Assessment #7

Integrating Behavioral Health into Accountable Care Organizations: Challenges, Successes, and Failures at the Federal and State Levels

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Integrating Behavioral Health into Accountable Care Organizations: Challenges, Successes, and Failures at the Federal and State Levels

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Executive Summary

The concept of the Accountable Care Organization (ACO) as a public health program element was initially promoted as an option for the Medicare program and, as proposed, offered little room for participation by behavioral health providers, either as lead entities in forming ACOs or as participants in ACO networks. The opportunity for behavioral health providers to become part of the ACO structure grew marginally with adoption of the final version of the regulations governing the Medicare Shared Savings program, but participation was still to be restricted by the attribution of patient outcomes to the patients’ primary care providers and a continued limitation on which behavioral health providers could participate.

The incorporation and integration of behavioral health into the ACO model began to grow in design and popularity only after the Centers for Medicare and Medicaid Services (CMS) introduced the concept of the “Integrated Care Model” in a pair of 2012 State Medicaid Director letters. By July 2016, nine state Medicaid programs had active ACO elements or pilots, and a tenth state had submitted a proposal to modify and extend an existing § 1115 (statewide) Medicaid waiver using three separate ACO models. Seven more states were in the process of setting up their own Medicaid ACO programs.

The promise that the ACO model could serve as a means of integrating behavioral and medical services in both the Medicare and Medicaid programs has not been achieved. Although researchers have found significant interest in integrating behavioral health providers into the ACO model, challenges have been posed by behavioral health workforce shortages and the slow adoption of costly health information technology by behavioral health providers lacking access to the Medicaid and Medicare meaningful use provider incentives available to other types of providers. Even within ACOs striving toward achieving integration, levels of integration vary among sites.

In addition, even where behavioral health providers do participate in some form of integrated care model, behavioral health measures are seldom used in measuring outcomes or determining shared savings.

Initial Federal ACO Architecture Did Not Welcome Behavioral Health

Medicaid is the single largest payer in the United States for behavioral health services. Spending for Medicaid recipients with a behavioral health diagnosis is nearly four times higher than for those without. The average yearly Medicaid costs for someone with diabetes, for instance, are below $10,000 for those with no behavioral health condition, but more than $35,000 for those who have a mental illness and substance use issue. As many as one in five Medicaid enrollees has a behavioral health diagnosis, and this population accounts for almost half of total Medicaid expenditures.¹

Nevertheless, the Federal public program Affordable Care Organization concept, as initially formulated by Congress and implemented by the Centers for Medicare and Medicaid Services (CMS) in the Medicare Shared Savings program, was not one which welcomed or even

¹ Behavioral Health in the Medicaid Program—People, Use, and Expenditures, June 2015 Report to Congress by the Medicaid and CHIP Payment and Access Commission (MACPAC), Chapter 4.
envisioned the inclusion of behavioral health providers, either in forming ACOs or as participants in ACO provider networks.

Section 3022 of the Affordable Care Act\(^2\) authorized “ACO professionals” to form ACOs within a Medicare Shared Savings Program. In doing so, it defined “ACO professional[s]”\(^3\) to include physicians, dentists, podiatrists, optometrists, chiropractors, physician assistants, nurse practitioners, or clinical nurse specialists, as long as those professionals were in (1) group practice arrangements, (2) networks of individual practices, (3) partnerships or joint venture arrangements between hospitals and ACO professionals, (4) hospitals employing ACO professionals, or (5) any other groups of providers of services and suppliers the Secretary determines appropriate.\(^4\) The underlying statutory authority did not explicitly authorize any type of behavioral health provider to form an ACO, although the authorization for physician-formed ACOs arguably implicitly permitted psychiatrists, as physicians, to form ACOs.

With regard to whom an ACO could treat, under 42 U.S.C. § 1395jjj(d)(3), an ACO that avoided treating “at-risk” patients who might increase the ACO’s costs was to be subject to sanctions, but the statute did not define who might qualify as an “at risk” patient.

In April 2011, when CMS first proposed\(^5\) the Medicare Shared Savings Program (MSSP) regulations using ACOs as a means to achieve value-based services and integrate care within the Medicare program, it further limited the types of entities that could be authorized to form ACOs. CMS first limited the term “ACO professional” to only doctors of medicine or osteopathy.\(^6\) It then limited the definition of a “hospital” authorized to form an ACO to acute care hospitals subject to a prospective payment system.\(^7\) Those limitation eliminated the possibility that psychiatric hospitals might be permitted to form ACOs.

Although CMS permitted their participation within an ACO network, the preamble to the proposed regulations explicitly prohibited federally qualified health centers (FQHCs) and rural hospital centers (RHCs)—entities that might be providing behavioral health services on-site—from forming ACOs. Further limiting the ability of behavioral health providers to form or participate in ACOs was the assignment of enrollees to participating entities based on the identity of enrollee’s primary care physician, defined as a physician with a primary specialty designation of internal medicine, general practice, family practice, or geriatric medicine (but not psychiatry).\(^8\) The final regulations did permit assignment based on primary care services furnished by FQHCs and RHCs, but only via attestation by a primary care physician who directly provided services at the FQHC or RHC.\(^9\)

Although the proposed regulations included the statutory threat of sanctions for avoiding the provision of care for “at-risk enrollees,” it did not explicitly define “at-risk enrollees” to include

\(^2\) § 1899 of the Social Security Act [42 U.S.C. § 1395jjj].
\(^3\) 42 U.S.C. §§1395jjj(h)(1), 1395x(r)(1), and 1395u(b)(18)(C)(i).
\(^4\) 42 U.S.C. § 1395jjj(b)(1).
\(^5\) Department of Health and Human Services: Centers for Medicare and Medicaid Services: Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Federal Register 19528 to 19654 (April 7, 2011).
\(^6\) 42 CFR 425.4.
\(^7\) Ibid.
\(^8\) Ibid.
\(^9\) 42 CFR 425.102(a)(6) and (7).
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individuals with mental illness or substance use disorders. It did define the term to mean individuals who: (1) have a high-risk score under CMS’ HCC risk adjustment model; (2) are considered high cost due to having two or more hospitalizations each year; (3) are dually eligible for Medicare and Medicaid; (4) have a high utilization pattern; or (5) have had a recent diagnosis that is expected to result in increased cost ... all categories into which individuals with behavioral health conditions might be considered to fall. In the preamble to the proposed regulations, CMS suggested that a number of chronic conditions might fall within the final category, including depression and dementia, but the preamble language lacked the force of law. In the final MSSP/ACO regulations published in November 2011, “at risk beneficiary” was explicitly defined for the first time to include an individual diagnosed with a mental health or substance use disorder.

Of the 333 MSSP ACOs and 22 Pioneer (alternative model, developed as an afterthought in 2012, with higher levels of savings and risk) ACOs operating in 2014, all improved in 27 of the 33 quality metrics and 53 percent met spending targets set under the MSSP. However, only one of those 33 quality metrics was behavioral health-related—“Screening for Depression.”

Medicare Shared Savings Program Savings Remain Elusive

Only 92 ACOs earned shared savings bonuses from CMS. Eighty-nine MSSP ACOs reduced costs compared to their benchmarks, but did not qualify for incentive payments because they did not meet the minimum savings threshold. The Pioneer ACOs, which were entities with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements, did somewhat better, but only about one-half — 11 of 21 — earned the shared savings necessary to encourage them to continue in the ACO initiative.

By January 2016, the number of Medicare ACOs had grown to over 477 nationwide, serving nearly 8.9 million enrollees since the Medicare Shared Savings Program began in 2012. In January 2016, CMS announced it was launching a new ACO model called the Next Generation ACO Model (NGACO Model). The initiative was intended to facilitate the Administration’s goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to alternative payment models by the end of 2016 and 50 percent by the end of 2018.

The twenty-one ACOs selected to participate in the NGACO Model in 2016 had significant experience coordinating care for populations through ACO initiatives and included provider groups ready to assume higher levels of financial risk and reward, but even they achieved only

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10 42 CFR 425.4.  
11 76 Federal Register 19625 (April 7, 2011).  
13 42 CFR 425.20.  
14 Medicare Shared Savings Program, Quality Measures and Performance Standards (on-line) Table 33, ACO Quality Measures.  
15 Fewer than 30% of ACOs Saved Enough to Earn Bonuses in 2014, Advisory Board (August 26, 2015)  
16 New Hospitals and Health Care Providers Join Successful, Cutting-Edge Federal Initiative that Cuts Costs and Puts Patients at the Center of their Care, U.S. Department of Health and Human Services Press Office (January 11,2016).  

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limited profitability, with only four of the Pioneer ACOs and two of the MSSP ACOs earning savings to that point.\textsuperscript{17}

Research by the American Hospital Association suggested there had been several key success factors for the ACOs selected by CMS to participate in the Next Gen model. Those factors included redefining organizational, clinical, and network structures to create a highly integrated care delivery system, and recognizing opportunities for partnership or collaboration that supported care “across the entire health care system.”\textsuperscript{18}

**Impact of the Medicare Shared Savings Model on Mental Health**

Two studies published in the July 2016 *Health Affairs* suggested that Medicare ACOs had had only limited success in improving the management of mental health.

In the first study (to be referenced hereafter as the “Busch study”), Pioneer ACO contracts were found to have lowered spending on mental health admissions in the first year of the ACO contract, but not in subsequent years. Spending was not lowered at all by the non-Pioneer ACOs studied. ACOs were found to have resulted in no changes in mental health admissions, increased outpatient follow-up after mental health admissions, increased diagnoses of depression, or improved mental health status.\textsuperscript{19}

The authors of the Busch study suggested that ACOs might not be well-positioned to manage behavioral health care because of limited organizational integration of behavioral health and primary care providers, citing an earlier October 2014 *Health Affairs* study that concluded “few ACOs pursue innovative models that integrate care for mental illness and substance abuse with primary care.”\textsuperscript{20} The authors attributed this lack of integration to several causes: the traditional separation of behavioral and medical care providers, inadequate behavioral health care training for the primary care physicians authorized to form ACOs, and different regulatory and billing requirements for behavioral health and primary care. The authors said that all of these impediments made it challenging for mental health and primary care providers to integrate their workflows and practice models within the ACO structure.

