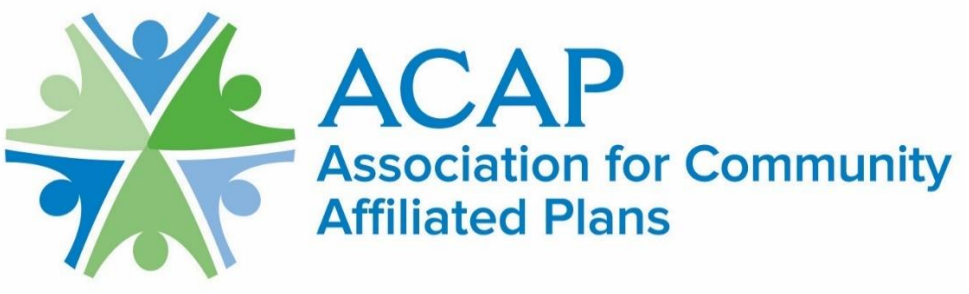


# Integrating Physical and Behavioral Health Care:

## An Initiative Planning Toolkit for Health Plans

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April 2016

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## Introduction

In the United States, 1 in 4 adults has a behavioral health condition. Of those, two-thirds—or about 25 million people—have a co-occurring medical condition.[1] Adult enrollees covered by Medicaid who have a behavioral health diagnosis incur three times the health care costs compared with people without a behavioral health diagnosis.[2] Much of the increased cost can be attributed to services for physical, not behavioral, health.[3] Individuals with behavioral health disorders are more than twice as likely to describe themselves as having fair or poor health status than those without such conditions.[4] Most importantly, individuals with behavioral health conditions die decades earlier than those without, in part due to preventable medical conditions.[5]

*By ensuring that both the physical and behavioral health needs of individuals are identified and treated regardless of the setting in which they first seek care, and that the delivery of services is coordinated, people with co-occurring physical and behavioral conditions will have improved health outcomes, lower costs, and a better experience with the health care system.*

A lack of coordination between physical and behavioral health providers, including limited coordination between mental health and substance abuse treatment providers, contributes to these higher costs and poorer outcomes. For more than one-third of individuals with a mental health disorder accessing care, primary care is their sole source for health care services–their conditions often go untreated or undertreated.[6] At the same time, when an individual receives a majority of their care from mental health professionals, their physical health care needs may go underdiagnosed, undertreated or unmanaged.

In a health care system this fragmented, the opportunities to achieve further integration are vast. To respond to this opportunity, the Association for Community Affiliated Plans (ACAP) convened a collaborative of ACAP-member health plans to focus on improving integration of behavioral and physical health services. The collaborative was underwritten through grant funding from the Open Society Foundations.

The collaborative centered around the project planning process; each plan was provided educational materials and networking opportunities on topics related to integrated care. This toolkit reflects the project planning process, lists the resources provided to collaborative plans, and summarizes a subset of their projects, whether already fielded or in development. Although there are many resources targeted toward providers' efforts to integrate care, we hope this toolkit imparts an understanding of how ACAP health plans participating in the collaborative approach, think about, and promote integrated care.

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[1] Druss B and Walker E. "Mental Disorders and Medical Comorbidity." Robert Wood Johnson Foundation. February 2011.
[2] Medicaid and CHIP Payment and Access Commission (MACPAC). "Behavioral Health in the Medicaid Program—People, Use, and Expenditures." June 2015.
[3] Melek SP et al. "Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry." Milliman. April 2014.
[4] Kaiser Commission on Medicaid and the Uninsured. "The Role of Medicaid for People with Behavioral Health Conditions." November 2012.
[5] Thornicroft G. "Physical health disparities and mental illness: the scandal of premature mortality." The British Journal of Psychiatry Nov 2011, 199 (6) 441-442.
[6] Russel L. "Mental Health Care Services in Primary Care." Center for American Progress." Center for American Progress. October 2010.

## The Promise of Behavioral Health Integration

The promise of integrating physical and behavioral health is simple. By ensuring that both the physical and behavioral health needs of individuals are identified and treated regardless of the setting in which they first seek care, and that the delivery of services is coordinated, people with co-occurring physical and behavioral conditions will have improved health outcomes, lower costs, and a better experience with the health care system.

