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Medicaid Handbook: Interface with Behavioral Health Services

Module 6

Care Coordination Initiatives

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Module 6: Care Coordination Initiatives

The health care environment at the federal and state levels is ripe with ideas aimed at better coordination of consumer care. The coordination efforts are intended to improve delivery system performance and lower health care costs. At the federal level, such initiatives are virtually synonymous with the health care reform movement. States are implementing innovative health care delivery systems modeled on programs introduced in the Affordable Care Act or, in some instances, using those models to create something truly "home grown."

Coordinated and integrated health care models are discussed throughout this handbook. Organizationally, these issues are raised in several other modules. In particular, note the discussion of targeted case management in Module 3. Several dominant options are described below.

Emphasis on quality outcomes is a theme that consistently runs through the care coordination initiatives discussed in this handbook and one that is generally prevalent in Medicaid programs today. For example, as of the time of publication of this handbook, the Centers for Medicare & Medicaid Services (CMS) had been working closely with states for 2 years to support the voluntary collection of the initial core set of health care quality measures for children in Medicaid and the Children's Health Insurance Program (CHIP). Additionally, all states contracting with a Medicaid managed care plan must have a written and CMS-approved strategy for assessing and improving the quality of managed care services offered by the state. Moreover, as described further below, measurement of quality outcomes is an important platform of the success of the health home initiative included in the Affordable Care Act. The emphasis on quality in the Medicaid program reflects the recognition that delivery of high *quality* services to consumers should have priority over high *volume* of services.

Health Homes

Section 2703 of the Affordable Care Act adds §1945 to the Social Security Act and allows states the option of amending their Medicaid State Plans to provide health home services for enrollees with chronic conditions. The goal of this new initiative is improved integration and coordination of physical health, behavioral health, and long-term services and supports for individuals with chronic illness. CMS is working closely with the Substance Abuse and Mental Health Services Administration (SAMHSA), the HHS Assistant Secretary for Planning and Evaluation (ASPE), the Health Resources and Services Administration (HRSA), and the Agency for Healthcare Research and Quality (AHRQ) to ensure that state-proposed health homes are appropriately developed.[1]

The integration of physical and behavioral health care is critical to achievement of the enhanced outcomes that are required of health homes. The Affordable Care Act health home provision affords states the opportunity to build a person-centered care system, which results in improved outcomes for consumers and better services and value for state Medicaid programs and behavioral health agencies. Health homes are an important tool in addressing the needs of people with mental or substance use disorders (M/SUD). It is estimated that 70 percent of individuals in

this population have at least one chronic physical health condition; 45 percent have two; and almost 30 percent have three or more.[2]

States implementing a health home initiative will be required to measure outcomes. Although federal regulations regarding health homes were not finalized as of the publication of this handbook, CMS has shared a recommended core set of health care quality measures for assessing the health home service delivery model that it intends to promulgate in the rulemaking process. CMS chose the recommended core set of health home measures because they reflect key priority areas such as behavioral health and preventive care. The eight recommended measures are—

- Adult body mass index (BMI) assessment
- Ambulatory care sensitive condition admission
- Care transition—transition record transmitted to health care professional
- Follow-up after hospitalization for mental illness
- Plan—all cause readmission
- Screening for clinical depression and follow-up plan
- Initiation and engagement of alcohol and other drug dependence treatment
- Controlling high blood pressure[3]

A health home is a model of service delivery that coordinates and integrates all types of care needed by an enrollee: physical health care, behavioral health care, and long-term services and supports. Additionally, §2703 of the Affordable Care Act created six health home services that are also delivered through the health home model. *Health home services* are—

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
4. Individual and family support
5. Referral to community and social support services, if relevant
6. The use of health information technology to link services, as feasible and appropriate

States implementing a health home will receive 90 percent federal financial participation (FFP) for eight consecutive quarters from the effective date of the state plan amendment (SPA) for these six services; they will receive their regular FFP for these services after eight quarters. During and after the eight quarters, they will receive their regular FFP for other Medicaid-covered services delivered to the health home enrollee.[1]

States wishing to implement a health home can target one or all of the following populations—

- Individuals who have at least two chronic conditions
- Individuals who have one chronic condition and are at risk for another
- Individuals with one serious and persistent mental health condition

Chronic conditions, described in §1945(h)(2) of the Affordable Care Act include a mental and/or substance use disorder, asthma, diabetes, heart disease, being overweight as evidenced by a BMI over 25, or having another condition that is approved by the HHS Secretary.[1]

Section 1945(a) of the Affordable Care Act describes three types of *health home provider* arrangements that a state can use to deliver health home services: designated providers; a team of health care professionals, which links to a designated provider; and a health team.

