷ The ACE's governing body must include a representative from at least one behavioral health provider.⁸ 	<ul style="list-style-type: none"> No direct integration support.
Iowa <i>Accountable Care Organizations (ACOs)</i>	<ul style="list-style-type: none"> No behavioral health services included in payment calculations. 	<ul style="list-style-type: none"> No behavioral health quality metrics are included. 	<ul style="list-style-type: none"> ACOs are required to establish a plan for coordinating behavioral health and physical health services.⁹ 	<ul style="list-style-type: none"> No direct integration support.
Maine <i>Accountable Communities (ACs)</i>	<ul style="list-style-type: none"> Behavioral health services included in TCOC calculations.¹⁰ 	<ul style="list-style-type: none"> Follow-up after hospitalization for mental illness (tied to payment). Initiation and engagement of alcohol and other drug dependence treatment (tied to payment). Out of home placement for children and adults (reporting only).¹¹ 	<ul style="list-style-type: none"> ACs must form contractual or informal partnerships with at least one behavioral health provider.¹² If an AC's lead entity is contracted with a health home practice, behavioral health home organization or community care team, those entities must participate as AC providers.¹³ 	<ul style="list-style-type: none"> Using SIM funding to build data-sharing capacity, train providers, and host learning collaboratives to facilitate implementation of data sharing tools within behavioral health practices.¹⁴
Minnesota <i>Integrated Health Partnerships (IHPs)</i>	<ul style="list-style-type: none"> Behavioral health services included in TCOC calculations.¹⁵ 	<ul style="list-style-type: none"> Depression remission at six months (tied to payment).¹⁶ 	<ul style="list-style-type: none"> Encourages shared savings to be distributed to behavioral health providers and offers "bonus points" to IHPs on their shared savings calculations for enacting such arrangements.¹⁷ 	<ul style="list-style-type: none"> Using SIM funding to build data-sharing capacity, train providers, and host learning collaboratives to facilitate implementation of data-sharing tools within behavioral health practices.¹⁸ Prioritized SIM grant infrastructure funding for behavioral health providers that have partnered with an IHP.¹⁹
New Jersey <i>Accountable Care Organizations (ACOs)</i>	<ul style="list-style-type: none"> Behavioral health services are not included in TCOC calculations. 	<ul style="list-style-type: none"> May be "local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two" 	<ul style="list-style-type: none"> ACOs must include at least four behavioral health providers in the defined geographic area served by the ACO.²⁰ 	<ul style="list-style-type: none"> No direct integration support.

State	BH in Payment Models	BH Quality Metrics	BH Integration Requirements and Incentives	BH Integration Support
Oregon <i>Coordinated Care Organizations (CCOs)</i>	<ul style="list-style-type: none"> CCOs manage the cost of behavioral health services under their global budget.²¹ 	<ul style="list-style-type: none"> Alcohol or other substance misuse (tied to payment). Follow-up after hospitalization for mental illness (tied to payment). Follow-up care for children prescribed ADHD medication (tied to payment). Screening for clinical depression and follow-up (tied to payment).²² 	<ul style="list-style-type: none"> 1115 waiver establishes a Health Evidence Review Commission to oversee prioritization of health services, and requires representation of behavioral health.²³ Integration of behavioral health is one of five levers to drive savings and quality improvement and one of seven quality improvement focus areas that CCOs must commit to improving.²⁴ 	<ul style="list-style-type: none"> The Oregon Transformation Center provides CCO providers with learning collaboratives and trainings focused on complex care and integration of behavioral health.²⁵
Vermont <i>Accountable Care Organizations (ACOs)</i>	<ul style="list-style-type: none"> Behavioral health services are optional in TCOC calculations.²⁶ 	<ul style="list-style-type: none"> Follow-up after hospitalization for mental illness (tied to payment). Initiation and engagement of alcohol and other drug dependence treatment (tied to payment). Anti-depressant medication management (reporting only). Depression screening and follow-up (reporting only). Follow-up care for children prescribed ADHD medication (reporting only).²⁷ 	<ul style="list-style-type: none"> Mental health and substance abuse providers must be represented in ACO governance.²⁸ 	<ul style="list-style-type: none"> Using SIM funds to expand HIT and HIE interfaces to mental health providers.²⁹ Providing grants to behavioral health providers develop innovative care delivery transformation and cost reduction models.³⁰