A growing evidence base supports the aims of integration. Much of the research around integration to date has focused on depression and anxiety disorders, largely those treated through collaborative care models.[7] A 2012 meta-analysis that investigated the effectiveness of collaborative care models for depression and anxiety found that the model of care is more effective than usual care in terms of outcomes and patient satisfaction.[8] One randomized controlled trial found that integrating care for older adults with depression and co-occurring medical disorders resulted in savings versus expected costs averaging more than $3,000 per patient over a four-year period.[9] Another study concluded that patients with depression who received integrated mental health services were 54 percent less likely to have emergency department visits than those that did not receive integrated care.[10] The results also extend to child and adolescent populations. A 2015 meta-analysis demonstrated that integrated care improves behavioral health outcomes compared to usual primary care for children and adolescents.[11]

Integration can also increase access to mental health and substance use disorder treatment and begin to reduce the stigma associated with the use of behavioral health care services.[12] Thus, implementation may be worthwhile even if some of these models do not show significant cost and quality improvements.

The benefits of integrated care are expected to extend beyond depression and anxiety to other behavioral health conditions such as substance use disorder and comorbid physical health conditions. But additional research needs to be conducted to solidify this theory. Physical and behavioral health are inseparably linked, as evidenced by the high prevalence of co-occurring conditions.

The persistent chasm between physical and behavioral health is seen by many as an artifact of substance use disorder and mental health services being treated in silos separate from physical health conditions, largely due to differences in regulatory requirements and funding streams. Bridging this gap is an immediate priority. Providers, health systems, and health plans are exploring approaches to better integrate care. As they do, their efforts can inform the evidence base for effective integrated care strategies.

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[7] Institute for Clinical and Economic Review. "Enhancing Patient Outcomes and Health System Value through Integration of Behavioral Health into Primary Care." June 2015.

[8] Archer J et al. "Collaborative care for depression and anxiety problems (Review)." *The Cochrane Library* 2012, Issue 10.

[9] Unutzer J et al. "Long-term Cost Effects of Collaborative Care for Late-life Depression." American Journal of Managed Care 2008 Feb; 14(2): 95-100.

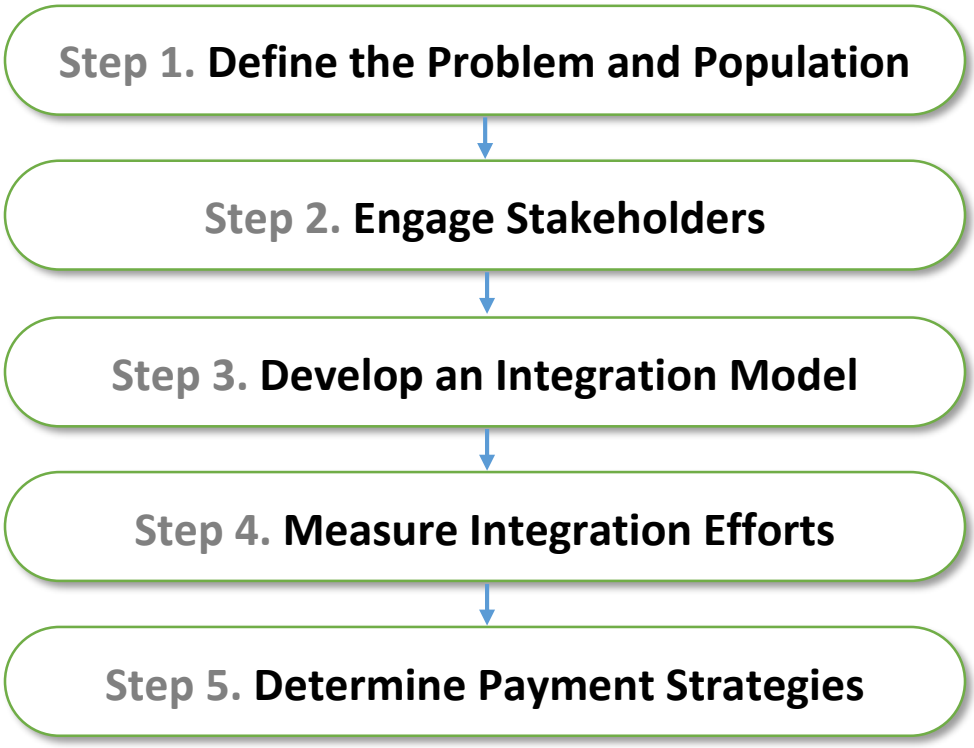
[10] Reiss-Brennan B et al. "Cost and Quality Impact of Intermountain's Mental Health Integration Program." Journal of Healthcare Management 2010 Mar/April; 55(2).