The authors of the Busch study noted that Medicare ACO contracts had, to that date, included only “Screening for Depression” as the one quality measure specific to behavioral health, and they suggested that provided little additional incentive to improve behavioral health care beyond the broader incentives to lower spending through better care management in general. The authors suggested additional quality measures specific to mental illness might create a greater, more sustained focus on mental illness. However, they cautioned that the use of additional quality measures would need to be weighed against the costs for the ACO entities of measurement and

\textsuperscript{17} Killroy C., *Next Generation ACOs: Four Factors for Success*, Hospitals and Health Networks, American Hospital Association (July 25, 2016).
\textsuperscript{18} Ibid.
\textsuperscript{20} Lewis V.A., Colla C.H., Tierney K., Van Citters A.D., Fisher E.S., and Meara E., Few ACOs Pursue Innovative Models that Integrate Care for Mental Illness and Substance Abuse with Primary Care, *Health Affairs*, October 2014, pp. 1808-16.
the unintended consequences of potentially inadequate risk adjustment for more medically complex, socially disadvantaged patients.

The authors of the Busch study also found that claims data indicated that the Pioneer ACOS that reduced spending in the first year had only a small proportion of Medicare enrollees with mental illness. There were no reductions in outpatient mental health spending to suggest efforts to address behavioral health care in general.21

Busch et al suggested that, given the limited integration of mental health providers in ACO contracts, using information systems that support referrals to high-quality mental health providers might help, but they warned that behavioral health workforce shortages were likely constraining referral efforts, and even the effective integration of behavioral health providers into ACO contracts.

The second July 2016 Health Affairs article (hereafter referred to as the “Fullerton study”)22 offered a more optimistic outlook than the first. The authors examined qualitative data from 90 organizations participating in Medicare ACOS from 2012 to 2015 and found mixed degrees of engagement in improving behavioral health care for their enrollees. The challenges found in the second study included those same workforce shortages, a lack of data availability, and the difficulty of finding sustainable financing models. All this, despite what the authors found to be a substantial interest in integrating behavioral health among the majority of the ACOS surveyed.

The authors of the Fullerton study focused on the extent to which ACOS recognized and focused on behavioral health as an important contributor to improving quality of care and generating savings, the types of approaches ACOS used to address behavioral health, and the primary challenges they faced when trying to implement improvements in behavioral health care. They found that almost all ACO personnel recognized the contribution of behavioral health disorders to high utilization and spending. At many ACOS, care coordination teams recognized that a greater percentage of their high-risk and high-cost enrollees had complex behavioral health and psychosocial needs. Furthermore, the ACOS recognized the connection between high-cost behavioral health enrollees and repeat hospitalizations, repeated uses of the emergency department, and longer than expected hospital stays.23

Of the 69 ACOS interviewed in the Fullerton study, 43 had developed at least one behavioral health initiative to meet their enrollees’ needs.24 Most ACOS initiated or expanded programs to provide behavioral health care for their enrollees and to improve coordination between primary care and behavioral health care providers. Approaches ranged from implementing integrated care models to improving relationships with behavioral health care providers outside the ACO. Many ACOS implemented multiple approaches, often as part of larger delivery transformation efforts.

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24 Ibid.
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One example cited was a reorganization of the providers participating in the ACO to become patient-centered medical homes with greater emphasis on care coordination.25

Often, there was variation even within a single ACO regarding behavioral health access, with care integrated at some sites but a lack of behavioral health providers at others. Many behavioral health initiatives evolved over time as the availability of staff or other resources expanded or contracted. Others recognized a need to address behavioral health as they worked with their high-cost enrollees. In the end, Fullerton et al wrote, many ACOs utilized a trial-and-error approach to align the resources of the organization and community with the perceived behavioral health needs of their enrollees.26

Most of the ACOs surveyed in the Fullerton study used licensed clinical social workers to coordinate care or to treat behavioral health issues, especially depression, but some were unable to maintain their social worker workforce because of a lack of funding or workers. ACOs often co-located behavioral health care providers (usually licensed clinical social workers) in primary care sites to provide assistance with initial referrals for behavioral health services or other short-term needs. One ACO initially placed a social worker in one of its primary care clinics, but found that demand for that social worker’s services was so high that the ACO centralized the social worker to make the social worker available to other primary care clinics. Two other ACOs took the opposite approach of co-locating primary care services in their mental health clinics.27

Other ACOs had centralized social work teams. One ACO used social workers to follow up with patients identified through depression screening. Some ACOs placed providers in clinics specifically developed for patients with complex needs. At least one ACO had one integrated clinic for patients with complex needs and one integrated team for home visits.28

Instead of co-locating licensed clinical social workers with primary care teams, some ACOs hired social workers to support their internal medical care coordination teams or to serve as independent centralized resources for both short-term behavioral health care and long-term coordination of referrals for mental health treatment. Medical care coordination teams often included pharmacists, licensed clinical social workers (or, less frequently, other social workers), and community resource specialists, in addition to nurse care coordinators. The coordinators referred patients with significant mental health issues to social workers for assistance in resolving psychosocial issues, providing short-term behavioral health services, or coordinating long-term mental health treatment. In other ACOs, social workers played a key role without being explicitly included in the care management team, the Fullerton study found.29

Fullerton et al found that multiple ACOs adjusted their referral networks to better serve enrollees with behavioral health needs by improving connections to community resources, partnering with a behavioral health facility to improve access to care, and/or reorganizing internal behavioral health resources to improve access to and coordination with primary care providers. Some of the ACOs surveyed used FQHCs to provide integrated care, while others included as a partner a significant outpatient mental health facility, such as a community mental health center or other

26 Ibid.
28 Ibid.
large stand-alone mental health provider.\textsuperscript{30} Other ACOs created either contractual or informal partnerships with behavioral health organizations.\textsuperscript{31}

ACOs also referred enrollees to home health agencies and visiting nurse associations for behavioral health and social work services. Others explored the potential use, to expand access, of videoconferences for outpatients, although Fullerton \textit{et al} found that few had actually developed those capabilities.\textsuperscript{32}

The Fullerton study authors reported that one Shared Savings Program ACO developed a mental health “center of excellence” to which primary care physicians could refer patients when their care needs exceeded what could be provided in the primary care clinic. This “center of excellence” housed a behavioral health team that could coordinate with primary care physicians in the same organization. One Pioneer ACO leader reported developing a concierge model in which a psychiatrist consulted with the primary care provider and provided a recommendation on medication management, with the patient then returning to their primary care physician for ongoing management.\textsuperscript{33}

The Fullerton authors found that the level of integration varied across the organizations sites. Most ACOs provided integrated care on a limited basis, either to selected patients (such as those with specific physical health conditions and depression) or in selected locations (such as in larger sites or those sites focused on enrollees with complex needs).\textsuperscript{34}

Because “Depression Screening” was the one behavioral health-related quality metric that CMS collected, many ACOs enhanced the depression or behavioral health screenings in their primary care settings, teaching primary care providers how to screen for depression, educating about the value of managing patients with behavioral health issues, or both. Some ACOs developed clinical pathways for people with positive depression screens that included provider prompts on how to respond. ACOs varied in how they handled patients who screened positive for other mental illness or substance use disorders during these visits. Other ACOs were resistant to screening and noted that physicians could identify mental illness without a screening tool.\textsuperscript{35}

Some ACOs acknowledged the existence of unmet health care needs for Medicare enrollees with behavioral health issues but had not yet addressed this gap in care. The Fullerton authors classified these ACOs into three groups:

1. The first group of ACOs planned to implement specific programs, such as tele-psychiatry initiatives and pilot programs to integrate licensed clinical social workers into their care model. Others were in earlier stages of formulating their strategies or noted that behavioral health had been replaced by other priorities. While believing that focusing on behavioral health would benefit their organizations, personnel at two ACOs said that they did not have the resources because they had lost money on the ACO initiative or did not have financing in place to make the necessary changes.

\textsuperscript{30} Ibid.  
\textsuperscript{31} Ibid.  
\textsuperscript{32} Ibid.  
\textsuperscript{33} Ibid.  
\textsuperscript{34} Ibid.  
\textsuperscript{35} Ibid, pp. 1261-62.
2. ACOs in the second group felt that behavioral health care was better addressed at the provider practice level than at the ACO level.

3. In the third group was a handful of ACOs that did not consider behavioral health to be a priority. Two of these ACOs felt that mental health was better addressed in the community than by the ACO.\(^{36}\)

Generally, the ACOs surveyed in the Fullerton study focused more on mental illness than on substance use disorders. Some explicitly said they were focusing on mental illness and not on substance use disorder treatment, although they acknowledged the latter was an important issue. One interviewee said that finding appropriate language to identify and discuss substance use disorders required training (presumably due to the restrictions of 42 CFR Part 2). Another noted a significant lack of substance use disorder providers. Two said their ACOs were doing nothing for substance use disorder treatment beyond using a patient contract when prescribing Schedule II drugs.\(^{37}\)

**Challenges for Medicare ACOs**

Both those ACOs that addressed behavioral health issues and those that did not identified the following challenges to doing so in the Fullerton study:

1. **A scarcity of behavioral health workforce** was frequently cited, either within the ACO itself or within the surrounding community to whom patients could be referred, particularly a lack of psychiatrists and other behavioral health professionals with expertise in substance use disorders. The geographic constraints of being located in a rural or remote area were often factors. Poor reimbursement rates, particularly low Medicaid reimbursement, were also considered a factor in the lack of a behavioral health labor pool by some interviewed in the Fullerton study. In addition, a number of interviewees noted that some types of licensed behavioral health providers could not bill Medicare directly, while others said many behavioral health care providers did not see Medicare patients because of the program’s historically limited coverage.

2. **The challenge of developing a sustainable funding model for behavioral health services in a fee-for-service (FFS)-based reimbursement system** was noted. ACOs interviewed by Fullerton et al said the FFS system and insurers that carved out behavioral health coverage drove the separation between behavioral and physical health care. Generally, ACOs funded behavioral health and care coordination by outside funding or funding from their profits, assuming providers would be unable to cover their salaries through billing.

3. ACO personnel also described challenges related to **sharing mental and substance use disorder data**, because of the extra security protection required for that data. Many ACOs blamed CMS’s suppression of data for substance use disorder diagnoses or related procedures for a lack of reliable behavioral health data for their enrollees. As a result, ACOs could not perform the same data analytics they could perform for other chronic diseases, nor could they use claims data to identify enrollees for additional outreach. ACO personnel also said privacy restrictions limited the use of internal electronic health

\(^{36}\) *Ibid*, p. 1262.

record data to identify people with behavioral health needs and hindered coordination of care between behavioral and physical health care provider sites.