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ENDNOTES

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- 2 M. Lardieri, G. Lasky, and L. Raney. *Essential Elements of Effective Integrated Primary Care and Behavioral Health Teams*. Substance Abuse and Mental Health Services Administration, March 2014. Available at: http://www.integration.samhsa.gov/workforce/team-members/Essential_Elements_of_an_Integrated_Team.pdf
- 3 *Medicaid Accountable Care Organizations: Program Characteristics in Leading-Edge States*. Center for Health Care Strategies, February 2014. Available at: <http://www.chcs.org/resource/medicaid-accountable-care-organization-program-design-characteristics-review-of-six-states/>
- 4 Ibid.
- 5 Solicitation for Accountable Care Entities. Illinois Department of Healthcare and Family Services. Available at: http://www2.illinois.gov/hfs/sitecollectiondocuments/hfs%20acesolicitation_080113.pdf
- 6 ACE Health and Quality of Life Measures. Illinois Department of Healthcare and Family Services. Available at: <http://www2.illinois.gov/hfs/SiteCollectionDocuments/ACEQualityMeasures.pdf>
- 7 Solicitation for Accountable Care Entities, op. cit.
- 8 Ibid.
- 9 Iowa Medicaid Accountable Care Organization Agreement, Iowa Department of Health Available at: [http://dhs.iowa.gov/sites/default/files/ACO%20Agreement%20470-5218%20\(Final%203%2014\).pdf](http://dhs.iowa.gov/sites/default/files/ACO%20Agreement%20470-5218%20(Final%203%2014).pdf)

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- ¹² *Medicaid Accountable Care Organizations: Program Characteristics in Leading-Edge States*, op. cit.
- ¹³ MaineCare's Accountable Communities Initiative. June 2015. Available at: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/2015%20AC%20Pres%20for%20VBP%20Site.pdf
- ¹⁴ D. Brown and T. McGinnis, op. cit.
- ¹⁵ Request for Proposals for Qualified Grantee(s) to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration. Minnesota Department of Human Services Health Care Administration. Available at: http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_194216.pdf
- ¹⁶ Ibid.
- ¹⁷ Request for Proposals for Qualified Grantee(s) to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees, op. cit.
- ¹⁸ D. Brown and T. McGinnis, op. cit.
- ¹⁹ Themes from the Accountable Care Organization (ACO) Payment Reformers Consultation. National Academy for State Health Policy, December 2014. Available at: http://www.nashpcloud.org/Themes.from.the.ACO.Consultation12.4.14_v2.pdf
- ²⁰ *Medicaid Accountable Care Organizations: Program Characteristics in Leading Edge States*, op. cit.
- ²¹ Ibid.
- ²² *Quality Measurement Approaches of States Medicaid Accountable Care Organizations Programs*, op. cit.
- ²³ *Oregon Health Plan (OHP) Centers for Medicare & Medicaid Services Amended Waiver List and Expenditure Authority*, 2012. Available at: <http://www.oregon.gov/oha/OHPB/Documents/cms-waiver.pdf>
- ²⁴ Ibid.
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- ²⁶ *Medicaid Accountable Care Organizations: Program Characteristics in Leading Edge States*, op. cit.
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- ²⁹ *Integrating Behavioral Health within Medicaid Accountable Organizations: Emerging Strategies*. Center for Health Care Strategies webinar. February 10, 2015. Available at: http://www.chcs.org/media/CHCS-ACO-LC-BH-Integration-Webinar_Final.pdf
- ³⁰ Ibid.