[11] Asarnow JR et al. "Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis." JAMA Pediatrics. 2015 Oct; 169(10): 929-937.

[12] Collins C et al. "Evolving Models of Behavioral Health Integration in Primary Care." Milbank Memorial Fund, 2010.

## Overview of the Integration Project Planning Process

Based on the work of the ACAP collaborative, the following is an outline of the overarching steps that plans should take when developing a project to integrate physical and behavioral health services. This toolkit provides an overview of each of these steps, including how collaborative plans thought about each of these topics while developing their own integration projects.




In addition to the text, there are breakout boxes with resources and tips:

| Icon | Meaning |
|---|---|
|  | Additional resources and research on topics. Many include links where the tools can be accessed online. |
|  | Tips, tricks, and additional helpful insights based on plans' experience and research. |

## Step 1: Define the Problem and the Population

When selecting a population on which they could tailor their projects, collaborative plans conducted their own analyses. Most decided to narrow their focus through first selecting either:

A. Members in active treatment with certain providers or provider groups; or
B. Members who have specific conditions that could most benefit from integrated care.

This toolkit outlines the efforts plans' made when thinking through integrating care; for program descriptions and results from plans that have already adopted integrated care, see: Safety Net Health Plans: Working in Underserved Areas to Integrate Behavioral Health and Primary Care

***A. Selecting Patients in Treatment with Specific Provider(s):*** Some collaborative plans opted to focus their projects on selected providers, thereby improving care for their patients. Among the variables that entered into plan decision-making processes around provider selection included:

- ✓ Whether to leverage existing relationships with providers, or to use the project as an entrée to forging new relationships;
- ✓ Whether to initially focus on behavioral health or primary care providers;[13]
- ✓ Geography and provider availability: one plan leveraged integrated care to improve access to behavioral health services in rural areas of their state; and
- ✓ The willingness of providers to engage in the practice transformation required to support integration.

Plans may also want to consider integrating substance abuse services in either mental health or physical health care settings. The Forum on Integration developed a guide entitled "Purchasing Integrated Services for Substance Use Conditions in Health Care Settings" to provide lessons learned on this approach.

**CareSource,** a health plan serving more than 1.4 million members in Ohio, Kentucky and Indiana, decided to focus their integration project on their Medicaid population engaged in treatment at one of ten Ohio community mental health centers, giving them the opportunity to build more expertise in integrated care. Behavioral health services are carved out of Medicaid managed care in Ohio, but these services are set to be carved back in to Medicaid MCOs beginning in 2018. This project will further strengthen CareSource's relationships with the providers at the ten community mental health clinics prior to the carve-in.

CareSource intends to focus on improving care coordination for pregnant women served by these community mental health clinics—Ohio ranks 49th in the country on infant mortality outcomes. CareSource intends to facilitate behavioral health providers' coordination with the appropriate OB-GYNs through identifying and notifying the behavioral health specialist of care gaps to ensure moms are receiving the pregnancy care necessary to have a healthy baby.

***B. Selecting Patients with Specific Condition(s):*** When selecting a population to focus on, plans considered:

- ✓ The prevalence of the condition; and
- ✓ The impact an intervention could have on both quality and cost.

[13] The description of Passport Health Plan's model under the "Developing a Model" section of this toolkit provides an example of how a plan worked identified an access problem and utilized co-location to address it.

Diagnoses associated with severe and persistent mental illness (SPMI) were the most common areas of focus for plans. Individuals with SPMI have expected lifespans averaging 25 years shorter than individuals without SPMI.[14] Schizophrenia and other psychotic disorders were two of the top five principal diagnosis for hospitals stays among high-cost, high-need members in both the Medicaid and Medicare programs.[15]

Other populations focused on by plans were patients living with:

- HIV/AIDS;
- Depression concurrent with COPD, diabetes, or irritable bowel syndrome; and
- Members with a recent inpatient stay.