4. ACO personnel told the Fullerton authors that both enrollees and providers resisted discussing mental health issues. This challenge was attributed to: (i) cultural stigma; (ii) providers’ resistance to screening for depression or mental health absent clear pathways for treatment or referral; and (iii) resistance from psychiatrists who feared the complexity of their patients’ needs would increase if care for depression was provided in primary care settings where social workers treating less complex patients were the providers.38

**Medicaid Integrated Care Models**

On **July 10, 2012**, CMS issued the first two of three State Medicaid Director Letters (SMDLs)39 outlining how states might utilize an “integrated care model (ICM)” to move from FFS reimbursement to value-based reimbursement for integrated care. A third SMDL was issued **August 30, 2013**, and focused on reimbursement methodologies that could be adopted in the context of ICMs to incentivize improved quality and outcomes and reduce costs by sharing program savings with high performing providers.40

The first two letters specified that, for the purposes of the letters themselves and future communications, CMS was defining ICM to include Accountable Care Organizations (ACO), ACO-like models, medical/health homes, and other health care delivery and financing models that emphasize person-centered, continuous, coordinated, and comprehensive care. ICMs were to include integration of various types of health care services, including behavioral services.

CMS noted in the second letter that, historically, in an effort to formally coordinate a Medicaid beneficiary’s care while still paying providers FFS reimbursement, states had implemented primary care case management (PCCM) programs that limited a beneficiary’s “free choice of providers.” Because free choice of providers is limited, states had to operate these programs under an § 1115 waiver/demonstration authority or a Medicaid managed care authority (making a PCCM program a “managed care program” even though reimbursement was not capitated).

After reviewing the existing statutory options for an appropriate pathway for ICMs, CMS said it would now be providing states the opportunity to implement ICMs furnishing services authorized under § 1905(a)(25) of the Social Security Act and, by reference, as a state plan option under § 1905(t)(1). CMS said these models would be consistent with the statutory description of optional state plan PCCM services, and that states could use that authority to offer coordinating, locating, and monitoring activities broadly and create incentive payments for providers who demonstrate improved performance on quality and cost measures.

Under this authority, CMS told states, they could opt to reimburse providers through a “per member per month (PMPM)” arrangement or through incentive-based shared savings. However, as under the MSSP, CMS said ICMs implemented as a state plan option could identify as providers only individual practitioners, physicians, nurse practitioners, certified nurse-midwives,

39 *Integrated Care Models, SMDL #12-001 and Policy Considerations for Integrated Care Models, SMDL #12-002* (both July 10, 2012).
40 *Shared Savings Methodologies, SMDL #13-005* (August 30, 2015).
physician assistants; physician group practices; or entities employing or having arrangements with physicians to provide such services. This, despite the fact that, under 42 CFR 431.51, Medicaid state plans are required to allow a beneficiary to obtain services from any willing and qualified service provider.

CMS reminded states that § 1902(a)(30)(A) of the Act requires that services under Medicaid must be available to enrollees at least to the extent they are available to the general population, and that the ICM model must be designed to be consistent with this basic statutory requirement. Care managers required by ICMs could coordinate a full range of services beyond primary care, including the integration behavioral health care.

CMS warned that PMPM-based rates must reflect a comprehensive state plan reimbursement methodology that explains how the state constructs payment rates. Rates were to be economical and efficient in accordance with § 1902(a)(30)(A) of the Act.

**Integrated Care Models with Shared Savings**

CMS said an alternative approach to reimbursing ICMs would be through payments for improvements in health care quality. States could offer these payments as the base reimbursement methodology for the ICM provider, or as deferred compensation. CMS said it was interested in partnering with states to reward providers for quality improvement and achievement (e.g., improving patient care, focusing on person-centered care, and using electronic health records). States could offer tiered payments based on a provider’s improvement in process-based or outcome based measures, or both. In addition, states could calculate a payment based on shared savings and reward providers for the quality improvements or outcomes.

**Provider Designation:** Because ICM activities (locating, coordinating, and monitoring care) are long-range endeavors, CMS suggested states might be interested in formalizing the relationship between Medicaid enrollees and providers by ensuring that the enrollee selects an ICM provider who has an established and continuous relationship with the beneficiary. The trust between a beneficiary and provider would be key to the effective coordination of care. Providers should be directed to develop care plans that address person-centered short and long-term needs and goals, maintain continuous outcome and quality data, and allow for payment to reward efforts.

CMS reminded states that, when considering provider designation policies, they should be cognizant of the “free choice of provider” regulation at 42 CFR 431.51 that requires that a Medicaid-eligible individual be able to seek care from any willing and qualified service provider. To ensure freedom of choice within an ICM as a state plan option, states must have an effective opt-out process for enrollees who no longer wish to participate in the ICM program or who wish to switch ICM providers. States also needed to ensure that the designated relationship does not inhibit free choice within any Medicaid service.

**Provider Attribution Methodology** - When designing an ICM, CMS said states should employ a method that provides reasonable assurance a provider’s intervention can be connected to improved health care outcomes. Attribution methodologies must accommodate enrollees changing care coordination providers during designated periods in which quality achievements, and/or shared savings, are calculated.
In the third, 2013 Medicaid Director Letter on ICMs, CMS offered states methodological considerations that should factor into any shared savings proposal, as well as technical guidance and a series of questions that CMS expected states to answer when submitting proposals for agency approval. The agency said it expected shared savings methodologies to encourage care coordination and practice transformation activities that improve quality and health outcomes. CMS said it was not interested in partnering with states on shared savings proposals that are based only on cost savings and that do not improve quality and health outcomes or limit access to eligible enrollees. The services and/or activities to coordinate and transform care delivery for Medicaid enrollees and the quality metrics that are the basis for the shared savings payments must be defined in either the state plan or waiver documentation.

**Methodological Considerations for Medicaid Shared Savings Payments**

CMS told states in the third letter that the analyses that informed the Pioneer ACO model and the MSSSP ACOs could serve as potential resources to help states develop similar shared savings initiatives under Medicaid. But it recognized that Medicaid enrollees are often different from Medicare enrollees in saying that states would not be mandated to develop methodologies that mirror those programs. CMS said it would not define approval criteria or require specific standards that states would need to meet for approval. The agency did not foresee a “one size fits all” approach to shared savings. Instead, it said, its goal would be to work in partnership with states to develop methodologies that mitigate risk and realize rewards associated with shared savings methodologies, and that could be replicated nationally.

As states contemplated shared savings payment methodologies within the context of their overall health reform agendas, they would need to consider which providers should be eligible to receive incentive payments and the populations that these providers serve. As with any Medicaid incentive payment, a state shared savings reimbursement methodology would have to clearly describe: the criteria that providers must meet to receive incentive payments, the actual payment calculation, including any caps on shared savings or risks, and the methodology for distributing shared savings payments.

States would have to articulate the qualification of providers that are eligible to participate in shared savings payments, but CMS warned that shared savings incentive payments should be limited to providers with higher levels of qualification (such as an enhanced ability to report quality measures or an organizational capacity that coordinates care across the delivery system). CMS also said it anticipated that states might be interested in rewarding individual primary care practices directly, or recognizing networks of providers that are organized through a single provider entity and pass down savings to individual providers within the network. It said either model would be supportable.

CMS laid out a number of questions that, in creating an integrated care model, CMS said states would have to consider. Those included:

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41 Shared Savings Methodologies, SMDL #13-005 (August 30, 2015).
42 Ibid.
• Which providers are eligible to receive payment under the shared savings methodology?
• Are certain providers within these designations targeted? (e.g. primary care practices, mental health and substance abuse providers, long-term care service and support providers, patient-centered medical homes, accountable care organizations)?
• How does a provider qualify for a payment?
• Which activities must a provider conduct to receive payments?
• Which quality measures will the state use as a basis to determine payment?
• If providers are targeted, are they targeted through provider qualifications or contracts? How will a state define eligible providers? How does the proposal address freedom of choice?
• Is provider participation mandatory or optional?
• What method will the state use to determine the shared savings amount and distribute payments to providers?
• How often and when are payments to be made to providers?
• Will provider risk be one-sided, two-sided, or both (e.g. one-sided in initial years, transitioning to two-sided in later years)?
• What percentage of the savings are providers and provider organizations eligible to receive?
• Are there limits on the amount of additional costs a provider may incur as a result of participation? How does the state plan to calculate that percentage? Is the percentage tiered based on quality performance or some other factor? Will there be a minimum savings percentage that must be met in order to prevent payment due to random variation?
• How are the claims for the shared savings payments made? Is the MMIS or some other system used to adjudicate claims?
• What are the state requirements to hold providers accountable for the required activities and/or interventions paid through the shared savings methodology?
• Which delivery systems will the model impact (e.g. primary care, long-term care, behavioral health, etc.)?
• What services/activities will the model providers conduct through the model?
• What services will be considered for coordination in the model?
• Do these services go above and beyond current care coordination within the State plan or waiver programs?
• What key characteristics must the providers possess or strive to achieve that are integral to implementing the model?
• What processes will be used to assign, enroll, or otherwise attribute enrollees to providers under the program?
• How many enrollees must be attributed, enrolled, or assigned in the program to determine statistical validity of the data and outcomes?
• How will the program account for enrollees who enter or leave Medicaid during the year?
• What is the minimum number of enrollees required to be attributed, enrolled, or assigned per provider to determine statistical validity of the data and outcomes?
How Have Integrated Care Models Panned Out Since 2012?

To date, 9 states—including Oregon, Minnesota, Utah, Colorado, Illinois, Vermont, New Jersey, Maine, and Rhode Island have launched Medicaid ACO programs, and 8 more—Washington, Michigan, Alabama, North Carolina, New York, Connecticut, Massachusetts, and Maryland are actively pursuing them. Medicaid ACOs in Colorado, Illinois, Maine, Minnesota, New Jersey, Oregon, Utah, and Vermont have cumulatively served more than 2.5 million enrollees and cumulatively saved around $167.9 million.

