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Catalog of Medicaid Initiatives Focusing on Integrating Behavioral and Physical Health Care:

Final Report

Prepared for:
Medicaid and CHIP Payment and Access Commission (MACPAC)

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Project Purpose

Over the last decade, in an effort to improve health outcomes, improve patient care experiences, and reduce costs, state Medicaid agencies have embarked on state-level reforms to integrate coverage and financial accountability for physical and behavioral health care services. There is a large body of literature on the integration of mental health into the primary care setting, and several recent initiatives to define a lexicon of terms for integrated care, such as the Agency for Healthcare Research and Quality (AHRQ) Lexicon for Behavioral Health and Primary Care Integration and the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) Standard Framework for Levels of Integrated Healthcare. However, little is known about how state-level reforms promoting integration impact access, outcomes, and costs among Medicaid enrollees. Amidst all the activity at the state level around this topic, it is difficult to define in the most basic terms how the integration of programs and financing at a state level facilitate clinical integration at the point of care for individuals and what potential it holds for achieving stated goals.

As a foundational step toward better understanding the impact of these reforms, the Medicaid and CHIP Payment and Access Commission (MACPAC) contracted with the State Health Access Data Assistance Center (SHADAC) within the University of Minnesota's School of Public to conduct a comprehensive scan of state-level Medicaid programs aiming to integrate behavioral and physical health care services. SHADAC then cataloged their structures, services, financial models, and performance measures.

Project Methods

This project consisted of a comprehensive web search of state program information across the 50 states (and District of Columbia) on efforts to integrate physical and behavioral health services in Medicaid. The review is limited to specific programs initiated by the state to integrate behavioral and physical health. As such this review is not a comprehensive list of all behavioral health integration efforts underway that might affect Medicaid beneficiaries. For example, to the extent that a managed care plan may have a special effort to coordinate or integrate care for members with behavioral health conditions, such an effort is not captured here. However, this review does provide an illustrative overview of the types of payment models, integration mechanisms, target populations and provider types that characterize Medicaid behavioral health integration initiatives.

As a first step, SHADAC, working with MACPAC staff, defined the most common overarching models of behavioral health integration in Medicaid. This work identified that most behavioral health integration efforts can be categorized as one of the following four models:

- Accountable Care Organizations (ACOs): Establishing ACOs, whereby integration is promoted and accountability for quality and cost is shared at the provider level
- Health Homes: Integrating behavioral and medical care by providing health home services, including care management and coordination, to populations with identified serious mental illness or other chronic behavioral health conditions, a new Medicaid option for states under the Affordable Care Act (ACA)
- Managed Care: Combining physical and behavioral health benefits, consolidating funding streams, and entering into contracts with managed care organizations (MCOs) or behavioral

health organizations (BHOs) to provide access to comprehensive physical and behavioral health services; and

- Primary Care Case Management (PCCM) and Patient-Centered Medical Homes (PCMH): Emphasizing the integration of physical and behavioral health care as part of enhanced PCCM or PCMH initiatives

After categorizing the behavioral health integration efforts into one of these four models, the review was then focused to include only state-initiated behavioral health integration efforts. This could include statewide or county efforts, but focused the review to only include efforts that were implemented through state Medicaid programs and policies, and not those driven at the provider or plan level.

Additionally, the review included integration efforts that primarily focus on integrating behavioral and physical health. Many managed care models integrate behavioral health services in conjunction with broader efforts to coordinate care for beneficiaries across the health care system, including integrating the full array of physical, behavioral, long term care, and support services for members. In these instances it is often difficult to isolate the effects of behavioral health integration efforts on individuals with behavioral health disorders.

For purposes of this project, behavioral health conditions encompassed all mental health conditions. Programs in the planning and development stages or programs that had expired as of March 1, 2015 were also not included.

Key on-line resources in our search included, but were not limited to, current and pending Medicaid waivers for behavioral health integration programs, Medicaid State Plan Amendments, CMS-approved Medical Health Home Model initiatives, state government, county and local websites, and PubMed and Google Scholar for published articles highlighting integration efforts in Medicaid programs at the state or sub-state level including evaluations. For a few programs with limited publicly available information, SHADAC reached out to Medicaid or program staff via email with questions to fill in data gaps. After gathering a significant amount of data and information on a wide variety of possible state programs, SHADAC identified key dimensions for collecting uniform information on each state's program. Summaries of the programs' attributes, key organizations, payment models, and integration components are included in Tables 1 and 2. Detailed descriptions of each program are cataloged in the Appendix.

