



Measuring Physical and Behavioral Health Integration: A Look at State Approaches in the Context of Value-Based Purchasing

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Introduction

The case for an integrated approach to care—one that can seamlessly and collaboratively address patients’ physical and behavioral health needs—is compelling. Individuals with behavioral health conditions, either a mental health diagnosis, a substance use disorder, or both, are some of the Medicaid’s most costly enrollees.¹ Analyses indicate this subset of high-cost enrollees typically has a complex combination of chronic physical and behavioral health conditions. Comprehensive and effective treatment for this population is challenging, due to siloed systems, access issues in behavioral health, and fee-for-service payment methodologies that do not support the integrated care of people with complex needs. Physical and behavioral health integration as a clinical approach presents an opportunity to promote quality, enhance access, and lower costs.² Research indicates that integrated care management strategies such as health homes³ and evidence-based models such as Collaborative Care^{4, 5} can improve outcomes for people with complex, co-morbid physical and behavioral health conditions while potentially reducing costs.

What is Integrated Care?

What does integration look like within the state context? The Agency for Healthcare Research and Quality’s Lexicon for Behavioral Health and Primary Care provides some broad parameters, defining physical and behavioral health integration within the primary care setting as “care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.”⁶

For additional resources on integrated care definitions, see [The Agency for Healthcare Research and Quality: Academy for Integrating Behavioral Health and Primary Care](#) and the [SAMHSA-HRSA Center for Integrated Health Solutions](#).

Through Medicaid payment incentives, regulatory reform, learning collaboratives, and other policy levers, state policymakers—in partnership with key stakeholders—are increasingly supporting integrated care approaches to address the needs of high-cost, complex Medicaid populations. Concurrently, policymakers are moving Medicaid payment strategies toward value-based purchasing (VBP) methodologies that incentivize quality—as defined through an agreed-upon set of key quality measures—while reducing the total cost of care for the target population. For states, these initiatives and investments raise questions: is the care being delivered actually “integrated”? And will these efforts sustainably reduce costs and improve quality?

This brief focuses on how three states—Alabama, Maine, and New York—are designing their measurement strategies to better understand the answers to these questions. These states were selected to highlight diverse state approaches in measuring integration that encompass both delivery system and payment reform strategies.

Key Findings:

- Leading states are taking a multi-level, multi-modal approach to measuring the implementation and effectiveness of integration.
- While specific measures vary, state value-based purchasing initiatives include behavioral health measures focused on a few key conditions.
- States are interested in moving away from a focus on process toward more outcome-oriented measurement for physical and behavioral health integration.
- States are exploring the use of measures beyond national measure sets to capture social determinants of health and behavioral health recovery.

Overview of State Approaches to Measuring Integrated Care in the Context of Value-Based Purchasing

State policymakers are taking a multi-level approach to physical and behavioral health integration: creating accountability for integrated care by embedding both physical and behavioral health measures in Medicaid payment reform strategies, building capacity for integrated care through targeted delivery system reforms, and then, often using contract and regulatory language to create alignment across strategies. In NASHP’s analysis of three states—Alabama, Maine, and New York—we found that these states favor nationally validated measures in their payment reform initiatives. In contrast, states are measuring the transformation of delivery systems through a combination of state-specific and nationally validated structural, process, and outcome measures. NASHP provides a brief overview of each state’s payment reform initiative, followed by a description of delivery system transformation efforts that focus on physical and behavioral health integration. Additional information about each state, including a selection of behavioral health measures used across specific initiatives, is included in Appendix A.

Defining Measurement

States highlighted in this brief use different kinds of measures to track the transformation of delivery systems toward more integrated care, and to identify the outcomes of those efforts for value-based purchasing. These measures may be state-specific, or may be drawn from nationally validated measure sets, such as the National Quality Forum (NQF), or validated survey tools, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS). In this brief, we also differentiate between outcome, process, and structural measures⁷:

- Outcome measures assess results of care (e.g., percent of patients that had controlled cholesterol)
 - Process measures assess whether an action occurred (e.g., percent of patients that received depression screening)
 - Structural Measures assess the conditions under which the provider is providing care (e.g., patient-centered medical home certification, presence of an EHR)
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Alabama

Through a 1115 waiver, Alabama is implementing significant payment reform initiatives, building on system delivery reforms already underway.