Barriers to the Inclusion of Behavioral Health Services in ICMs

Access to Health Information Technology

Timely and accurate data collection and analysis are essential to a Medicaid ACO’s operation, since data allows ACOs to track patient utilization and costs, and target patients for care management interventions and programs. States implementing ACOs must establish and data infrastructure to adequately support ACOs by storing and analyzing ACO data. A challenge behavioral health providers have in participating in ACOs is that they typically do not have access to advanced electronic infrastructure because they have been mostly excluded from the meaningful use incentive payment programs available to other providers. While the uptake of electronic medical records (EMR) by medical providers has risen significantly in recent years, use is dramatically lower among behavioral health providers and only a small proportion are connected to Health Information Exchanges (HIEs), in contrast to their counterparts in the medical/surgical arena. Smaller behavioral health providers can be overburdened by the process of implementing an EMR, and they can be priced out of the market for such products. They may also lack staff familiar with system requirements for data exchange and interoperability.

Participation in Medicaid ACOs can provide financial supports to help behavioral health providers in securing the necessary systems to allow for an exchange of information with other treating providers. Several states with ACO programs—including Minnesota, Maine, and Vermont—have, under their respective State Innovation Model (SIM) initiatives, worked to build up this data-sharing capacity. In addition to funding the adoption of information technology and EMRs, these supports have included training on various technologies and learning collaboratives to re-define operational workflows and facilitate implementation of data-sharing tools within behavioral health practices.

One Federal initiative that might prove to be helpful over time is the February 2016 CMS proposal to provide states with a Federal 90 percent Health Information Technology for Economic and Clinical Health (HITECH) Act match, for the administrative costs of infrastructure linking providers otherwise eligible for meaningful use payment incentives to other providers—such as behavioral health providers—not eligible for those incentives. The proposal would not provide payments directly to behavioral health providers for EMR and health information technology infrastructure, but it would provide the match to states for the

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43 Medicaid ACOs: State Activity Map, Center for Health Care Strategies, May 2016.
44 State Medicaid Director Letter SMD #16-003, Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers (February 29, 2016).
Integrating Behavioral Health into Accountable Care Organizations

administrative costs of state activities that promote non-meaningful use-eligible Medicaid providers’ use of EHR and HIEs.

Information Exchange Privacy Issues

Behavioral health and/or substance abuse providers also face issues with sharing sensitive patient information. Federal regulation 42 CFR Part 2, intended to protect the confidentiality of patient alcohol and drug treatment records, requires additional patient consent beyond the patient information disclosure restrictions under the Health Insurance Portability and Accountability Act (HIPAA) before patient alcohol and drug treatment information can be shared between treating providers. This can lead to fragmented and incomplete patient records. In addition, a lack of clarity and understanding of the regulation has led some providers to avoid sharing any patient health information for individuals undergoing treatment for substance used disorders out of fear of legal liability for improper implementation leading to illegal disclosures.

In addition, many states are encountering obstacles in using HIE and all-payer claims databases to facilitate data sharing between ACOs and behavioral health providers due to those 42 CFR Part 2 restrictions. In many cases, HIEs and clinical registries do not have the functionality to accommodate the consent and re-disclosure protocols required under 42 CFR Part 2 by stripping away the protected substance use disorder treatment information before transmission.

Oregon is pursuing the inclusion of all behavioral health claims in its All Payer All Claims database. However, the data has not yet been integrated due to questions around the potential need for state legislation to require “Part 2 providers” that do not have patient consent to disclose to submit patient data to the state’s Coordinated Care Organizations (CCOs) and ACOs operating in the commercial sector. Oregon is considering alternative mechanisms for analyzing cost and utilization trends related to substance abuse treatment in its all-payer claims database.

State ACO Profiles

The State Innovation Models (SIM) Initiative was created by the Centers for Medicare and Medicaid Innovation (CMMI) to provide financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models. Models were expected to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) enrollees, and all the residents of participating states.

On February 21, 2013, CMMI awarded nearly $300 million in grants to 25 states in Round One of the SIM Initiative. Thirteen of those states received SIM grants for their shared savings model proposals: Arkansas, Colorado, Hawaii, Illinois, Iowa, Maine, Massachusetts, Minnesota, New York, Oregon, Texas, Utah, and Vermont.45

As of May 2016, 7 of those 13 states ─ Colorado, Illinois, Maine, Minnesota, Oregon, Utah, and Vermont ─ plus Rhode Island and New Jersey—had launched Medicaid ACO or ACO-like programs. Not counting Rhode Island and New Jersey, the ACO states were serving more than

2.5 million enrollees and had cumulatively saved, as of September 2015, around $167.9 million. In July 2016, Massachusetts also submitted a waiver extension to CMS for a program that would utilize three different models of ACOs.46

A September 2015 Center for Health Care Strategies Technical Assistance Tool47 outlined the four strategies that those first eight states were using to drive coordination of behavioral health and physical health services in Medicaid ACO models:

1. including behavioral health services in ACO payment models (Illinois, Maine, Minnesota, and Oregon);
2. requiring ACOs to report behavioral health quality metrics and tying some of these metrics to payment (Illinois, Maine, Minnesota, New Jersey, Oregon, and Vermont);
3. encouraging ACOs to include behavioral health providers in ACOs and/or ACO governance structures (Colorado, Iowa, Illinois, Maine, Minnesota, New Jersey, and Vermont); and
4. providing direct support to ACOs to integrate behavioral health services into their models, either by leveraging SIM grants to bolster information-sharing and health information technology (Maine, Minnesota, Oregon, and Vermont), or by providing training for physical health providers on behavioral healthcare practices (Colorado, Maine, and Oregon).

Oregon

In 2011, Oregon Governor John Kitzhaber worked with the state legislature to create Coordinated Care Organizations (CCOs), described as “ACOs on steroids”.48 The Centers for Medicare and Medicaid Services (CMS) approved a modification to Oregon’s previously existing § 1115 Medicaid waiver on July 5, 2012, allowing the Oregon Health Authority (OHA) to change its program design through June 30, 2017.49

The coordinated care model was to feature:

- best practices to manage and coordinate care that included integrating behavioral, physical, and dental health care, evidence-based shared treatment plans, and co-located services;
- shared decision-making, with enrollees taking a health risk assessment as one of the first key steps in becoming involved in their own health outcomes;
- performance measurement that included measures of access, quality, patient satisfaction, patient activation, service utilization, and cost;

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46 Section 1115 Demonstration Project Amendment and Extension Request, Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid, July 22, 2016.
47 State Approaches for Integrating Behavioral Health into Medicaid Accountable Care Organizations, Center for Healthcare Strategies, September 22, 2015.
• population and episode-based payments, with incentives for quality health outcomes instead of volume-based fees;
• transparency of provider prices and plan cost-sharing; and
• limiting cost growth to a sustainable rate, utilizing population-based contracts that included risk-adjusted annual increases in the total cost of care for services reimbursed.

Under the federal waiver, the OHA, which oversees both Medicaid and CHIP in the state, was to provide CCOs with stable funding to serve patients enrolled in the Oregon Health Plan for the first year of the program and require the CCOs to achieve a 1 percent reduction in the rate of growth in per capita Medicaid spending by the second year of the waiver, with a 2 percent spending reduction in years 2013 through 2015. In exchange, the federal government was to provide approximately $1.9 billion over 5 years to support the program, but large penalties would be imposed if the required savings weren't achieved.

In 2012, Oregon’s Medicaid agency released a Request for Application and contracted with 16 CCOs. The CCOs were to be responsible for contracting with health care providers in their region to provide care to Medicaid enrollees. By the end of 2015, Oregon had 906,584 CCO enrollees, with individual CCO enrollment ranging from 228,263 to 11,347 enrollees. That was up from 528,689 at the end of 2013, with individual CCO enrollments ranging from 5,957 to 148,201.

Oregon’s evaluations of the use of behavioral health outcomes measures and benchmarks with ACOs are far more advanced than for any other state ACO program, and so follow in some detail.

**Oregon CCO Behavioral Health Outcomes Measures and Benchmarks**

State legislation established a Metrics and Scoring Committee in 2012 to establish outcomes and quality measures for CCOs. In October 2012, the Committee identified 17 outcome measures and quality measures required by CMS to be used in the incentive program. In addition, OHA established 16 state performance metrics. Five of the 33 measures were behavioral health-related: “Alcohol and Drug Abuse (SBIRT),” “Depression Screening and Follow-Up,” “Electronic Health Record Adoption,” “Follow-Up after Hospitalization for Mental Illness,” and “Mental, Physical, and Dental Health Assessments for Children in Department of Human Services (DHS) Custody.”

In 2013, only 3 of the 15 CCOs operating met the benchmarks for both “Depression Screening” and “SBIRT”. Fourteen of the 15 CCOs met the benchmarks for “Depression Screening” alone, and 3 met benchmarks for “SBIRT” alone. All but 2 CCOs met the benchmark for “Electronic Health Record Adoption,” while 9 met the benchmark for “Follow-Up after Hospitalization for Mental Illness.”

By the mid-2015 report to the legislature, 7 of 16 CCOs met the benchmarks for both “Depression Screening” and “SBIRT”. None met the benchmarks for “SBIRT” alone, while 6 met the benchmarks for “Depression Screening” alone. Fourteen CCOs met the benchmark for “Electronic Health Record Adoption,” while 13 met the benchmark for “Follow-Up after Hospitalization for Mental Illness.”
Children with mental health diagnoses had slightly higher rates of developmental screening during the first three years of life in 2015. However, children with mental health diagnoses in DHS custody had lower rates of mental, physical, and dental health assessments on entering foster care, which meant greater challenges with care coordination and a greater need for mental health services.

By mid-2015, Oregon had reduced emergency department utilization by 23 percent through its CCO initiative, but Medicaid members with mental health diagnoses had much higher rates of emergency department utilization than the statewide rate of readmissions. This conformed to national trends; individuals with more severe mental health conditions are more likely to have multiple emergency department visits during a year. Oregon continues to monitor this metric to determine if additional community services can lead to reduced utilization of emergency departments by individuals with mental health diagnoses.

“Follow-Up Visits after Hospitalization for Mental Illness” for children and adolescents ages 6 to 17 were higher than for adults, 81 percent to 75 percent, respectively. “Follow-Up Visits after Hospitalization for Mental Illness” were slightly higher for members with severe and persistent mental illness than statewide, 77 percent to 74.7 percent.

“SBIRT” visits for alcohol or substance abuse were higher for Medicaid members with mental health diagnoses across all age groups, compared to statewide. “SBIRT” visits were slightly higher for individuals with severe and persistent mental illness than statewide.