1) A MACPAC report provides an overview of the utilization of mental health services in the Medicaid program—broken out by adults, children, and dual eligibles.

2) Milliman conducted an analysis using both commonality and costs of co-occurring conditions to make estimates on the economic impact integrating services could have—the results are a ranked list of conditions ideal for integrated settings.

**Affinity Health Plan** has served the Bronx, New York community for 30 years and currently operates in the Medicaid, Medicare, and Marketplace lines of business and operates a Special Needs Plan (SNP) for people who are dually eligible for Medicaid and Medicare. Affinity opted to focus their efforts on individuals diagnosed with schizophrenia. The plan serves a comparatively high number of members with this condition, they usually have noticeably worse health outcomes, and schizophrenia is readily identified through claims. Diabetes was the most common co-occurring condition within this population; it was also the condition for which members were most likely to be out of compliance for diabetes management. Affinity intends to pilot their interventions with federally qualified health centers (FQHCs) which serve a sufficient number of patients with co-occurring diabetes and schizophrenia.

## Step 2: Engage Stakeholders

AHRQ developed a guide to aid in managing stakeholders as part of the quality improvement process. Although it's tailored for projects focused on children, most of the lessons learned are applicable to any quality improvement project.

Engaging stakeholders in project planning provides a venue for multiple perspectives to be considered. It also helps to build buy-in among community partners. Before engaging stakeholders, most plans identified their populations, providers, and developed at least a high-level description of their integration model. Stakeholders provide acute insight into members' and providers' barriers to integrated care and how the plan's project could more effectively address those barriers. The types of stakeholders that collaborative plans identified for outreach included:

- Mental health providers;
- Primary care providers;
- Members;
- Pharmacists;
- Advocates;
- Social service providers (e.g., food and housing support organizations); and
- Government officials.

[14] Parks J, Svendsen D, Singer P, and Foti M. "Morbidity and Mortality in People with Serious Mental Illness." National Association of State Mental Health Program Directors, Medical Directors Council. October 2006.
[15] Jiang H, Weiss, A, Barrett M, and Sheng M. "Characteristics of Hospital Stays for Super-Utilizers by Payer, 2012." Agency for Healthcare Research and Quality. May 2015.

Plans intended to conduct interviews, use focus groups, or engage steering committees to obtain feedback from identified stakeholders. For plans engaging steering committees, two strategies were deployed:

A. Leveraging an existing steering committee, or
B. Developing a new steering committee with the sole purpose of providing input on the integration project.

**Plans may engage social support organizations beyond just providing input on the model:** Passport envisions providing satellite space for community-based organizations such as housing, transportation, and unemployment support organizations at the clinic. The hope is the clinic would truly be able to address the whole person, including providing solutions to social determinants of health.

***A. Leveraging an Existing Steering Committee to Obtain Model Feedback:*** **Passport Health Plan,** a provider-sponsored Safety Net Health Plan in Kentucky currently serving nearly 300,000 Medicaid members, opted to use their existing Behavioral Health Advisory Group to provide input on their project. This advisory group meets quarterly and includes:

- Members, some of whom serve as peer mentors for the SPMI population;
- Advocates;
- Providers; and
- Pharmacists.

Passport is working with the largest community mental health clinic in their network to determine whether to go forward with an integrated care model that would bring primary care into the behavioral health setting for the SPMI population. The group has been critical in helping Passport understand barriers that members face when navigating the health care system as well as meaningful ways to communicate with members about programs. For example, in the past the steering committee has reviewed written communication materials and provided valuable perspective on how best to tailor them for the SPMI population.

For case studies on how ACAP plans address social determinants: Positively Impacting Social Determinants of Health.

***B. Initiating a New Steering Committee:*** High-level or severe behavioral health services, including substance use treatment services, are carved out of Medicaid managed care in California. In response, **L.A. Care Health Plan**, the nation's largest publicly operated health plan serving close to two million members in Los Angeles county, intends to focus on members diagnosed with SPMI to select a primary care provider that will work with their behavioral health specialists and coordinate care. To guide the initiative's development, L.A. Care has engaged the Los Angeles Department of Mental Health, Department of Public Health-Substance Abuse Prevention & Control, Department of Health Services (all parts of the Los Angeles Health Agency), providers, and community-based partners in a steering committee. The committee will work together to develop the program design, determine the workflow, payment mechanisms, and identify quality measures.