Payment reform: Alabama is in the process of implementing Regional Care Organizations (RCOs), which will contract with local providers and be responsible for controlling costs and improving quality. RCOs will be charged with developing robust provider networks capable of providing comprehensive and coordinated physical and behavioral health services to Alabama's Medicaid population. RCOs will receive per member per month payments, a percentage of which will be withheld and returned based on performance tied to quality metrics. RCOs will also have the opportunity to share in savings or losses. Alabama aims to incentivize integrated care in this model through the use of targeted outcome measures: nine of the 42 measures that RCOs will report are related to behavioral health and/or integrated care; two of the 10 linked to payment relate to behavioral health. Additionally, RCOs, which will include health home providers, will be required to contract with community mental health centers and provide specific services, including case management and behavioral health care coordination, to their attributed members.

Delivery System Reform: As part of Alabama's 1115 waiver, the state is investing in Integrated Provider Systems (IPS) to be the engine for more coordinated and integrated delivery systems. Through waiver funding, IPSs will build capacity to support one or more of the state's demonstration objectives: improved prevention and management of chronic disease; improved access to and care coordination of health services; improved birth outcomes; and healthcare delivery system financial efficiency.⁸

Moreover, RCOs are built on Alabama's health home program, which targets Medicaid beneficiaries with one or more serious mental illness (SMI) diagnoses, two or more chronic conditions, or one chronic condition with the risk of developing a second. Through health homes, practices are incentivized to integrate care through a combination of process, structural, and outcome measures, including use of health information technology (HIT), establishment of a multi-disciplinary care teams, and specific integrated care components, including joint training with community programs.⁹ Other quality metrics for Alabama health homes reflect the CMS core set¹⁰, and include behavioral health and integrated care measures such as follow-up after hospitalization for mental illness, care transitions, initiation and engagement of alcohol and other drug dependence treatment, and screening for clinical depression and follow-up.

Alabama ties delivery system investments and payment reform initiatives together through alignment of quality measures and through various programmatic requirements. IPS projects must select from the RCO measure set when identifying measures to track progress toward IPS project goals; the state also fosters alignment through the use of two common behavioral health measures in both the health home program and the RCO initiative. Program requirements ensure that RCOs are the lead entities for IPS projects, and providers must contract with RCOs in order to participate in these capacity-building projects. RCOs are also required to partner with health homes.

Maine

Maine incentivizes integrated behavioral health and primary care in both its delivery system and payment reform approaches.

Payment Reform: Maine's VBP strategy focuses on Accountable Communities (ACs), which are responsible for managing care for an assigned population of Medicaid members. ACs must include pri-

mary care providers, as well as certain specialty providers that serve individuals with specific chronic conditions, developmental disabilities, and/or behavioral health needs.¹¹ ACs are paid through one of two models: in one model, participating ACs may share in savings that result from the AC's ability to manage total cost of care and meet or exceed performance benchmarks on quality measures. The second model offers the AC a higher percentage of potential shared savings, but also includes some downside risk if the AC does not meet its savings target. ACs are incentivized to integrate care through the need to control costs and perform well on quality measures in order to earn a portion of any cost savings. Two of seven elective performance measures are tied to behavioral health, while six of the 14 required measures are tied to care coordination.

Delivery System Reform: Building on its multi-payer patient-centered medical home program, the state has also developed two health home programs—one that targets a broad population of members with chronic conditions, and one that has a specialized serious mental illness/serious emotional disturbance (SMI/SED) focus. Providers participating in these programs (which include primary care practices, community mental health centers, and community care team (CCT) providers) must meet 10 core standards and other requirements, many of which focus on building care management and integrated care capacity.^{12, 13} For instance, providers must perform a baseline assessment of their integrated care capacity and work toward implementing policies and processes that integrate physical and behavioral health care services. Providers must commit to behavioral health screening, and use of an integrated data set for population-based health management. Both health home programs are tracked using a measure set built on the Health Home Core Measure set that includes behavioral health.¹⁴ In the chronic care health home program, four out of 23 clinical quality measures relate to behavioral health, while in the behavioral health home program, 10 of the 38 clinical quality and patient satisfaction measures relate directly to behavioral health and integrated care.¹⁵ For the SMI/SED population, Maine is also developing recovery-oriented measures that relate to housing, employment, and functional status. Data will be pulled from various sources, including a survey targeting individuals who use the service, and information tracked by the state's administrative services organization.