Initiation of Follow-Up Care for Children Prescribed ADHD Medications” for the first time were higher for individuals with mental health diagnoses than statewide (64 percent to 61 percent). The state attributed this to rapid development during adolescence when many mental health conditions often emerge, and first identification of those conditions during the adolescent well-care visit.

**Oregon CCO Quality Pool: Phase One Distribution**

Each Oregon CCO was paid for reaching benchmarks or making improvements on incentive measures. The Oregon Health Authority held back three percent of the monthly payments to CCOs, depositing them into a common "quality pool". The payments from the quality pool were divided among all CCOs, based on their size (number of members) and their performance on the incentive metrics. CCOs could earn 100 percent of their share of the quality pool in the first phase of distribution by:

- meeting the benchmark or improvement target on 12 of 16 measures;
- meeting the benchmark or improvement target for the electronic health record adoption measure; and
- having at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

The 2015 quality pool from which incentives were paid totaled almost $168 million, four percent of the total amount all CCOs were paid in 2014. All but one of the 16 CCOs received 100 percent of their full share of the quality pool, meeting between 12.7 and 16.9 of the quality measures. The one lesser-performing CCO received only 60 percent of its quality pool after meeting only 9.8 quality measures; it was the third smallest participating CCO. But the CCO meeting the greatest number of quality measures was the second smallest CCO.
Oregon CCO Challenge Pool: Phase Two Distribution

The Oregon CCO Challenge Pool includes funds remaining after quality pool funds are distributed. The 2015 challenge pool was $1.25 million. Challenge pool funds are distributed to CCOs that met the benchmark or improvement target on four incentive measures, two of which were behavioral health-related:

- “Alcohol and Drug Abuse (SBIRT)”
- “Diabetes HbA1c Poor Control”
- “Depression Screening and Follow-Up” and
- “Patient-Centered Primary Care Home (PCPCH) Enrollment.”

In 2015, all but 2 of the 16 CCOs met all 4 of the challenge pool measures. The two lesser-performing CCOs met 2 and 3, respectively of the measures. All but 1 of the CCOs received in excess of 100 percent of their total quality pool allocations.

Minnesota

In 2010, the Minnesota legislature passed legislation mandating that the Minnesota Department of Human Services (DHS) develop and implement a demonstration to test alternative health care delivery systems, including ACOs. Minnesota launched its Medicaid ACO program first in Hennepin County, which began enrolling low-income, childless adults in January 2012.

In 2013, the Minnesota Medicaid program began entering into shared savings and risk agreements with ACOs, using the previously mentioned SIM grant from CMMI. The state began soliciting bids from entities around the state to participate in Medicaid as ACOs. Six ACOs became operational in 2013, three more in 2014, seven more in 2015, and an additional three in 2016, bringing the total to 19 ACOs, serving 342,000 Medicaid enrollees and achieving estimated savings of $76 million dollars. Those savings have been used in part by the ACOs to expand use of care coordinators, extend hours for primary care clinics, and develop partnerships with community supports.

Under the Minnesota program, in their first year of participation, ACOs can share in savings across a number of Minnesota programs, including the Prepaid Medical Assistance Program (PMAP), Minnesota Care (MNCare), and Special Needs Basic Care (SNBC), and include members enrolled under fee-for-service or in any of Minnesota’s Medicaid MCOs. Incentives are aligned across the MHCP population segments.

A May 2015 provider survey by the Minnesota Department of Health found that roughly half of the state’s hospitals, clinics, and physicians were part of an ACO (Medicaid, Medicare, or

50 Minnesota Session Laws 2010, First Special Session chapter 1, article 16, section 19, codified as Minnesota Statutes § 256B.0755.
52 Baseline Assessment of ACO Payment and Performance Methodologies in Minnesota for the State Innovation Model (SIM), Minnesota Department of Health Economics Program, IBM Corporation, and KPMG LLP, May 29, 2015.
commercial), with 40 percent of the commercially insured population in Minnesota receiving care from a provider affiliated with an ACO.

The survey participants (65 providers and 8 health plans) said they had experienced a wide range of obstacles to the continued growth and advancement of ACO models:

- the need for more telehealth to be developed for mental health and specialists;
- legal and regulatory hurdles, resource availability, and the lack of maturity of information technology;
- limited availability of data that all parties considered accurate;
- financial hurdles related to reconciling service delivery with existing reimbursement methodology, and managing risk;
- the need for health plan product design to better align patient engagement and therapeutic compliance;
- an undue focus on hospital organizations and only a moderate amount of clinical integration;
- a lack of the provider training and education needed to increase their understanding and potential acceptance of risk-based contracting; and
- the need for a better consensus about what constitutes “quality” and how to measure it, with CMS-promoted quality measures differing from those promoted and collected by the state.

**Vermont**

In 2008, the Vermont state legislature instructed the Vermont Health Care Reform Commission (HCRC) to assess the feasibility of an ACO pilot project. Key stakeholders in that initial assessment included the legislature, the state’s three major commercial insurers, three community hospitals, one tertiary hospital, the state hospital association, the state medical society, the business community, state health reform staff, the Vermont Department of Health, and the Vermont Department of Banking, Insurance, Securities, and Health Care Administration. Based on the HCRC’s findings, legislation was passed supporting the implementation of at least one pilot ACO. The state recommended that participating ACOs include mental health services among the services covered by a global budget paid each ACO.

Vermont in 2014 launched a three-year shared savings model utilizing ACOs on a statewide, all-payer basis. Two of the state’s three major ACOs—Community Health Accountable Care, comprised primarily of community health centers, and OneCare Vermont, sponsored by the University of Vermont Medical Center in Burlington and Dartmouth-Hitchcock Medical Center in New Hampshire.—joined the state’s Medicaid shared savings program. To participate in the Medicaid ACO program, an ACO was required to have a minimum of 5,000 lives.

The state used a $45 million SIM grant awarded in February 2013 to support the rollout of a clinical data system to provide state ACOs with the data they needed to manage their patients. All three ACOs, including the third ACO participating only in the commercial market and MSSP, the Accountable Care Coalition of the Green Mountains (ACCGM), collaborated with the state’s health information exchange, Vermont Information Technology Leaders (VITL), to build a single common infrastructure. That infrastructure was used to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information.
about patients. The system enabled providers in the state to track their patients’ services use in a timely fashion.

Minimum savings rates (MSR) expected of the participating ACOs ranged from 3.6 percent to 3.9 percent for the ACOs with the fewest number of members to 2 percent for ACOs with memberships of 60,000 and above. If total savings for an ACO were greater than or equal to the MSR, the ACO was to be eligible to share in the savings. If not, the ACO would not be eligible to share in savings.

Together, the two ACOs in the Medicaid program helped nearly 1,000 providers participate in statewide managed care for around 40 percent of the state’s Medicaid population, or 64,515 enrollees. As of September 2015, 60 percent of Vermonters were participating in either the Medicaid ACO program or the parallel commercial insurance ACO program.

Through better coordination of care for those Vermonters, the two ACOs were able to avoid $6,754,568 and $7,847,440 in health care costs respectively in 2014, for a total of just over $14.6 million in the first year of the program. The ACOs and the state split those savings, saving the state’s Medicaid budget nearly $7 million in costs.53

Behavioral Health Not Central to the Vermont ACO Initiative

Unfortunately, behavioral health services were not among the core services initially required of Vermont’s participating ACOs, although ACOs were encouraged to partner with behavioral health providers. The core services included: inpatient hospital, outpatient hospital, professional services, ambulatory surgery center, clinic, federally qualified health center, rural health center, chiropractor, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, and dialysis facility. However, non-core services—services not attributable to primary care providers participating in the ACOs—included services administered by the Department of Mental Health through Designated Agencies and Specialized Service Agencies, and services administered by the Division of Alcohol and Drug Abuse Programs, along with pharmacy, personal care, dental, non-emergency transportation, services administered by the Department of Disabilities, Aging and Independent Living, services administered by the Department for Children and Families, and services administered by the Vermont Department of Education.

The 29 core quality measures required to be reported by ACOs initially included only two behavioral-health related measures: “Follow-Up After Hospitalization for Mental Illness: 7-Day” and “Initiation & Engagement of Alcohol and Other Drug Dependence Treatment Initiation and Engagement.” “Depression Screening by 18 Years of Age” was initially considered, but was rejected before startup. Instead, “Screening for Clinical Depression and Follow-Up” was included as an evaluation and monitoring measure which had to be reported, but for which payment was not made to participating ACOs.54

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54 VT ACO Pilot Year 1 Performance Measures Approved by GMCB and VHCIP Core Team and Steering Committee, November 2013 (January 16, 2014).
Vermont Proposes NextGen ACOs

In April 2016, Vermont released a Request for Proposals for its Next Generation Accountable Care Organization (Vermont Next Gen ACO) program which will build on the state’s existing Medicaid ACO model beginning in January 2017. Although Vermont’s Next Gen ACO is to be structured similarly to the CMS Next Generation ACO Model serving Medicare enrollees, Vermont’s new ACO approach is attempting to go beyond its Medicare-inspired counterpart to make providers even more accountable for cost and patient outcomes.

The Vermont Next Gen model requires participating ACOs to accept full risk for their Medicaid patients in exchange for a capitated payment, while the Medicare Next Gen approach includes the options of prospective payments paired with a shared savings methodology or a partial capitation arrangement with gains/losses capped at 15 percent of benchmark projections.

The Vermont Next Gen ACO departs from the state’s current Medicaid ACO program by:

- shifting from a shared savings methodology to a prospective capitated payment;
- reducing the number of quality metrics from 28 to six, all of which are linked to payment; and
- utilizing risk stratification methodologies that have not been required in the shared savings-based model.56

Only one of the six quality metrics planned for CY 2017 will be behavioral health-related—“Follow-Up after Hospitalization for Mental Illness (7-Day Rate).”57

Colorado

The Accountable Care Collaborative (ACC) is Health First Colorado’s (the Colorado Medicaid Program’s) primary health care program. ACC enrollees get the regular Health First Colorado benefit package and choose a primary care medical provider (PCMP)—a doctor, nurse practitioner, or physician assistant.