Findings

A scan of online resources uncovered 19 state Medicaid initiatives in 17 states that focus specifically on integrating behavioral and physical health care for Medicaid beneficiaries. These initiatives can be loosely categorized into one of the following models: managed care, enhanced primary care case management/patient-centered medical homes (PCCM/PCMH), health homes, and Accountable Care Organizations (ACOs). However, half of these programs were behavioral health homes.

Most of the programs documented in the catalog are relatively new. Only three programs date back to 2010 or earlier, with 16 having been developed since 2011 (including eight programs implemented since 2014). Additionally, half of the initiatives focused on Medicaid beneficiaries with severe mental

illness (SMI), while the other half are focused more broadly on all Medicaid beneficiaries, those enrolled in a specific program, or individuals with mental illness that is not necessarily severe.

Approximately half of the programs we studied chose to integrate physical health into behavioral health care environments, several integrated behavioral health into physical health care settings, and a few opted for two-way integration without a clear "lead" discipline. Few of the programs (only about one quarter) showed clear evidence that behavioral and physical health were co-located in the same facility. However, since most of the documentation we found described efforts at a programmatic level, it is possible that more individual practices have co-located providers than we could detect.

It was also difficult to determine the extent to which these programs share data to help care managers and providers from different health care disciplines communicate and coordinate care for shared patients. Additionally, although all of the programs we encountered described some use of care coordination or case management to assist in integration of care, each used different methods and activities to define care coordination or case management.

Some of these programs are beginning to publish individual case-studies to highlight the effects of these programs on health outcomes and costs. These initial data suggest that integration may have potential to improve outcomes and reduce costs for certain populations, but ultimately more time and study are needed to determine the effectiveness of these programs and to understand which components of integration are most important to successful results.

This project provides the Commission foundational information describing integration efforts underway in state Medicaid programs. However additional research, incorporating different qualitative methods, such as interviews with program managers and providers participating in integration initiatives, would be necessary to fill in information gaps.

Summary Tables of Select Medicaid Initiatives Integrating Behavioral and Physical Health

Tables 1 and 2, below, provide summary-level information on the key attributes, target populations, participating organizations, and payment models associated with Medicaid initiatives profiled as part of our cataloging effort. The full catalog with all information collected on each state is provided for reference in the Appendix to this report.

Table 1. Key Attributes and Target Populations

State	Program Name	Start Year	Area	Pilot?	Medicaid Target Population	Includes Dually-eligible Beneficiaries?	Other Groups Included in Target Population
			Statewide Select region(s)	Yes No	Children All children Children with SED/SMI only Other children Adults (21-64) All adults Adults with SMI only Other adults Elderly (65+) All elderly adults	Yes No	Medicare No, Medicaid only Private coverage[1] Uninsured
Managed Care							
AZ	Mercy Maricopa Integrated Care	2014	Select region	No	Adults with SMI only[2]	Yes	No, Medicaid only[3]
FL	Magellan Complete Care Serious Mental Illness Specialty Plan	2014	Select regions	No	Children with SED/SMI only[4] Adults with SMI only	Yes	No, Medicaid only
MA	Massachusetts Behavioral Health Partnership	2012	Statewide	No	All children[6] All adults[6]	Yes	No, Medicaid only
MN	Preferred Integrated Network Program	2009	Select region	No	Children with SED/SMI only Adults with SMI only	Yes	No, Medicaid only
Primary Care Case Management/Patient-Centered Medical Homes							
NC	Community Care of North Carolina	2010[7]	Statewide	No	All adults	Yes	No, Medicaid only
VT	Blueprint for Health	2006	Statewide	No	All children All adults All elderly adults	Yes	Private coverage Medicare
Health Homes							
IA	Integrated Health Homes	2013	Statewide	No	Children with SED/SMI only Adults with SMI only	Yes	No, Medicaid only
KS	KanCare Health Homes	2014	Statewide	No	Children with SED/SMI only Adults with SMI only	Yes	No, Medicaid only

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ME	MaineCare's Behavioral Health Homes Program	2014	Statewide	No	Children with SED/SMI only Adults with SMI only	Yes	No, Medicaid only
MD	Maryland Health Home Program	2013	Statewide	No	Children with SED/SMI only Adults with SMI only[8]	Yes	No, Medicaid only
MO	Missouri Community Mental Health Center Healthcare Homes	2012	Statewide	No	All children[9] All adults[9]	Yes	No, Medicaid only
NJ	New Jersey Behavioral Health Homes	2014	Select region	No	Adults with SMI only	Yes	No, Medicaid only
OH	Ohio Health Homes	2012	Select regions	No	Children with SED/SMI only Adults with SMI only	Yes	No, Medicaid only
OK	Oklahoma Health Homes	2015	Statewide	No	Children with SED/SMI only Adults with SMI only	Yes	No, Medicaid only
RI	Community Mental Health Organization Health Homes	2011	Statewide	No	Children with SED/SMI only? Adults with SMI only	Yes	No, Medicaid only
WV	West Virginia Health Homes	2014	Select regions	No	Other children[10] Other adults[10]	Yes	No, Medicaid only
Accountable Care Organizations							