In order to align integrated care incentives across delivery system and payment reforms, Maine requires ACs to contract with behavioral health and community providers connected to its health home model, if associated primary care practices are included in the AC system. Additionally, Maine has worked to align performance measures between its Accountable Communities and Health Homes programs: both behavioral health-related performance measures reported by ACs are present in the measure sets for both health home programs.

New York

New York is promoting integrated care through myriad initiatives, targeting both payment reform and service delivery transformation.

Payment Reform: The state's integrated managed care plans are tracked on 74 measures reported out through the system's Quality Assurance and Reporting Requirements program (QARR). Thirteen out of 74 measures relate to behavioral health and integrated care. New York's managed care plans can earn supplemental incentive payments based on their performance on a subset of 28 quality incentive

measures, six of which are related to behavioral health. Specialty behavioral health managed care organizations (MCOs), called Health and Recovery Plans (HARPs), provide integrated behavioral health and primary care services for individuals with serious mental health conditions. HARPs, like the state's traditional managed care plans, will begin to report on QARR metrics in 2016 and are eligible to receive supplemental incentive payments based on performance on a subset of these measures. HARPs will also be required to report on home and community based services (HCBS) performance measures. In addition, the state is currently considering incorporating recovery-oriented measures related to housing, employment, and corrections involvement.¹⁶

Delivery System Transformation: Beyond the state's managed care VBP strategy, New York's Delivery System Reform Incentive Payment (DSRIP) 1115 waiver supports the creation of performing provider systems (PPS)—providers and hospitals that join together to provide comprehensive care to an attributed group of patients. PPSs can earn supplemental payments based first on reporting and then performance on structural, process, and outcome measures across four domains (see box). Sixteen PPS quality measures relate to behavioral health and/or integrated care. Of those measures, 12 are common to the 2016 QARR for managed care plans.^{17, 18} PPSs are required to take on quality improvement initiatives, many of which relate to behavioral health integration.

New York's DSRIP Measurement Strategy

Domain 1 – Organizational Measures and Health Home Measures

Domain 2 – System Transformation

Domain 3 – Clinical Improvement

Domain 4 – Population-wide Measures¹⁹

New York supports and incentivizes integrated delivery system capacity through advanced primary care, patient-centered medical home, and health home models. Practice capacity and performance are tracked through a combination of process, structural, and outcome measures. Health homes, for instance, must report on process and structural measures tied to care management, patient engagement, and development of integrated care plans, among others, to support Medicaid beneficiaries with mild-to-moderate behavioral health conditions as well as individuals with SMI.²⁰ In addition to the measures included in the Health Home Core Measure Set, New York health homes are also tracked on utilization of certain mental health services, follow up after hospitalization for mental illness, and other behavioral health measures.²¹ Six out of seven of the measures related to behavioral health in New York's health home measure set are common to the QARR for managed care plans and the DSRIP measure set for PPSs.

Beyond the use of common measures, New York has woven integrated care incentives across delivery system and payment reforms in a number of ways. The state's menu of MCO VBP models specifically includes an integrated primary care approach focused on practice outcomes. MCOs may enter into arrangements with value-based purchasing contractors, which in turn support integrated care through system transformation and other measurement domains. The aforementioned PPSs are not necessarily contracting entities, but may enter into VBP contracts if they become independent practice associations, accountable care organizations, or another recognized contracting entity. Both the MCOs and the PPSs work with patient-centered medical homes, health homes, and other providers that have built integrated

care capacity through state Medicaid payment incentives and other investments. The PPSs report on member engagement with health homes, while the MCOs are required to ensure adequate access to health homes for their members.²²

Key Findings

Although the states highlighted in this brief have taken diverse approaches to measuring integrated care capacity and outcomes, recurring themes emerged in review of these efforts that may be helpful to other states engaged in similar system delivery and payment reform initiatives. The following are a few common themes and lessons learned from highlighted states:

Leading states are taking a multi-level, multi-modal approach to measuring the implementation and effectiveness of integration.