Implemented in May 2011, the ACC began with one practice and roughly 500 people attributed to that primary care practice. It had four main goals, none of which were behavioral health-focused:

- ensure access to a focal point of care or medical home;
- coordinate medical and non-medical care and services;
- improve member and provider experiences; and
- provide the necessary data to support these goals and move them forward.

By June 2015, the program had grown to nearly 520 practices statewide with enrollment approaching 900,000 members—approximately 70 percent of all Colorado Medicaid expansion adult enrollees. During FY 2014-15, there was an increase in the percentage of ACC enrollees attributed to a primary care provider of roughly 10 percentage points. For the Medicaid

55 State of Vermont Department of Vermont Health Access, Vermont Health Connect Request for Proposals, April 7, 2016.
56 Ibid.
expansion population, the increase was 20 percentage points. The Colorado initiative had saved the state $77 million over the first four years.\textsuperscript{58}

A fundamental building block of the ACC is the 7 regional networks of both medical and social providers—Regional Care Collaborative Organizations (RCCOs)—across the state. The RCCOs are charged with “helping [their networks of] providers navigate the disparate parts of a fragmented health care system while simultaneously working to make the system more cohesive.” The RCCOs support those providers with coaching and information, managed and coordinated member care, connect enrollees with non-medical services, and report on costs, utilization, and outcomes for enrollees. The RCCOs receive care coordination payments of between $8 and $10 and a pay-for-performance bonus for performance on three quality metrics.

RCCOs receive data and analytics support from the State Data and Analytics Contractor (SDAC) to help providers see service utilization. Regions that meet or exceed targets on three key quality performance indicators—none of which are behavioral-health related—receive the pay-for-performance incentive payments. This encourages RCCOs and primary care providers to engage partners to meet their goals.\textsuperscript{59}

**Integrating Behavioral Health and Primary Care in Colorado**

Because full integration of all health services is the stated long-term goal of the ACC, the state allows integrated Community Mental Health Centers apply to be primary care providers.

Pediatric Partners of the Southwest (PPSW) partnered in October 2014 with Rocky Mountain Health Plans to begin an integrated behavioral health pilot program for children within the PPSW medical home, utilizing two behavioral health consultants. That program has evolved into a team-based care model, providing care coordination, support, evaluation, and referrals for PPSW enrollees related to behavioral health. Based on the Rocky Mountain effort, CMMI awarded Colorado a SIM grant in February 2015 to transform the Colorado healthcare delivery system by better coordinating physical and behavioral health.

RMHP Prime, established under statutory authority enacted in 2012,\textsuperscript{60} shares savings with its primary care provider network and community partners to improve the integration and coordination of care for Medicare-Medicaid dual eligible clients. During FY 2014-15, enrollment surpassed initial projections by roughly 6,500 enrollees, at nearly 34,000 enrollees as of June 2015. While quality data had still not been compiled as of that date, initial findings indicated the program’s payment methodology had positively impacted the level of collaboration between diverse provider types and community organizations. According to the Colorado Department of Health Care Policy Financing, “[t]he model … also furthered practice transformation efforts and increased the integration of behavioral health in primary care.”\textsuperscript{61}

\textsuperscript{58} Vermont’s ACO Shared Savings Programs in a National Context, Center for Health Care Strategies Presentation, April 13, 2016.
\textsuperscript{59} Ibid.
\textsuperscript{60} Colorado House Bill 12-1281.
Integrating Behavioral Health into Accountable Care Organizations

Utah

In response to concerns that Utah Medicaid program growth had exceeded the state’s annual revenue growth rate for the previous two decades and the long-term sustainability of the Medicaid program, the 2011 Utah legislature passed and the Governor signed Senate Bill 180. That bill required the Utah Department of Health to “maximize replacement of the fee-for-service delivery [Medicaid] model with one or more risk-based delivery models”

Senate Bill 180 provided some specific goals and guidance on restructuring the Medicaid program’s provider payment structure to “reward health care providers for delivering the most appropriate service at the lowest cost that maintains or improves recipient health status.” The legislation required that the Medicaid program:

- identify evidence-based practices and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost;
- pay providers for packages of services delivered over entire episodes of illness;
- reward providers for delivering services that make the most positive contribution to maintaining and improving a recipient’s health status;
- use providers that deliver the most appropriate services at the lowest cost;
- restructure the program to bring the rate of growth in Medicaid more in line with the overall growth in General Funds; and
- restructure the program’s cost sharing provisions and add incentives to reward recipients for personal efforts to maintain and improve their health status.

To achieve these goals, effective January 2013, the Medicaid Division implemented four ACOs for Medicaid clients in four counties: Weber, Davis, Salt Lake, and Utah. Members living in other counties had the choice of enrolling in any approved ACO available in their county of residence or enrolling in the state’s FFS program.62

Each ACO was to be responsible for providing enrolled Medicaid members with all medical services covered by Utah Medicaid, exclusively through providers on the ACO’s network. The ACOs were to provide a wide range of services, but, once again, those services did not include behavioral health services, except facility-based medical detoxification from addiction. In addition, while most prescription drugs were included in the pharmacy benefit, mental health-related drugs were not, nor were the following substance use treatment drugs: naltrexone, the buprenorphine-naltrexone combination Suboxone, disulfiram products such as Antabuse, and Campral.

Mental health benefits are provided in 27 of 29 Utah counties through Prepaid Mental Health Plans (PMHP); in the remaining two counties, mental health services are FFS. When an enrollee presents with a possible mental health condition to his or her ACO primary care provider (PCP), it is the responsibility of the PCP to determine whether the enrollee should be referred to a psychologist, pediatric specialist, psychiatrist, neurologist, or other specialist. Mental health conditions may be handled by the PCP or referred to the enrollee’s PMHP when more

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62 Managed Care: Accountable Care Organizations, Utah Department of Health: Medicaid.
specialized services are required.\footnote{Utah Model ACO Contract, § 4.10 Covered Services: Mental Health Services (July 1, 2014)}

Each ACO is permitted to offer more benefits and/or fewer restrictions than the Medicaid scope of benefits, but must specify which services required prior authorization and the conditions for authorization.

Providers are paid by the ACO. Medicaid pays the ACO a monthly fee for each Medicaid member enrolled in the ACO, and the ACO then pays its providers. Risk-adjusted capitated payments to the ACOs must be approved by CMS.

By May of 2015, the program had transitioned 120,000 Medicaid enrollees to full-risk ACOs, 71.3 percent of Utah Medicaid enrollees were enrolled in an ACO, appropriation increases for Utah Medicaid ACOs had been limited to 2 percent per year, and $17 million in savings had been achieved.\footnote{Utah: Accountable Care Organizations Transforming Medicaid, Presentation by Emma Chacon, Assistant Division Director, Division of Medicaid and Health Financing, Utah Department of Health (May 29, 2015).} In July 2015, enrollees living in Box Elder, Cache, Iron, Morgan, Rich, Summit, Tooele, Wasatch, and Washington counties were, for the first time, also required to enroll in an ACO, resulting in more than 86 percent of Medicaid enrollees receiving services other than their behavioral health services through ACOs.\footnote{Utah Health Status Update: Industry and Occupation Impact on Health (September 2015), p. 3.}

**Maine**

Under the Maine Accountable Communities (AC) Initiative, MaineCare’s version of Accountable Care Organizations (ACOs), the Maine Department of Health and Human Services entered, in 2014, a three-year contract with four AC “Lead Entities” under which groups of providers could share in savings for an assigned population, with the exact amount of any shared savings payments tied to the AC’s score on a range of quality measures. The Department contracts with the Lead Entity, which represents the providers that comprise the AC; the Department does not contract with individual providers. The existing four ACs are currently made up of 67 primary care practices. The AC must include providers that directly deliver primary care services, but the program offers broad flexibility as far as what types of providers may be part of the AC and how the AC is structured and operates.

The AC Initiative was considered an important component of Maine’s SIM grant-funded program, under which Maine was building on the foundation of an existing multi-payer PCMH Pilot and Health Homes Initiative to form multi-payer ACOs that commit to a set of core measures for public reporting and payment reform efforts. The SIM goals are multi-payer alignment on core quality measures and value-based payment.

An AC Lead Entity must be a physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services; a nurse practitioner; a certified nurse-midwife; or a physician assistant. The Lead Entity must have a primary specialty designation of internal medicine, general practice, family practice, pediatrics, geriatric medicine, obstetrics or gynecology; and/or practice in a RHC, FQHC, an Indian Health Services center, or School Health Center. Non-psychiatrist behavioral health providers cannot be Lead Entities. However, mandated care coordination services for members with behavioral health needs include

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targeted case management (TCM) services for children with Serious Emotional Disturbance (SED) and adults with substance abuse disorders, and CI Services for adults with SMI.

The Department implemented Behavioral Health Homes (Stage B) early in 2014 to provide intensive care management for adults with SMI and children with SED. Members with SMI or SED receiving services through TCM or CI have the option of receiving Behavioral Health Home services with a greater emphasis on integration with physical health through a partnership with a Health Home primary care practice.

ACO primary care sites that partner with a behavioral health organization to form a Behavioral Health Home must extend an invitation to the Behavioral Health Home Organization (behavioral healthHO) to participate in the AC as well. In March 2016, there were 25 community mental health providers participating across the four ACOs.

Participating ACOs are eligible to participate in one of two shared savings models. The payment models are based on AC performance against a risk-adjusted total cost of care (TCOC) target for all qualifying MaineCare members attributed to the AC for the year. The TCOC target is calculated using risk-adjusted MaineCare FFS claims data. The Department calculates a risk score utilizing a proprietary scoring system embedded in its MSIS system that is based on diagnoses, condition interactions, National Drug Codes, and the age and sex of the population assigned to the AC. The Benchmark TCOC is adjusted based on the increase or decrease in the risk of the assigned populations between the Base Year and subsequent performance years. Shared savings for reducing total costs is also contingent on performance on quality measures from the domains of care coordination and patient safety, preventive health, and at-risk populations, as well as patient experience outcomes. All risk/gain payments are calculated and disbursed annually via a reconciliation payment.

In May 2016, MaineCare reported that, although mental health and substance abuse disorder treatments were considered keys to success of the AC program, privacy laws were creating major barriers to integrated care delivery and electronic health record (EHR) compatibility had also presented significant challenges. Attribution was also proving a challenge.