## Step 3: Develop an Integration Model

Models of integrated care are generally thought of on a continuum from 'coordinated' to 'fully integrated' care.[16] In coordinated care models there is very little communication between behavioral

[16] SAMHSA—Center for Integrated Health Solutions. "A Standard Framework for Levels of Integrated Healthcare." April 2013.

and physical health providers, but there is some sort of recognition of the existence of the other. For example, a physical health provider conducts a substance abuse risk screening and, after a positive screening, refers the member to treatment. Care coordinators or navigators may also serve as a resource to help members connect behavioral and physical health services while not requiring significant practice change on behalf of either provider type.[17] Co-location, next along the continuum, requires behavioral and physical health providers to share a physical space. This could be in person or through telemedicine, but the functions of each provider type largely remain separate (e.g., locating a PCP in a behavioral health clinic). To move from co-location to integrated care, behavioral and physical health providers must communicate frequently in person about patients, use the same management and billing systems, and have roles and a culture that blend behavioral and physical health.[18]

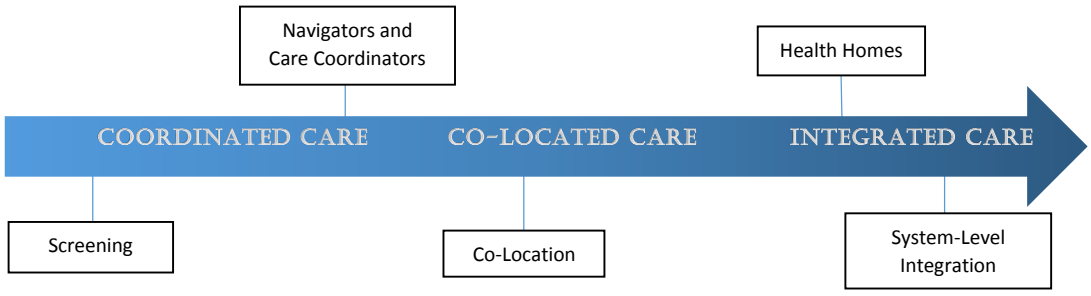



**Chart developed by the Kaiser Family Foundation**

Plans participating in the collaborative selected from the full range of integration models—proof that the model selected must reflect the local market conditions and willingness and capacity of a plan's providers to participate in an integrated care setting.

***Coordinated Care:*** For their Medicaid population, **L.A. Care Health Plan** provides behavioral health services for mild and moderate behavioral health conditions, but services for SPMI and substance abuse disorder (SUD) are carved out to Los Angeles County Health Agency so that the plan is not responsible for the specialty mental health and SUD portion of the behavioral health benefit package. In an effort to realign these different funding sources to provide whole-person care, L.A. Care developed their model around addressing the physical health needs of members with SPMI. People with SPMI who receive services from one of two pilot behavioral health clinics will be asked to change their primary care physician (PCP) to a PCP or a primary care clinic identified by the plan because of their willingness to provide physical health services to this population; all of L.A. Care's Medicaid members either select or

[17] Kaiser Family Foundation. "Integrating Physical and Behavioral Health Care: Promising Medicaid Models." February 2014.
[18] SAMHSA—Center for Integrated Health Solutions. "A Standard Framework for Levels of Integrated Healthcare." April 2013.

## THE COLLABORATIVE CARE MODEL

The Collaborative Care model is the model of care supported most thoroughly by evidence. Under this model, care is provided by a collaborative team of both physical and behavioral health providers as well as care managers. Patients are tracked in a registry and outreached using a population health-based approach. Treatments provided must be evidence-based and outcomes must be measured. The payment mechanism used to reimburse this model incentivizes improvements in quality and clinical outcomes.

The Advancing Integrated Mental Health Solutions, or AIMS Center, has many resources on this this model, including an implementation guide.

are assigned a PCP. The PCPs will visit the behavioral health clinics to provide care for their assigned members with SPMI. These PCPs are working closely with the behavioral health clinicians to create an integrated health community by working to address gaps in care in real time. Currently, the two behavioral health clinics only provide services for people with higher levels of mental illness. L.A. Care is encouraging the clinics to also hire behavioral health professionals who can provide services to individuals with mild to moderate behavioral health issues to ensure that as members' health needs change, they can remain within the same clinic community.