States are using a number of policy levers to promote integrated physical and behavioral health care, and these diverse policy levers require different approaches to measurement:

- States are incorporating both physical and behavioral health measures into their VBP quality strategies to ensure alignment with integrated care initiatives and to promote accountability for whole-person care. States rely heavily on nationally validated measures for VBP.
- States are building integrated care capacity in delivery systems, and using diverse approaches, in addition to nationally validated measures, to track and measure this transformation. (See **text box** for some of the recurring process and structural measures states use to track provider transformation to integrated care.)
- States use contracts and/or regulations to promote systemic cohesion across delivery system and VBP initiatives. New York requires its MCOs to partner with a sufficient number of health homes to provide this integrated care model to their identified population. The state's Performing Provider Systems – the DSRIP reform vehicle – are also measured by member participation in the Health Homes program. Maine's ACs are required to partner with Community Care Teams and Behavioral Health Homes if they are also partnering with the primary care practices associated with those providers. Meanwhile, Alabama is offering RCO-contracted providers funding through IPS to support infrastructural changes that will allow practices to better align how they provide care with broader delivery system reform goals and objectives.

While specific measures vary, state value-based purchasing initiatives include behavioral health measures focused on a few key conditions.

To support integrated models of care, states tend to select behavioral health measures focused on a few key conditions, depending on the target population. For instance, broad-based Medicaid VBP initiatives typically include one or more measures targeting depression. If children are a part of the target population, measure sets may include behavioral health screening or measures related to management of ADHD. Initiatives that include populations with more serious mental illness may include medication adherence measures or measures that track key health outcomes in individuals using antipsychotic medications. (See **text box** for more detail on these common domains and measures.)

Recurring National Measures

Mild-to-Moderate Behavioral Health Conditions

- Antidepressant medication management (NQF #0105)
- Screening for clinical depression and follow-up plan (NQF #0418)
- Initiation of alcohol and other drug dependence treatment (NQF #0004)
- Follow-up care for children prescribed ADHD medication (NQF #0108)

Severe and Persistent Mental Illness

- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (NQF # 1932)
- Cardiovascular monitoring for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (NQF #1927)
- Adherence to antipsychotic medications for individuals with schizophrenia (NQF #1879)
- Follow-up after hospitalization for mental illness (NQF #0576)

Care Coordination

- Timely transmission of transition record (discharges from an inpatient facility to home/self care or any other site of care) (NQF #0648)
- HBIPS-6 Post discharge continuing care plan created (NQF #0557)
- HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge (NQF #0558)

States are exploring measures that can capture social determinants of health and behavioral health recovery.

State policymakers interviewed for this brief acknowledge that straying from nationally validated, claims-based measurement is challenging. State-specific measures often involve additional reporting burden for providers, data may be difficult to standardize, and the measures may not have an established evidence base to justify their use, which is especially important when outcomes are linked to payment. However, state policymakers expressed interest in finding and using more measures that track recovery from behavioral health disorders and progress on social determinants of health. New York's HARPs, for instance, will be required to incorporate home and community-based service requirements into their reporting. The state is also considering the use of recovery-oriented measures that capture information on housing and employment. Similarly, Maine plans to measure housing, employment, and functional status in its Behavioral Health Homes program.

States are interested in moving away from a focus on process toward more outcome-oriented measurement for physical and behavioral health integration.

State interviewees recognize that investing in infrastructure to support physical and mental health integration requires tracking changes in the delivery system that are process-oriented (e.g., the use of health information technology or consistent screening for behavioral health needs). However, state policymakers note the need to transition over time to a measurement strategy that focuses on more population-based outcomes and less on the processes that support those outcomes.

Recurring Structural and Process Measures Tracking Integration Capacity

Structural Measures

- PCMH or other advanced primary care practice accreditation
- Development of multi-disciplinary teams, including behavioral health capacity
- Care management/care coordination capacity
- Existence of formal agreements with primary care and/or behavioral health providers
- Information-sharing protocols with primary care, behavioral health and/or other community providers
- Identified point of contact/liaison with community providers
- Electronic health records

Process Measures

- Mental health and substance use disorder screening
 - Use of population-based tools or disease registries
 - Use of integrated care planning tools
 - Participation in learning collaboratives and/or workforce training
 - Use of health information exchange
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Considerations for State Policymakers in Measure Selection

Discussions with featured states yielded the following considerations for other state policymakers contemplating measure selection for integrated care initiatives:

What measures are already in use? State Medicaid agencies and the plans and providers with whom they contract are awash in measure sets, including Meaningful Use, the health home core set, the CMS Adult and Child Core Set, Healthcare Effectiveness Data and Information Set (HEDIS) measures, and others. State policymakers noted that adding additional measures is not usually needed, but that using subsets of measures already in use, and/or using these measures in new ways to improve care, can be an efficient approach. (For more information on which measures these three states are utilizing and for what purposes, please see Appendix A.)