**New Jersey**

In New Jersey, ACOs formed by nonprofit corporations were authorized under a 2011 law creating a three-year pilot. The legislation required the governing board of each Medicaid ACO to include behavioral health providers, as well as general hospitals, clinics, private practice offices, physicians, dentists, patients and other social service agencies or organizations. In order to ensure the ACOs had a community orientation, there was to be one ACO in each municipality or in each geographic area defined by the ACO, in which at least 5,000 Medicaid enrollees resided.

The Medicaid ACO law contemplated that each Medicaid ACO would have access to a revenue stream generated by the award of a share in the Medicaid savings attributable to the ACO’s efforts in its designated geographic area (“gainsharing”). The ACOs would be expected to

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67 [Presentation: MaineHealth Accountable Communities ACO Contract](#), National Association of ACOs (NAACOS) Spring Meeting, Katie Fullum Harris, March 30, 2016.


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provide community health services with the goal of improving care and reducing the rate of cost increase. Other foci of gainsharing mandated by statute included:

- care coordination through multi-disciplinary teams, including care coordination of patients with chronic diseases and the elderly;
- expansion of the medical home and chronic care models;
- increased patient medication adherence and use of medication therapy management services;
- use of health information technology and sharing of health information; and
- use of open access scheduling in clinical and behavioral health care settings.70

If the ACOs could drive down the rate of Medicaid costs as compared with projected costs while establishing high standards of care and community engagement, they would share in the gain Medicaid realized from their efforts.

However, the gainsharing was mandatory under the law only under FFS Medicaid, and even in 2011, only a minority of Medicaid recipients were served through the FFS system. The majority were enrollees in managed care organizations (“MCOs”) contracting with Medicaid. By 2013, when the initiative was to get underway, almost all Medicaid recipients in New Jersey were being served through MCOs under a waiver, and those MCOs were not required to enter into gainsharing agreements with ACOs.

A 2014 study by Seton Hall Law School’s Center for Health and Pharmaceutical Law and Policy, suggested MCOs would be expert at system-wide management of provider networks and claims management, and ACOs would be situated to provide services sensitive to the nature of the local delivery system’s pathways, and, more significantly, the community’s social, ecological, and economic circumstances.71 However, the study’s suggestion that the two models could be merged into a hybrid model faced at least one obstacle: the governance requirements under the ACO law were quite clear that the leadership of Medicaid ACOs must comprise community representatives, providers, and social service agency representatives. In the alternative, the study suggested, ACOs could serve as subcontractors for MCOs, taking on services consistent with their close community ties and intensive care coordination missions.

New Jersey’s MCO contract requires that MCOs coordinate care with community partners, including community social service agencies and behavioral health providers.72 MCOs were required to monitor their success with health promotion and care access, and to report performance measure results on a wide variety of population health measures. They had particular contractual obligations with respect to care for elderly enrollees and people with disabilities, including overseeing “life indicators.”

ACOs were required to have at least four behavioral health care providers in their networks.73 However, as late as July 2015, the state was retaining a carved-out mental health/substance use disorder system for the coordination and monitoring of most mental health/substance abuse

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70 § 10:79A-1.6(a)(1)(i) and(d)(1)(ix).
72 Contract between the State of New Jersey Department of Human Services Division of Medical Assistance & Health Services and [Medicaid MCO], Contractor (Jan. 2014), Article 4 at 34.
73 Medicaid ACOs in New Jersey, Presentation at the National Health Policy Forum by Derek DeLia, PhD, Rutgers Center for State Health Policy (December 11, 2015).
conditions. The MCO retained responsibility for mental health and substance use disorder screening, referrals, prescription drugs, and treatment of a wide range of “conditions altering mental status,” including dementia, psychoses, alcohol- or drug-induced persisting dementia or amnesia, substance abuse and nicotine dependence, delirium, mood disorder, anxiety disorder, behavioral or personality change or disorder due to known physiological condition, and post-concussional syndrome.74

**Illinois**

A 2011 Illinois law mandated that, by January 1, 2015, at least half of the state's three million Medicaid enrollees had to be enrolled in a risk-based managed-care plan.75 The state created a variety of ways to accomplish this, such as traditional managed-care organizations led by private health insurers. But Illinois wanted to include hospitals and doctors as part of the solution, leading to the “ACE Initiative.” Illinois S.B. 26 of 201376 amended the 2011 managed care law to require that, no later than August 1, 2013, the Department of Humans Services issue a purchase of care solicitation for Accountable Care Entities (ACE) to serve children and parents or caretaker relatives of children eligible for Medicaid. An ACE could be a single corporate structure or a network of providers organized through contractual relationships with a single corporate entity.

An ACE was required to cover, at a minimum, primary care, specialty care, hospitals, and behavioral healthcare.77 The state’s solicitation for ACE providers also specified that awardees had to have established procedures for coordinating with non-Medicaid providers such as housing and social service providers.78 An ACE operating in Cook County had to be capable of serving at least 40,000 eligible individuals in the county; an ACE operating in Lake, Kane, DuPage, or Will Counties had to be capable of serving at least 20,000 eligible individuals in those counties; and an ACE operating in other regions of the State had to be capable of serving at least 10,000 eligible individuals in the region in which it operates.79

Under the ACE model, the participating provider groups agreed to contract with Illinois for three years to care for defined Medicaid populations in a specific geography. An ACE was required to identify a lead entity required to assume legal responsibility for executing the ACE contract with the Department. An ACE could identify a single lead entity or organize a network of providers through contractual relationships to develop a single lead entity. A lead entity could be a Medicaid-enrolled Provider, a non-Medicaid enrolled provider, or a local governmental non-Medicaid authority, but it could not be an existing MCO.80

Under the initiative, the ACEs would eventually be taking on full risk for their patients, both medically and financially. During the first 18 months of operation, hospitals and physicians were to receive two types of payment from the state. Illinois Medicaid still reimbursed all medical

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74 Contract between the State of New Jersey Department of Human Services Division of Medical Assistance & Health Services and [Medicaid MCO], Contractor (Jan. 2014), Article 4 at 34.
75 Illinois P.A. 96-1501 enacting 305 ILCS 5/5-30.
77 Ibid.
78 State of Illinois Solicitation for Accountable Care Entities.
80 State of Illinois Solicitation for Accountable Care Entities.
claims on the usual FFS basis, but the state also pays ACEs out of its cost savings a care-coordination fee of $9 PMPM for Family Care enrollees and $20 PMPM for adult enrollees. In months 19 through 36 of ACE operations, unless the ACE selected a shorter period, an ACE was to be paid on a pre-paid capitation basis for all Medicaid-covered services, under contract terms similar to those of MCOs, with the state sharing in risk through stop-loss insurance for high-risk individuals. In the fourth year of the contract and after the contract ends, providers were to bear full financial risk under a full-risk capitated payment, converting either to Managed Care Community Networks or health Maintenance organizations.\textsuperscript{81}

Of the 29 quality measures that ACEs were to be judged when the program started up in 2014, four were behavioral health measures: “Follow-Up Care for Children Prescribed ADHD Medication,” “Antidepressant Medication Management,” Adherence to Antipsychotic Medications for Individuals with Schizophrenia,” and “Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.”\textsuperscript{82} Only four of the 29 measures were tied to payment, but one of the four was “Follow-Up after Hospitalization for Mental Illness,” which apparently replaced the ADHD measure previously contemplated.\textsuperscript{83}

Systems were required to invest in information technology and data tools to track and share each Medicaid patient’s clinical history. They were also required to be part of the Illinois Health Information Exchange, a private platform for securely sharing patient data run by the state. During the first 2 years of an ACE’s operation, the Department was required to provide claims data to the ACE on its enrollees on a periodic basis no less frequently than monthly.\textsuperscript{84}

In September 2014, nine provider-led ACEs officially launched and started enrolling Medicaid members. By July 2016, ACEs were required to have become managed care entities.\textsuperscript{85}

**Rhode Island**

On February 26, 2015, Rhode Island Governor Gina Raimondo signed an executive order establishing the Working Group to Reinvent Medicaid. The Governor directed the group to identify sustainable savings initiatives that would transform Rhode Island’s Medicaid program to pay for better outcomes, better coordination, and higher-quality care, rather than patient volume. The initiatives were to focus on, among other goals, a better coordination of mental and physical healthcare.

In response, the General Assembly passed in June 2015, the Reinventing Medicaid Act,\textsuperscript{86} with an expectation of savings in excess of $100 million.

One of the initiatives launched was a three-year Rhode Island “Accountable Entities (AEs)” pilot slated to begin in January 2016. Under the pilot, Certified Accountable Entities, contracting with Medicaid managed care organizations, were to have responsibility for coordinating the full

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\textsuperscript{81} Illinois P.A. 98-0104, § 11-20.
\textsuperscript{82} ACE Health and Quality of Life (HQOL) Measures (March 27, 2014) and Illinois Department of Healthcare and Family Services Healthcare and Quality of Life Performance Measures Specifications for the Accountable Care Entities (August 18, 2014).
\textsuperscript{83} State of Illinois Solicitation for Accountable Care Entities, Attachment C-1.
\textsuperscript{84} Illinois P.A. 98-0104, § 11-20.
\textsuperscript{85} Illinois Department of Healthcare and Family Services: Provider Notice: Care Coordination Health Plan Transitions for Medicaid Participants in ACEs and CCEs (January 4, 2016).
\textsuperscript{86} Rhode Island P.L. 2015, ch. 141, art. 5, § 20
continuum of healthcare services for defined Medicaid populations with complex and specialized needs. An AE’s governing board was required to include a mental health or chemical dependency treatment provider.87

Rhode Island expects an effective participating AE to be able to meet the needs of the entire Medicaid population in the state, but also to have distinct competencies that enable it to recognize and address the special needs of high-risk and “rising risk” population groups. According to the state’s October 2015 request for applications (RFA),88 one of two high priority capabilities for the Medicaid population which must be met by participating AEs is physical and behavioral health integration. The RFA notes that 40 percent of state spending on high-cost users (those with more than $15,000 in annual payments for services) is on high utilizers living in the community. Eighty-two percent of expenditures in the community were for persons with co-occurring mental health or substance and physical health needs, underscoring the need for an integrated person-centered approach to care.