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			Statewide Select region(s)	Yes No	Children All children Children with SED/SMI only Other children Adults (21-64) All adults Adults with SMI only Other adults Elderly (65+) All elderly adults	Yes No	Medicare No, Medicaid only Private coverage[1] Uninsured
CO	Accountable Care Collaborative	2011	Statewide	No	All children All adults All elderly adults	Yes	No, Medicaid only
MN	Hennepin Health	2012	Select region	No	Other adults[11]	Yes	No, Medicaid only
MN	Integrated Health Partnerships Demonstration: Southern Prairie Community Care	2014	Select regions	No	All children All adults All elderly adults	No	No, Medicaid only

Table 1 Notes:

(1) Private coverage includes self-insured employers
(2) Medicaid adults with SMI (including dually-eligible beneficiaries) are the only individuals who receive integrated physical health/behavioral health benefits; other Medicaid-covered children and adults with general behavioral health needs receive behavioral health services only
(3) Non-Medicaid eligible individuals receive certain behavioral health and other social services only
(4) Children ages six and older
(5) Adults with disabilities or blindness who are ages 19 and older
(6) Enrolled in MassHealth's Primary Care Clinician (PCC) Plan
(7) Community Care of North Carolina officially launched statewide in 2001; behavioral health integration efforts began in 2010
(8) Also includes adults with an opioid substance use disorder (SUD) and risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use
(9) Beneficiaries must have SMI (OR) other behavioral health problems combined with another chronic condition

(10) Program is open to Medicaid beneficiaries of any age with bi-polar disorder who are at risk or infected with hepatitis types B and/or C
(11) Covers Medicaid-eligible, childless adults with incomes under 133 percent of the Federal Poverty Level

Table 1 Acronyms:

- SMI/SED Serious Mental Illness (Adults)/Serious Emotional Disturbance (Children)

Table 2. Key Organizations, Payment Model, and Integration Components

State	Program Name	Key Organizations	Payment Model	Direction of Integration			Co-location?	Independent Evaluation?
				PH into BH	BH into PH	Two-way		
		BHO(s) CMHCs/CBHCs County FQHCs Hospital/provider system(s) MCOs PCPs Other Other lead entities	Enhanced payments Incentives Shared savings Shared risk Other	Yes No	Yes No	Yes No	Yes No	Yes No
Managed Care								
AZ	Mercy Maricopa Integrated Care	MCO	Shared risk	Yes	No	No	Yes	No
FL	Magellan Complete Care Serious Mental Illness Specialty Plan	BHO	Shared risk	No	No	Yes	Yes	Yes
MA	Massachusetts Behavioral Health Partnership	BHO	Shared risk	No	No	Yes	No	No
MN	Preferred Integrated Network Program	MCO County	Shared risk	Yes	No	No	Yes	Yes
Enhanced Primary Care Case Management/Patient-Centered Medical Homes								
NC	Community Care of North Carolina	Other lead entity PCPs	Enhanced payments	No	Yes	No	Yes	Yes
VT	Blueprint for Health	Other lead entities PCPs	Enhanced payments	No	Yes	No	No	No
Health Homes								

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IA	Integrated Health Homes	BHO CMHCs FQHCs	Enhanced payments Incentives	Yes	No	No	No[1]	Yes[5]
KS	KanCare Health Homes	MCOs CMHCs Counties FQHCs Other	Enhanced payments Incentives	No	No	Yes	No	Yes[5]
ME	MaineCare's Behavioral Health Homes Program	CMHCs PCPs	Enhanced payments	Yes	No	No	No	Yes[5]
MD	Maryland Health Home Program	CBHCs	Enhanced payments	Yes	No	No	No	Yes[5]
MO	Missouri Community Mental Health Center Healthcare Homes	CMHCs	Enhanced payments	Yes	No	No	No	Yes[5]
NJ	New Jersey Behavioral Health	CMHCs	Enhanced payments	Yes	No	No	Yes[2]	Yes[5]