Do measures align across initiatives? Similarly, all states reported alignment across initiatives as an important consideration when developing their measurement strategy. In Maine, for instance, state policymakers made an effort to align Accountable Communities measures with those of health homes, in order to focus provider efforts as much as possible. The state also developed its quality strategy for health homes in concert with the state multi-payer Patient-Centered Medical Home for further consistency at the provider level.

Do state initiatives support and align with outcomes? State initiatives and investments should work synergistically to support defined outcomes. In Alabama, for instance, state investments in health homes support overarching goals (and measures) in their RCO initiative. Many of the health home administrative entities have been selected to become RCO administrative entities.²³ In both New York and Maine, targeted delivery system investments (health homes, PCMH, and others) are seen as foundational to the success of VBP reform.

Is the state measuring change or measuring outcomes (or both)? Integrated VBP approaches require states to identify key outcomes that can be linked to payment, to hold participating entities accountable for improvements in care and for cost savings across both physical and behavioral health domains. For that function, nationally validated measures with clear and reliable data specifications—that may also align with other payers—are a good choice. States may also be interested in assessing the degree or amount of change in system delivery, in order to justify enhanced payments or ensure alignment with state transformation efforts. For this, state policymakers may want track specific structures or processes that indicate whether or not change is happening, such as the existence of shared care planning, the use of integrated health data for population-based monitoring, or partnerships and co-location strategies involving behavioral health or physical health providers.

Is the data available (and usable)? Key informants noted the need for more nuanced “measures that matter,” particularly in the behavioral health domain. Nationally validated, largely claims-based measures are a critical tool for state policymakers, but may not fully assess integrated care initiatives. Recent research in this area notes a dearth of measures that address integrated care initiatives in particular.²⁴ For example, claims-based measures may not adequately capture the indicators of recovery, often what matters most to patients and providers. However, data that is not readily accessible through claims can be expensive and complex to obtain, standardize, and use (e.g., patient record reviews, provider reporting, clinical data from electronic health records, etc.) State policymakers may want to explore what, if any, standardized data is already collected by other state agencies and could be leveraged for integrated care initiatives. New York, for instance, plans to incorporate assessment and reporting data currently gathered through the state’s home and community based services system as part of the HARP’s quality reporting. Maine is planning to use consumer surveys originally developed by the state’s mental health agency in support of its Behavioral Health Home model for children and adults.

Conclusion

Many states are working rapidly to develop policies and programs that promote the integration of behavioral health and physical health as a means to provide higher quality care at lower costs. To accomplish this, states are considering how to incentivize integrated care through VBP efforts already underway or in development. Analysis of the work of three states and how they approach the measurement of physical and behavioral health integration indicates that, while states take diverse approaches, common themes arise:

- States are taking a multi-level, multi-modal approach to measuring the implementation and overall effectiveness of integration, using a combination of structural, process, and outcome measures.
- While specific behavioral health measures may vary across states, Medicaid value-based purchasing initiatives include behavioral health measures focused on a few key conditions, such as depression.
- Nationally-validated, claims-based measures dominate state value-based purchasing measure sets, but states are also exploring the use of measures outside of national measure sets to capture social determinants of health and behavioral health recovery.

Endnotes

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Appendix A: Summary of Delivery System and Payment Reform Efforts Tied to Physical and Behavioral Health Integration