***Using Coordinators:*** **Amida Care** in New York, a Medicare Advantage Chronic Condition SNP (C-SNP) and a SNP in the state's Medicaid program providing services to individuals and their children with HIV/AIDS, employs External Care Coordination Specialists (ECCS) to address care gaps in primary care. Amida Care has an internal team—the Integrated Care Team (ICT)—that identifies care gaps based on claims data analysis and information reported by plan members and their physical and behavioral health providers. The ICT works with the ECCS to reach out to patients and providers to coordinate referrals, schedule appointments, and make sure that plan members keep their appointments. The ICT relays all this information to a Heath Home, for members who receive care in such a setting, so the Health Home can lead care coordination efforts.

**Staff of Amida Care's ICT:**
- **Care Coordinator (RN):** Team lead.
- **Health Services Specialist (AA/AS):** Care Coordinator's assistant; aids in documentation.
- **Case Manager Coordinator (BA/BS):** Completes the reassessments (must be completed every 180 days).
- **Pharmacy Technician (CPht):** Monitors patients' medication.
- **Community Health Outreach Worker:** Addresses social determinants.
- **Health Navigator:** Completes home visits.
- **Case Manager and Clinical Liaison:** Provides utilization management of behavioral health services and case management until a Health Home successfully engages and enrolls a member.

***Colocation:*** In Kentucky, **Passport Health Plan** supports co-location of a psychi, atrist and their assigned psychiatry resident in a rural primary care clinic one day a week. PCPs in the area have become comfortable managing the needs of people with mild and to moderate behavioral health conditions. Part of this is due to the dearth of behavioral health specialists in the area. The behavioral health specialists typically see patients with moderate to high levels of behavioral health need. While onsite, the specialists share an office with the PCPs. This

facilitates informal consultations with the PCPs while serving a training function for the resident. By having a residency program as part of this collocated site, the resident will learn about serving rural communities—and may consider staying in the region or serving a rural setting elsewhere, where behavioral health specialists shortages often persist.


The SAMHSA-HRSA Center for Integrated Health Solutions has developed a training curriculum for primary care providers delivering care in a mental health setting—it includes information on working with patients with SPMI.

***Integrated Care Setting and Telephonic Consultations:*** **Health Plan of San Mateo (HPSM)**, California's San Mateo County's community health plan for Medi-Cal (Medicaid) and other publicly funded health coverage programs, has developed the Total Wellness Program—a program consisting of behavioral health clinics with embedded primary care providers serving the SPMI population. The treatment team consists of behavioral health providers, primary care providers, nurse case managers, a health educator, and peer support staff. Together, the team develops holistic care plans for their patients. Behavioral health services are also embedded in several of HPSM's FQHCs for those with mild to moderate behavioral health conditions, under a program called the Primary Care Interface program. The makeup of the care team is similar to Total Wellness but the primary care provider takes the lead in directing the members' care at these sites. In both models, the primary care and behavioral health physicians do not share an electronic health record (EHR) system but they have access to the other's EHRs and are required to document accordingly. HPSM has access to all of the care plans so they can act as an extension of the care teams.

Health Plan of San Mateo also intends to set up a telephonic behavioral health consultation line for all of their primary care providers who are not practicing in an integrated care setting. They encourage all of their providers through a pay for performance (P4P) program to screen their members, using the PHQ-2 for depression, GAD2 for anxiety, and AUDIT-C for alcohol use. The call center will be available to primary care providers needing a behavioral health consultation for interventions, medication treatment, and referrals based on the results of the screenings.


Community Health Plan of Washington is integrating care using video conferencing both for provider-to-provider consultations as well as patient visits; a description of their approach is in ACAP's telemedicine paper.

## Step 4: Measure Integration Efforts

Measuring integration efforts can be broken into two overarching categories:

- Level of integration achieved both in terms of clinical and organizational functions; and
- Impact of integration interventions on outcomes.[19]


The Agency for Healthcare Research and Quality (AHRQ) has developed an Atlas of Integrated Behavioral Health Care Quality Measures; this includes a collection of measurement tools and surveys.