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				PH into BH	BH into PH	Two-way		
		BHO(s) CMHCs/CBHCs County FQHCs Hospital/provider system(s) MCOs PCPs Other Other lead entities	Enhanced payments Incentives Shared savings Shared risk Other	Yes No	Yes No	Yes No	Yes No	Yes No
	Homes							
OH	Ohio Health Homes	CBHCs	Enhanced payments Incentives	Yes	No	No	No	Yes[5]
OK	Oklahoma Health Homes	CMHCs Other	Enhanced payments	Yes	No	No	No	Yes[5]
RI	Community Mental Health Organization Health Homes	CMHCs	Enhanced payments	Yes	No	No	Yes[3]	Yes[5]
WV	West Virginia Health Homes	CMHCs FQHCs, Other	Enhanced payments	No	Yes	No	No	Yes[5]
Accountable Care Organizations								
CO	Accountable Care Collaborative	Other lead entities PCPs BHOs	Enhanced payments	No	Yes	No	Yes[4]	No
MN	Hennepin Health	Hospital/provider system County FQHC	Shared risk	No	Yes	No	Yes	Yes

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State	Program Name	Key Organizations	Payment Model	Direction of Integration			Co-location?	Independent Evaluation?
				PH into BH	BH into PH	Two-way		
		BHO(s) CMHCs/CBHCs County FQHCs Hospital/provider system(s) MCOs PCPs Other Other lead entities	Enhanced payments Incentives Shared savings Shared risk Other	Yes No	Yes No	Yes No	Yes No	Yes No
		MCO						
MN	Integrated Health Partnerships Demonstration: Southern Prairie Community Care	Other lead entity Hospital/provider systems FQHCs PCPs CMHCs Counties	Shared savings	No	No	Yes	No	No

Table 2 Notes:

(1) It is unclear whether Iowa Integrated Health Homes have physical health provider satellite offices within behavioral health homes.
(2) New Jersey Behavioral Health Homes must be fully or partially co-located within three years of certification.
(3) Co-location may vary by health home in Rhode Island, but some health homes include co-located behavioral and physical health.
(4) May exist in some cases, but likely depends on specific RCCO.
(5) An independent evaluation is underway to review all health home initiatives.

Table 2 Acronyms:

- BHO Behavioral Health Organization
- CMHC/CBHC Community Mental Health Center/Community Behavioral Health Center
- FQHC Federally Qualified Health Center

- MCO Managed Care Organization
- N/A Not Available
- PCP Primary Care Practice
- SMI/SED Serious Mental Illness (Adults)/Serious Emotional Disturbance (Children)

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Arizona: Mercy Maricopa Integrated Care

Basic Information	
Brief program description	The Arizona Department of Health Services, Division of Behavioral Health Services, contracts with community-based organizations known as Regional Behavioral Health Authorities (RBHAs) to administer behavioral health services. Mercy Maricopa Integrated Care (Mercy Maricopa), a not-for-profit managed care entity, is Maricopa County's RBHA and is accountable and at financial risk for the full spectrum of behavioral health and Medicaid-covered physical health services for the Medicaid population with Serious Mental Illness (SMI).
Geographic area	Maricopa County, containing the greater Phoenix area (statewide expansion planned in 2015)
Covered populations	• Medicaid-covered adults (including duals) with SMI receive physical, behavioral, and substance abuse services • Other Medicaid-covered children and adults with general mental health/substance abuse needs receive behavioral health and substance abuse services • Non-Medicaid eligible individuals with SMI receive behavioral health and substance abuse services, housing, and supported employment services; other non-Medicaid eligible individuals receive crisis services
Implementation date	• April 1, 2014 (Maricopa County) • Two new three-year contracts awarded to implement the program in Northern and Southern Regions beginning in October 2015.
Pilot program?	No
Participating payers	Medicaid only
Program statistics	Approximately 780,000 Medicaid eligible members – 17,000 of whom have SMI

Key Organizations	Core Services/Responsibilities	Provider Information
State contracts with Mercy Maricopa, a non-for-profit managed care entity sponsored by Mercy Care Plan and Maricopa Integrated Health System	Full continuum of Medicaid-covered and other publicly-funded behavioral health and substance abuse services. Outpatient and inpatient behavioral health care, supportive services (peer and family support), patient education, engagement, and follow-up. For Medicaid-covered adults with SMI, all Medicaid-covered physical health services. Intensive care management for high-risk/high-cost members with SMI.	Mercy Maricopa contracted provider network includes physical and behavioral health providers. Members have access to care coordinators, case managers (member and family single point of contact), and peer navigators (member educators/advocates).