Approach overview	Authority	Payment Incentive Strategy	How measures tie to payment	Key metrics related to integration
<p>ALABAMA</p> <p>Target Population(s): All Medicaid beneficiaries, except the aged, blind, disabled population and foster children</p>				
<p>Regional Care Organizations (RCOs): Integrated regional entities, which contract with local providers to provide care, responsible for controlling costs while improving quality</p> <p>Source: http://medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Topics_Issues/2.7.3_RCOs/2.7.3.1_RCO_QA_Committee/2.7.3.1_FY17_RCO_Incentive_Quality_Measures_v2.0_9-6-16.pdf</p>	<p>State law; 1115 waiver</p>	<ul style="list-style-type: none"> Per-member-per-month (PMPM) payment to RCOs; 2.5 % of capitated payment subject to withhold based on performance on quality metrics Opportunity for shared savings/ shared losses based on performance on quality measures and spending. 	<p>RCOs report on 42 quality metrics; 10 of those 42 are tied to the quality-based withhold</p>	<p>Financial Incentive Metrics:</p> <ul style="list-style-type: none"> Follow up after hospitalization (within 30 days, behavioral health related primary diagnosis) Antidepressant medication management Care Transition – Transition record transmitted to health care professional <p>Select Non-Financial Incentive Metrics:</p> <ul style="list-style-type: none"> Developmental screening in the first three years of life Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Follow-up care for children prescribed ADHD medication Screening and follow up for depression Child and adolescent major depressive disorder: suicide risk assessment Diabetes screening for people with schizophrenia or bipolar disorder using antipsychotic medications Adherence to antipsychotic medications for individuals with schizophrenia Hospital-based Inpatient Psychiatric Setting patients: care plan created and transmitted to next level of care provider

MAINE				
Target Population(s): General Medicaid Population; Individuals with specified chronic conditions; Adults and children with significant mental health needs				
<p>Accountable Communities (AC): Maine Medicaid contracts with organizations that serve as lead entities for the accountable community; AC must contract with primary care providers (PCPs), and at least one provider in each of the following categories: behavioral health, developmental disability, and chronic care. Payment to ACs comes from shared savings based on its total cost of care (TCOC) and performance on quality benchmarks, as earned. If AC providers include health home practices, practices' community care teams and/or behavioral health home partners must be invited to participate.</p> <p>Source: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/2015%20AC%20Pres%20for%20VBP%20Site.pdf</p>	<p>State Plan</p>	<p>Choice of 2 models: Model I - requires minimum of 1,000 members; shared savings capped at 10% of benchmark TCOC; no downside risk.</p> <p>Model II - requires minimum of 2,000 members, shared savings capped at 15% of benchmark TCOC; some downside risk.</p>	<p>Maine has 14 core and 7 elective measures; domains include at-risk populations, care coordination/patient safety; patient experience; preventive health. Each measure has a benchmark; ACs earn points for minimum attainment level or better.</p>	<ul style="list-style-type: none"> • Follow-up after hospitalization for mental illness • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. • CORE: Developmental Screening - First Three Years of Life

<p>Health Homes for individuals with chronic conditions: State plan Option supports payment to primary care providers and community care teams for care coordination and other health home services</p> <p>Source: https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html</p>	<p>State Plan Amendment</p>	<p>PMPM</p>	<p>Health Home providers are tracked on a number of process and structural measures in order to participate in the program and access PMPM payments.</p>	<p>State-Selected Measures in SPA (in addition to the Health Home Core Measure set):</p> <ul style="list-style-type: none"> • During the second year of MaineCare participation as a Health Home practice and annually thereafter • Depression and substance abuse screening (PHQ9 and AUDIT, DAST) for all adults with chronic illness, and substance abuse screening (CRAFFT) for adolescents. • Children age 1 to 3, and the MCHAT 1 for at least one screening between ages 16-30 months with a follow-up MCHAT 2 if a child does not pass the screening test. • State’s ten core standards for health homes, including: <ul style="list-style-type: none"> • Partnership with a Community Care Team • Practice-Integrated Care Management • Baseline assessment of their behavioral-physical health integration • Implementation of specific improvements to integrate behavioral and physical health care.
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<p>Behavioral Health Homes: state plan option supports payment to PCPs and Behavioral Health Home (community mental health) providers to support integrated care coordination.</p> <p>Source: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/HH/Behaviorial%20HH/BHH_quality_measures.pdf</p>	<p>State Plan Amendment</p>	<p>PMPM</p>	<p>Health Home providers are tracked on a number of process and structural measures in order to participate in the program and access PMPM payments.</p>	<p>Select State-Selected Measures in SPA (in addition to the Health Home Core Measure set):</p> <ul style="list-style-type: none"> • Out of home placement days for children • All readmissions for behavioral health diagnoses, including IMD • Cardio-Metabolic Screening for adults and children who are prescribed antipsychotic medications • Screening for clinical depression and follow-up plan • Follow up after hospitalization for mental illness • Functional improvement for both adults and children • Residential stability • Employment status (adults) • State’s 10 core standards for behavioral health homes, including a multi-disciplinary care team; primary care consultation to the team, population risk stratification and management.
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NEW YORK				
Target Population(s): General Medicaid Population and SMI population; SMI population; Population with chronic health needs, including SMI; General Medicaid Pop and specialty population				
<p>Managed Care: Carved-in MCOs that are accountable for both physical and behavioral health measures; specialty integrated MCOs for individuals with serious mental illness (HARPs).</p> <p>Source: https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2016/docs/qarr_specifications_manual.pdf</p>	<p>1115 Waiver, 1915(b)</p>	<p>Varied VBP options:</p> <ul style="list-style-type: none"> • Total care for total population; • Integrated primary care; • Selected care bundles; • Special needs 		<ul style="list-style-type: none"> • NYS MCOs report on HEDIS measures via the state’s QARR system. The QARR contains 74 measures, approximately 13 of which relate to behavioral health. A subset of measures are tied to payment, including: <ul style="list-style-type: none"> • Adherence to Antipsychotic Medications for People with Schizophrenia (NQF #1879) • Antidepressant Medication Management-Effective Acute Phase Treatment (NQF #0105) • Follow-Up After Hospitalization for Mental Illness Within 7 days (NQF #0576) • Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase (NQF #0108) • HARPs also report on QARR and subset of measures for payment incentives; HARPs also report on certain HCBS measures, and state is developing recovery measures for inclusion.