[19] Agency for Healthcare Research and Quality. "A Framework for Measuring Integration of Behavioral Health and Primary Care." June 2013.

Measures of integration efforts can include:

| Measure Category | Measure Type | Example |
|---|---|---|
| Integration Level Achieved | Structural | Do behavioral and physical health providers work comfortably together?[20] |
| | Process | Percentage of members receiving routine primary health care screening and associated interventions.[21] |
| Outcomes | Clinical | Emergency Room Utilization |
| | Functioning Level | Can you perform activities of daily living? |
| | Satisfaction | Percentage of patients satisfied with case management. |
| | Financial | Costs per member per month (PMPM) |

The population and model selected directed the measures collaborative plans selected.

**Children's Community Health Plan of Wisconsin**, a Safety Net Health Plan that provides Medicaid coverage in thirteen counties in eastern Wisconsin, has opted to embed care managers in two primary care clinics, including one pediatrician's office, to coordinate behavioral, physical, and social support services for their members. When analyzing their claims data, the most common co-occurring conditions were:

- Diabetes and depression;
- Depression and hypertension; and
- ADHD and asthma, for children.

The measures Children's Community Health Plan selected are aimed directly at improving health outcomes for members living with these conditions. They include:

| Type of Metric | Metrics Selected |
|---|---|
| Clinical | Emergency room utilization |
| | Utilization of behavioral health outpatient services |
| | Admissions to inpatient facilities, for both mental health and physical health conditions |
| | PAM (Patient Activation Measure) |
| | PHQ-9 (Depression Scale) |
| | GAD-7 (Anxiety Scale, if appropriate) |
| | Measures specific to diabetes, hypertension, and asthma |
| Cost | Per-member, per-month costs |
| Satisfaction | Home-grown member and provider surveys will be developed to measure the impact of the services |

[20] Agency for Healthcare Research and Quality. "Level of Integration Measure."
[21] SAMHSA—Center for Integrated Health Solutions. "PBHCI Candidate Measures." November 2012.

**CareSource's** measures focus on improving coordinated care for pregnant women in active treatment with one of 10 community mental health centers. Care managers are being deployed at these sites to help coordinate physical and behavioral health services for these women. The metrics they have selected to measure their efforts include:

CareSource is using their provider portal to both notify providers of care gaps and display how providers are doing relative to each other on selected quality measures. Part of the onsite care manager's duties include facilitating providers' use of the portal information.

| Type of Metric | Metrics Selected |
|---|---|
| Structural | Survey providers to determine if the level of care coordination has increased |
| Process | Members enrolled in case management, if appropriate |
| | Percentage of women engaged with the onsite case manager |
| Clinical | Emergency room utilization |
| | Prenatal and post-partum visit rates for women with identified Behavioral Health diagnoses (using HEDIS metrics) |
| Satisfaction | Select CareSource members complete a behavioral health satisfaction survey annually and will look towards reviewing the members associated to the 10 identified community mental health clinics versus the community mental health clinics with no onsite Care Management staff |
| Financial | Per-member per-month costs |

## Step 5: Determine the Payment Strategy

Although care coordination fee-for-service (FFS) codes are a payment option for integrated care models,[22] they do not do an optimal job at incentivizing activities at the core of coordinating care such as team huddles and informal consultations.[23] Moving to a value-based purchasing (VBP) approach has the potential to incentivize integration because providers are rewarded for activities that increase quality and decrease overall cost.[24]

CMS released a VBP framework that consisted of four categories: [25]

| Category | Definition | Examples[26] |
|---|---|---|
| Category 1 | FFS with no payment link to quality | FFS payments |
| Category 2 | FFS with a payment link to quality | Enhance payment with quality ties or P4P |
| Category 3 | Alternative payment models | Episode of Care Payment or Bundled Payments |
| Category 4 | Population based payment | Global Payment and Capitation |

[22] SAMHSA-HRSE Center for Integrated Health Solutions. Paying for Primary Care and Behavioral Health Services Provided in Integrated Care Settings.
[23] The Institute for Clinical and Economic Review. Enhancing Patient Outcomes and Health System Value through Integration of Behavioral Health into Primary Care. June 2015.
[24] Holly Korda and Gloria N. Eldridge. How Can We Bend the Cost Curve? Payment Incentives and Integrate Care Delivery: Levers for Health System Reform and Cost Containment. November 2011.
[25] Centers for Medicare and Medicaid Services. Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. January 2015.
[26] Kaiser Family Foundation. Medicaid Delivery System and Payment Reform: A Guide to Key Term and Concepts. June 2015.