- **Examples of providers that may qualify as a designated provider** include physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers (CMHCs), home health agencies, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined appropriate by the state and approved by the HHS Secretary. States may include additional providers in this category, including other agencies that offer behavioral health services.
- **Examples of the providers comprising a team of health care professionals** include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the state and approved by the HHS Secretary. These *teams of health care professionals* may operate in a variety of ways, such as in a free-standing, virtual, or hospital-based facility; community health center or CMHC; rural clinic; clinical practice or clinical group practice; academic health center; or any entity deemed appropriate by the state and approved by the HHS Secretary.
- **A health team** should be interdisciplinary and interprofessional. The team must include the following providers: medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers (including mental health providers and SUD prevention and treatment providers), doctors of chiropractic medicine, licensed complementary and alternative medicine practitioners, and physician's assistants.[1]

These arrangements afford states the flexibility to fashion the team and designated providers in ways that best address the populations it wishes to serve. This allows a unique opportunity to include peer counselors, navigators, recovering individuals, or other nonlicensed individuals who can offer unique experiences and insight.

The Affordable Care Act gives states considerable flexibility in designing their *payment methodology* for health home services. They may: (1) use a tiered payment structure that takes into account the severity of each person's conditions and the capabilities of the health home provider, (2) pay for health home services on a fee-for-service (FFS) or capitated basis, or (3) propose an alternate payment model for CMS approval. Whatever methodology is chosen, the state must include a comprehensive description of its rate-setting policies in its SPA.[1]

Because states have considerable leeway in designing their health home initiatives, examples of approved or submitted models provide insight into possible options. The following examples are specific to individuals with mental and/or substance use disorders.

Missouri (approved by CMS October 21, 2011)

- **Health Home Providers** are defined as CMHCs meeting state qualifications.
- **Delivery System** is managed care and FFS.
- **Target Population** includes: (1) individuals with serious and persistent mental illness (SPMI), (2) individuals with a mental or substance use disorder plus a chronic

condition, or (3) individuals with a mental or substance use disorder plus tobacco use. Chronic conditions include: asthma, cardiovascular disease, diabetes, having a developmental disability, or being overweight as evidenced by a BMI over 25.
- **Payment** is clinical care PMPM in addition to existing FFS or managed care payments for direct services. Administrative payment is included in the rate to support transforming traditional CMHCs into health homes. The state will make health home payments directly to health home providers. The state is interested in a shared savings strategy and performance incentive payments and plans to revisit the idea.[4]

New York (approved by CMS February 3, 2012)

- **Health Home Providers** are any interested providers or groups of providers that meet state-defined health home requirements; ensure access to primary, specialty, and behavioral health care; and support the integration and coordination of all care.
- **Delivery System** is managed care and FFS.
- **Target Population** includes: (1) individuals with SPMI; (2) individuals with two or more chronic conditions; or (3) individuals with HIV/AIDS and at risk for another chronic condition. Chronic conditions include: mental and/or substance use disorder, asthma, diabetes, heart disease, BMI over 25, HIV/AIDS, hypertension, and other conditions associated with 3M™ Clinical Risk Group.
- **Payment** is PMPM care management fee, adjusted based on region, case mix, and patient functional status (once the data become available).[4]

Rhode Island (approved by CMS November 23, 2011)

- **Health Home Providers** are Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Reevaluation (CEDARR) Family Centers that are certified to meet health home criteria. CEDARR Family Centers provide services to Medicaid-eligible children who are identified as having one or more special health care need.
- **Delivery System** is managed care and FFS.
- **Target Population** includes: (1) individuals with SPMI or serious emotional disturbance (SED), (2) individuals with two chronic conditions, or (3) individuals with one of the following conditions and at risk of developing another: mental disorder, asthma, diabetes, developmental disability, Down syndrome, or seizure disorder.
- **Payment** is an alternate payment method; the rate is developed based on level of effort required and the market-based hourly rate.[4]

Accountable Care Organizations and Coordinated Care Organizations

The Affordable Care Act contains two provisions that recognize the existence of accountable care organizations (ACOs)—one for providers of services to Medicare consumers and one for pediatric providers, including those reimbursed by Medicaid. Medicare ACOs are much more thoroughly defined in federal law and regulations than are pediatric ACOs. The federal law gives states considerable authority to define parameters for pediatric ACOs.

An ACO is an organization of providers such as hospitals, physicians, and others involved in patient care that shares responsibility for coordinating and providing care to patients and is accountable for the care of consumers assigned to it. ACOs are organized around the principles of: (1) patient-centered aims (defined as better overall health through higher quality care and lower costs for patients); (2) provider accountability through transparent performance measures that reflect those aims; and (3) payment reform that uses the measures to align provider support with the aims.[5]

The parameters of Medicare ACOs are specifically identified in the Affordable Care Act and the rules that accompany it.