AEs were to be required to report on 20 priority quality measures. Those measures were to include the following behavioral health-related measures: “Behavioral Health Utilization,” “Timeliness to Behavioral Health and Primary Care Appointments,” “Follow-Up after Hospitalization for Mental Illness within 7 days/30 days of Discharge,” and “Referrals and Link to Social Supports (Housing etc.),” “Referrals to Behavioral Health and Specialty Care,” and “Social Determinants—e.g., Housing Stability, Recidivism.” In addition, at least 5 of the 20 metrics must be specifically related to the program’s two priority capabilities for the Medicaid population, one of which is physical and behavioral health integration.89

In April 2016, Integra Community Care Network, a CMS-certified ACO, announced it would be the first ACO participating in the pilot, partnering with UnitedHealthcare Community Plan of Rhode Island. The Integra care provider network is composed of the Care New England and South County Health systems, Rhode Island Primary Care—the state’s largest primary care organization with 150 participating primary care physicians RIPCPC providers treat more than 150,000 Rhode Islanders. UnitedHealthcare has more than 20,000 enrollees in Rhode Island.

Integra intends to launch two types of Accountable Entities. The Type Two entity would be for a projected 4,000 adult individuals whose admission would be based on a diagnosis of serious mental illness or serious and persistent mental illness. The Type One, more traditional accountable care organization entity, would have 16,000 individuals enrolled based on their current primary care provider and his or her affiliation with Care New England, or a Care New England Medical Group, or South County Health.90

The Rhode Island Executive Office of Health and Human Services has issued two additional RFAs since the first RFA was issued, seeking additional participants in the AE program. The due date for the most recent RFA, published May 18, 2016, was July 1, 2016.

87 Accountability Entity Coordinated Care Pilot Program: Program Description and Application, Rhode Island Executive Office of Health and Human Services, October 30, 2015.
88 Ibid.
89 Ibid.
90 An Accountable Entity for Serious Mental Illness, Convergence R.I. Interview with Gary Bliss, Program Director for the Medicaid Accountable Entity with Care New England’s Integra Community Care Network (May 16, 2016).
**Massachusetts**

In a July 22, 2016 on-line summary of a request from MassHealth to CMS to extend its existing § 1115 waiver, MassHealth said it intended to implement:

> *an ACO approach [that] places a significant focus on improving integration and delivery of care for members with behavioral health needs and those with dual diagnoses of substance abuse disorder; as well as integration of long term services and supports (LTSS) and health-related social services. ... ACOs will be required to maintain formal relationships with community-based behavioral health and LTSS providers certified by MassHealth as Community Partners, furthering the integration of care. This shift from fee-for-service to accountable, total cost of care models at the provider level is central to the demonstration extension request, and to the Commonwealth’s goals of a sustainable MassHealth program. Massachusetts seeks new waiver and expenditure authority necessary to authorize ACOs.*

To encourage eligible MassHealth members to enroll in an MCO or ACO rather than the Primary Care Clinician (PCC) Plan, MassHealth proposes to provide fewer covered benefits to members who choose the PCC Plan, dropping chiropractic services, eye glasses, and hearing aids. Members who select the PCC Plan as their managed care option can choose to disenroll from the PCC Plan and enroll in an MCO or ACO at any time.

The waiver request says the demonstration, if approved, will offer providers the opportunity to form and participate in three different model designs of ACOs:

- **The Model A ACO/MCO** would be an integrated partnership of a provider-led ACO with a health plan. Members would enroll in Model A ACOs, which would serve as their health plan as well as their provider network. Model A ACOs would be responsible both for administrative health plan functions (such as claims payment and network development), and for coordinated care delivery for the full range of MassHealth managed care organization (MCO) covered services. Both the MCOs and Model A ACOs would be paid prospective capitation rates and bear insurance risk for enrolled members’ costs of care.

- **The Model B ACO** would be a provider-led entity that contracts directly with MassHealth and may offer members preferred provider networks that deliver coordinated care and population health management. MassHealth’s entire directly-contracted provider network (and contracted managed behavioral health “carve-out” vendor) would be available to Model B ACO members. At the end of the performance period, MassHealth would share savings and losses with the ACO based on the total cost of care the ACO’s attributed members incur.

- **The Model C ACO** would be a provider-led ACO that contracts directly with MassHealth MCOs. Members would enroll in MCOs, and the MCO would serve as their health plan, responsible for contracting provider networks and paying providers for MCO-covered services. MCO members would be attributed to Model C ACOs based on primary care relationships. At the end of each performance period, each MCO would share savings and losses with the ACO based on the total cost of care for the MCO’s enrolled members who

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91 *Section 1115 Demonstration Project Amendment and Extension Request*, Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid, July 22, 2016.

92 *Ibid*, p.3.
are attributed to the ACO. Under this third model, MassHealth would set parameters to foster alignment across payers at the ACO level, while still allowing flexibility for Model C ACOs and MCOs to negotiate contract provisions.

Under each of the models, MassHealth says MCOs will be expected to help ACOs determine how best to integrate behavioral health and LTSS community partners into care teams. Over time, according to MassHealth, including LTSS in the MCOs’ scope of services will align financial incentives for the MCOs to leverage community-based LTSS and behavioral health services and to ensure a preventative and wellness based approach. Partnering MCOs will be required to demonstrate competencies in the independent living philosophy, Recovery Models, wellness principles, cultural competence, accessibility, and a community-first approach, consistent with the One Care model.

A major focus of MassHealth’s restructuring approach and an explicit goal of the waiver demonstration will be the integration of physical health and behavioral health for individuals with a range of behavioral health needs, as well as strengthened linkages to social services to meet members’ needs in a more comprehensive way. This includes a focus on creating a system of behavioral health treatment that improves health outcomes, experience, and coordination of care across a continuum of behavioral health services, reduces health disparities, and incorporates recovery principles for children, youth, and adults with a range of mental health conditions and/or substance use disorders. A variety of strategies – including ACO approaches, the role of certified behavioral health community partners, contractual expectations for managed care plans, the Massachusetts Behavioral Health Partnership, ACOs, and other payment models – are expected to further this goal and strengthen approaches already in existence.  

MassHealth envisions:

- the formation and use of interdisciplinary care teams which include a member’s primary care provider (PCP), a behavioral health clinician, and an LTSS representative (as needed) working from one integrated care plan;
- seamless, person-centered care coordination for members with complex behavioral health, LTSS, and social needs;
- inclusion of community-based behavioral health providers with expertise across the entire care continuum of behavioral health treatments and services, from emergency and crisis stabilization through intensive outpatient, community-based services; and
- inclusion of community-based LTSS providers on the interdisciplinary care teams who demonstrate expertise in all LTSS populations including elders, adults with physical disabilities, children with physical disabilities, members with acquired brain injury, members with intellectual or developmental disabilities, and individuals with co-occurring behavioral health and LTSS needs.

The interdisciplinary care team will be expected to follow a systematic clinical approach, based on national standards and best practices, including the Substance Abuse and Mental Health Services Administration (SAMHSA) Recovery Principles for adults and System of Care Principles for children.

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93 Ibid., pp. 5-6.
94 Ibid., p. 6.
Another key feature of the proposed demonstration extension will be to address the opioid addiction crisis. Massachusetts proposes enhanced MassHealth substance use disorder services to promote treatment and recovery. Specifically, the demonstration would:

- incorporate 24-hour community-based substance use disorder treatment services at American Society of Addiction Medicine (ASAM) Levels 3.1 and 3.3 into the MassHealth benefit;
- expand access to 24-hour community-based services across the continuum of substance use disorder treatment (including members dually diagnosed with substance use disorders and mental illness);
- expand access to medication-assisted treatment;
- expand access to care management and other recovery-focused support; and
- engage development of the substance use disorder treatment workforce across the health care system.

MassHealth also intends to include peer support as an integral element of the demonstration. 95

**Recommendations**

For the ACO or Integrated Care Model to show any promise of true behavioral health integration, improved behavioral health outcomes, and revenues through true shared savings for participating providers, any ACO initiative adopted by a state should include the following elements:

- States should require that ACO leaders incorporate behavioral health providers in their governing bodies and networks, and may want to consider attribution of enrollees to behavioral health providers.
- States should be prepared to offer behavioral health providers incentives—financial and otherwise—for the adoption of health information technology to help facilitate the exchange of patient data between behavioral health providers, primary care and other medical/surgical providers, and the state.
- States should ensure that behavioral health quality outcomes are measured and reported, and that at least some portion of provider reimbursement is contingent on enrollee improvements on those outcomes.
- In order to facilitate enrollee participation and enrollee self-reporting and provider reporting of outcomes, education should be provided both enrollees and providers on how to best handle behavioral health societal stigma. Education on permissible disclosures under 42 CFR Part 2 restrictions should also be included in any educational and training module provided for participating providers, enrollees, and health information exchanges.

95 Comments by Massachusetts State Mental Health Commissioner Joan Mikula during a panel presentation “Being Seen! Peer Support for the Deaf and Hard of Hearing Communities,” NASMHPD 2016 Commissioners Meeting (August 7, 2016).
• States should preempt inevitable behavioral health workforce shortages by considering the inclusion of non-physician behavioral health providers in the ACO network and the use of tele-behavioral health to supplement in-person treatment.

• In addition, behavioral health provider reimbursement should be adequate to ensure that behavioral health providers are as accessible within the Medicaid ACO as they are in the general medical community. If a shared savings approach is to be used, the state may want to consider supplementing that approach through outcomes-based incentive payments sufficient to ensure that providers are not discouraged by low reimbursement from continued participation in the ACO initiative.

• ACO initiatives should be given time to develop in order to produce sustainable positive patient outcomes and provider revenues through shared savings or incentive payments significant enough for providers to want to participate.

Conclusions
States looking to adopt ACOs as a means of integrating behavioral health into their Medicaid programs should recognize that they will face considerable challenges in doing so, including:

• the inherent biases against behavioral health integration within the historic Federal framework introduced under the MSSP;

• behavioral health workforce shortages, particularly in rural and remote areas;

• the limited capabilities and resources of behavioral health providers for adopting integrating health information technology that allows the reporting and exchange of integral data;

• the limits on sharing enrollee data imposed by societal stigma and restrictions on the reporting of some patient data;

• limited adoption of behavioral health outcome measures on which enrollee improvements can be measured and provider shared savings based; and

• the absence of immediate provider revenues from the shared savings approach for participating ACOs and their providers.

While states have demonstrated some success in adopting elements of the Integrated Care Model advocated by CMS in 2012, those initiatives are still early in their development and, for the most part, outcomes are still inconclusive.