However, payment approaches associated with higher-level VBP categories have not been implemented on a large scale for physical and behavioral health integration efforts at the provider level. So far, states with programs aimed at integrating behavioral and physical health services for their Medicaid population are only using shared risk for incentivizing those organizations more familiar with assuming risk such as MCOs and ACOs, while enhanced FFS payment is being used for all health home programs.[27]

CMS' aim is that over time more payers will move along the payment continuum, increasingly using payment methodologies in the higher categories (Federal and state programs are promoting, and even at times mandating, payers' use of VBP).

Plan considerations prior to selecting a payment approach include:

- ✓ The health plan's ability to quickly develop the claims systems to facilitate VBP;
- ✓ The willingness and ability of providers to accept VBPs; and
- ✓ Provider partners' financial competencies and reserves required to take downside risk.

It's difficult to set up VBP without understanding the utilization of care coordination services. Therefore, plans may want get experience using FFS codes for integration first. That experience will help inform the appropriate structure of VBPs.

Given these factors, most plans participating in the collaborative are using or intend to start by using a P4P model to incentivize providers. A few plans are moving beyond and contemplating implementing category 3 and 4 payment approaches.

***Pay for Performance:*** **UPMC *for You***, a Safety Net Health Plan in western and central Pennsylvania whose companion companies manage commercial, Medicare, and SNP lines of business, encourages providers to screen for depression, in particular for members with chronic medical conditions such as chronic obstructive pulmonary disease (COPD), diabetes, and inflammatory bowel disease. PCPs can select their own evidence-based tool; most chose the PHQ-9. Providers are paid for screenings using traditional FFS codes (GO444). UPMC reviews claims data for members with the identified conditions and,as part of a larger pay for performance effort, offers providers a quarterly quality bonus for conducting the screenings.

UPMC recognizes that completed screenings are a beginning rather than an end in and of themselves. Accordingly, they have invested in solutions for providers who identify someone with depression. Depending on the patients' needs, providers have access to the "Prescription for Wellness" program, which allows PCPs to write a "prescription" for care engagement by a UPMC health coach. The health coach is salaried by the health plan and works with members individually.

In addition, if PCPs need a consult based on the results of a screening, the UPMC system has co-located behavioral health specialists in dozens of primary care practices. A large contracted behavioral health provider network is also available for referrals. UPMC also makes available to all health plan members *Beating the Blue,* an evidence-based online tool for cognitive-behavior therapy.

[27] State Health Access Data Assistance Center. "Catalog of Medicaid Initiatives Focusing on Integrating Behavioral and Physical Health Care: Final Report." MACPAC. July 2015.

***Higher-Level VBPs:*** **Passport Health Plan** is working to develop an integrated care site and designing a phased-in approach to VBP because the provider, at the outset, will not have the financial viability to assume risk. The first phase will likely include a case rate with an opportunity to participate in shared savings as well as P4P. The second phase will consist of risk sharing. **L.A. Care Health Plan** is also contemplating implementing population management or global payment for their integration project.

## Conclusion

Although the concept of integrated physical and behavioral health care is not new, it is somewhat still in its infancy of being adopted on a large scale. Although intuitively it makes sense that providing coordinated care would improve health outcomes as well as decrease costs, the evidence supporting this claim is still under development. It is important that as providers and payers implement integrated care models they are thoughtful about the ways in which they measure the impact of their models. Positive quality and cost outcomes may take extended periods of time to be realized. Even if positive results are not there relative to cost and quality, the satisfaction of providers and members delivering and receiving coordinated care may be worth the practice transformation. Payers will continue to play an important role in helping to increase and sustain integrated care models in the future.

Looking for other toolkits like this one? Community Health Plan of Washington, along with one of their provider's Neighborcare Health, has developed a toolkit on their COMPASS model, Care of Mental, Physical and Substance use Syndromes. Their toolkit includes job descriptions, training resources, and other tools they use to operate their model.

*The Behavioral Health Integration Collaborative and this toolkit were made possible by a grant from the Open Society Foundations.*