- Key characteristics include a formal legal structure with a governing board that is responsible for measuring and improving performance and a strong primary care focus.
- The organization is based on a shared savings and shared loss model. The benchmark is based on an estimate of what the total expenditures for the group of beneficiaries would have been without the ACO; the ACO gets shared savings if its actual costs are lower, but it must pay if they are higher.
- Primary care providers may only participate in one ACO, although hospitals and other providers may participate in more than one.
- The ACO must meet established quality and performance measures. Providers are removed if they fail to meet quality standards.
- ACOs are required to have a minimum patient population of 5,000.
- Patients are not required to seek care *in network*. Although providers will likely want to refer patients to hospitals and specialists within the ACO network, patients would be free to see doctors of their choice outside of the network without additional payment.[6]

Pediatric ACOs are discussed in Module 7.

Although many providers find the goals of the ACO to be laudable, there is significant criticism that the cost to establish one is prohibitive and that the structural requirements described in the Affordable Care Act are too prescriptive. According to the American Hospital Association, "the costs of the necessary elements to successfully manage the care of a defined population is considerably higher—$11.6 to $26.1 million—than the $1.8 million estimated by the Centers for Medicare & Medicaid Services (CMS)."[7]

Because providers will become aligned together to form ACOs, there are also antitrust concerns In order to clarify their antitrust enforcement policy regarding collaborations among independent providers that seek to become ACOs in the Shared Savings Program, the Federal Trade Commission and the Antitrust Division of the Department of Justice released the Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program. The antitrust analysis of ACO applicants to the Shared Savings Program seeks to protect both Medicare beneficiaries and commercially insured patients from potential anticompetitive harm while allowing ACOs the opportunity to achieve significant efficiencies. CMS will provide the Federal Trade Commission and the Antitrust Division of the Department of Justice with aggregate claims data regarding allowed charges and fee-for-service

payments for all ACOs accepted into the Shared Savings Program as well as copies of all of the applications to the Shared Savings Program of ACOs formed after March 23, 2010. The Federal Trade Commission and the Antitrust Division of the Department of Justice will vigilantly monitor complaints about an ACO's formation or conduct and take whatever enforcement action may be appropriate. The statement describes (l) the ACOs to which the Policy Statement will apply; (2) when the Federal Trade Commission and the Antitrust Division of the Department of Justice will apply rule of reason treatment to those ACOs; (3) an antitrust safety zone; and (4) additional antitrust guidance for ACOs that are outside the safety zone, including a voluntary expedited antitrust review process for newly formed ACOs. Additionally, upon request, the Federal Trade Commission and the Antitrust Division of the Department of Justice will provide an expedited 90 day review for newly formed ACOs that wish to obtain additional antitrust guidance.[8]

Some state Medicaid agencies have begun to develop health care delivery systems that *look like* ACOs, but are slightly different. Oregon, for example, is on the leading edge of this movement and recently won CMS approval to implement coordinated care organizations (CCOs). CCOs are similar to ACOs in some ways. They are community-based organizations using patient-centered primary care homes, fixed global budgets, and efficiency and quality improvements to reduce costs. Unlike ACOs, CCOs may function as a single corporate structure or a network of providers that are organized through contractual relationships.[6]

In Oregon, each city will have its own umbrella group (the CCO) charged with caring for the Medicaid population. Under these umbrellas will be hospitals, doctors, mental health providers, and dentists, as well as providers of community supports. The vision is that all health care businesses will stop competing for patients and will be linked electronically so that health care providers can share information. Patients then can choose whatever provider they need to get the best care. The sickest people will have outreach workers to help them navigate the system and avoid costly hospitalizations. These outreach workers will manage a caseload of about 30 patients.[9] The CCO will be paid with a lump sum (called a *global budget*) to manage a population of Medicaid patients.

Like an ACO, CCOs have quality standards, and providers may be removed for failure to meet them. Unlike ACOs, providers may participate in more than one CCO. In a CCO, the emphasis is on hiring community health workers, prevention, and traditional medical and nonmedical components of health (e.g., housing, transportation). In short, a CCO is a more *organic* version of an ACO. States are engaged in developing and defining models.