<p>Performing Provider Systems may work with various provider types and receive performance incentive payments based on four improvement domains.</p> <p>Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-02-25_measure_specific_rpting_manual.pdf</p>	<p>1115 DSRIP Waiver</p>	<ul style="list-style-type: none"> PPSs may participate in VBP arrangements through MCO contracts if they choose to become an independent practice association (IPA) or accountable care organization (ACO); PPSs may receive payment by meeting certain milestones in system transformation and for reporting on certain measures; the PPS may also receive payment for meeting project performance goals, annual targets, and achieving high performance measurement targets. 	<ul style="list-style-type: none"> Linkage between payment and quality measures varies: For pay for performance, a PPS must meet or exceed annual improvement targets on a subset of measures. 	<p>Under NY 1115 waiver, Performing Provider Systems receive payments based on four domains including Overall Project Progress, System Transformation, Clinical Improvement, and Population-wide measures.</p> <p>The ten measures eligible for high performance payments include the following behavioral health measures:</p> <ul style="list-style-type: none"> Potentially preventable emergency room visits (BH Population) Follow-up after Hospitalization for Mental illness Antidepressant medication management Diabetes monitoring for people with diabetes and schizophrenia Cardiovascular monitoring for people with cardiovascular disease and schizophrenia
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<p>Health Homes structured for specialty populations, such as people with serious mental illness.</p> <p>Source: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/new-york-spa-12-11.pdf</p> <p>Patient centered Medical Homes (PCMH) / Advance Primary Care (APC) Practices Practices that provide comprehensive, coordinated patient-centered care to patients. Patients seen here with behavioral health needs frequently have mild-to-moderate conditions.</p> <p>Source: http://nashp.org/state-delivery-system-payment-reform-map/</p>	<p>State Plan Amendment</p>	<ul style="list-style-type: none"> • Health Homes receive PMPM payments and can participate in VBP strategies through contracts with MCOs. • PCMH/APC practices receive PMPM payment and can participate in VBP through contracts with MCOs. APCs may also participate in multipayer payment incentives through the state’s SIM model. 	<ul style="list-style-type: none"> • Health Home providers are tracked on a number of process and structural measures in order to participate in the program and access PMPM payments. • APCs are required to meet a set of core capabilities, and can move to outcome-based payment by meeting defined performance targets. 	<p>Select State-Selected Measures in SPA_(in addition to the Health Home Core Measure set):</p> <ul style="list-style-type: none"> • Anti-depressant medication management • Follow up care for children prescribed ADHD medication • Adherence to antipsychotics for individuals with schizophrenia • Adherence to mood stabilizers for individuals with bipolar 1 disorder • Additional state capacity requirements, including a multi-disciplinary team that can manage integrated physical and behavioral health needs, HIT capacity, comprehensive and integrated care planning.
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