Money Follows the Person

The Money Follows the Person (MFP) Rebalancing Demonstration was enacted as part of the Deficit Reduction Act (DRA) of 2005. It is part of a comprehensive, coordinated strategy to assist states in reducing their reliance on institutional care while developing community-based long-term care opportunities.[10] Federal MFP rules specify five population groups that are eligible to participate in the MFP program: (1) individuals over age 65, (2) individuals with disabilities under age 65, (3) individuals with intellectual disabilities, (4) individuals with serious mental illness (SMI), and (5) others, such as individuals with two or more primary diagnoses and those who do not fit into one of the other four groups.[11]

As of 2007, the vast majority of MFP-eligible individuals (75 percent) were classified as age 65 or older and living in a nursing home; another 15 percent were individuals younger than age 65 living in a nursing home. Almost 9 percent were living in an intermediate care facility for the developmentally disabled, whereas just .8 percent were individuals younger than age 22 residing in an inpatient psychiatric hospital and .4 percent were individuals age 65 or older living in a mental hospital.[11] Because federal law prohibits Medicaid reimbursement for services provided to residents aged 22 to 64 years who reside in institutions for mental disease (IMDs), it is very likely that a portion of these individuals are participating in the MFP program but living in a place other than a facility likely to be classified as an IMD (e.g., a mental hospital). IMDs are discussed more thoroughly in Module 4.

Under the MFP grants, states must maintain: (1) a transition program that identifies Medicaid beneficiaries in institutional care who wish to live in the community and helps them do so, and (2) a rebalancing initiative that invests the enhanced federal matching funds MFP programs receive into programs and services that increase, relative to institutional care, the proportion of Medicaid long-term care expenditures flowing to community services and supports.[12]

MFP is a valuable opportunity for states because the program offers significant flexibility in determining the populations they want to transition out of institutional settings, the services they want to offer in the community, and how they want to use their grant money to accomplish set goals. For example, a state may use its funds to pay the first month's rent and security deposit for an individual transitioning from a mental hospital to an apartment. Or, a state may use its funds to pay a transitioning individual's unpaid utility bill that would otherwise prevent the individual from receiving a necessary utility service—such as electricity or water—in his or her new apartment.

Because states are developing their MFP programs very differently and at different paces, universal success is difficult to measure. However, a 2011 report published by Mathematica Policy Research—the entity with which CMS contracts for evaluation of state implementation efforts—shares the following statistics on the success of state MFP programs:

- Forty-three states and the District of Columbia have been awarded MFP demonstration grants—31 in 2007 and 13 in 2011. The first three MFP programs began transitioning participants in late 2007, and 30 programs were fully operational by the end of 2009. In calendar year 2010, the MFP demonstration grew to a total of nearly 12,000 transitions from institutions to community living and community-based care. Considering the amount of work it takes to transition just one individual, this is phenomenal progress.
- In 2010, on average, states were spending approximately $31,000 on home and community-based services (HCBS) per MFP participant. This per-person spending is more than one-third lower than that of average annual Medicaid spending on institutional care for elderly beneficiaries residing in nursing homes for at least 3 months, but nearly twice the per-person HCBS costs among all Medicaid beneficiaries and one-third greater than the HCBS costs of those in §1915(c) waiver programs. The greater per-person expenditures for MFP participants may partly reflect the additional services these beneficiaries receive; approximately one-third of the expenditures for MFP participants are spent on MFP demonstration or

supplemental services that states provide participants during the first year after they return to community living.

- When compared to beneficiaries who transitioned to the community in 2006 before the program began, MFP participants were far younger and less likely to be reinstitutionalized or die during the year after their transition.[12]

As originally conceived, in order to qualify for the MFP program, individuals were required to reside in an institution for 6 months. By the time an individual has been in an institution for 6 months or longer, the hurdles to his or her successful transition to the community are significant. By 6 months, many will have lost their living arrangement, household belongings (e.g., pots and pans, bedding, other items) may be dispersed, and their social network is weakened or nonexistent. The Affordable Care Act extends the MFP demonstration through September 30, 2016, and adjusts the amount of time an individual must be institutionalized in order to take advantage of the program from 6 months to 90 consecutive days.[13]

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive long-term services and supports to individuals enrolled in both Medicaid and Medicare. PACE serves individuals who are aged 55 years or older, certified by their state to need nursing home care, able to live safely in the community at the time of enrollment, and live in a PACE service area.[14]

Under the PACE program, an interdisciplinary team of health care professionals provides coordinated care to enrollees. For most enrollees, the comprehensive service package enables them to receive care at home rather than in a nursing home.[15] Although all PACE participants must be certified to need nursing home care, only about seven percent of participants nationally reside in a nursing home.[15]

Financing for the program is capitated, which allows providers to deliver all services that participants need rather than limit them to those reimbursable under Medicare and Medicaid FFS plans. The capitated funding arrangement rewards providers that are flexible and creative in providing the best care possible.[15]

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