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Arizona: Mercy Maricopa Integrated Care	
Physical Health/Behavioral Health Integration	
Integration mechanisms	Mercy Maricopa care manager completes Case Analysis Review (CAR) including: medical chart review, consultation with treatment team, review of claims/encounter data, root cause analysis, medication review, and placement review. The CAR is used in development of a patient-centric plan of care supporting physical and behavioral health, social and community service needs, placement goals, preferences and barriers. As of March 2013, Mercy Maricopa had 8 SMI clinics offering integrated services and anticipates 12 more integrated sites over the course of its current contract. Some clinics have co-location partnerships, but Mercy Maricopa is moving to integration.
Direction of integration	Physical health integrated into behavioral health.
Data sharing	Mercy Maricopa will provide a free HIE that supports communication between members of the treatment, allowing behavioral and physical health providers to share clinical information. Mercy Maricopa also plans to implement clinical workflow applications that will include electronic sharing of integrated care plans, electronic referrals, and unified center member charts. Mercy Maricopa will monitor claims data to uncover opportunities for avoiding risk and provide care alerts to providers.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	1115 Waiver Amendment, approved by the Centers for Medicare and Medicaid Services (CMS) in January 2013, allowing the state to serve as the only managed care plan for both acute and behavioral health conditions for Medicaid enrollees with SMI in Maricopa County.
Payment model	Capitated, risk-adjusted payment to Mercy Maricopa covering full spectrum of behavioral health and Medicaid-covered physical health services for Medicaid SMI population.
Performance measurement and results	Unclear
Key references and websites	http://www.azdhs.gov/bhs/aboutbhs.htm http://www.mercymaricopa.org/
Active as of:	March 2015

Appendix: Catalog of Medicaid Initiatives Integrating Behavioral and Physical Health

Colorado: Accountable Care Collaborative	
Basic Information	
Brief program description	Through its Accountable Care Collaborative (ACC) initiative, Colorado contracts with 5 Regional Care Collaborative Organizations (RCCOs) to establish networks of Primary Care Medical Providers (PCMPs) and to provide care coordination for Medicaid enrollees at the regional level. Although behavioral health is "carved out" of the ACC and financed through capitated payments with Behavioral Health Organizations (BHOs), the integration of behavioral health and long-term care with physical health is stated as a long-term vision of the ACC initiative. RCCOs are moving toward this goal in various ways. Colorado Community Health Alliance, an RCCO serving Boulder, Broomfield, Clear Creeks, Gilpin and Jefferson counties, is specifically working within its network of PCMPs to integrate behavioral health and medical services.
Geographic area	Statewide
Covered population	All Medicaid enrollees
Implementation date	2011
Pilot program?	No
Participating payers	Medicaid only
Program statistics	In June 2014, there were 609,051 members enrolled in the ACC program (58% of Colorado's Medicaid clients) – 70% of these enrollees were connected to a PCMP. Currently, 5 different organizations function as RCCOs across 7 regions of the state (1 organization serves 3 contiguous regions).

Key Organizations	Core Services/Responsibilities	Provider Information
RCCOs	• Establish provider networks • Support providers with coaching and information ("practice transformation") • Manage and coordinate member care • Connect members with non-medical services • Report on costs, utilization, and outcomes for members	RCCO leadership Care managers/coordinators
PCMPs	• Provide comprehensive primary care services • Act as medical homes for ACC members • Contract with RCCOs	Primary care doctors, nurse practitioners, and physician assistants; behavioral health providers in some cases
BHOs	• Provide enrollees with access to mental health or substance use disorder services	BHO's network of behavioral health providers.

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Colorado: Accountable Care Collaborative	
Physical Health/Behavioral Health Integration	
Integration mechanisms	The ACC program supports regional integration by: • Requiring that RCCOs and behavioral health organizations (BHOs) coordinate services • Allowing community mental health centers (CMHCs) to become PCMPs if contract requirements are met • Providing incentive payments for advanced medical homes • Providing CMHCs with guidance on how to bill for physical health services Individual RCCOs are employing various integration strategies. For example, Colorado Community Health Alliance (RCCO 6) is: • Improving the referral process with timely referrals to behavioral health services and a communication feedback loop with the PCMP • Developing tele-health video conferencing options for linking behavioral health providers to PCMP sites • Aiding PCMPs in bringing behavioral health professionals on site • Supporting PCMPs in developing/maintaining fully integrated physical-behavioral health clinics
Direction of integration	Integration of behavioral health into primary care settings
Data sharing	A Statewide Data and Analytics Contractor (SDAC) maintains, analyzes, and reports on claims data for the state, RCCOs, and PCMPs.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	Medicaid State Plan Amendment (SPA)
Payment model	RCCOs and PCMPs receive per member per month (PMPM) payments plus performance incentives based on meeting: • Key performance indicators • Enhanced medical home standards (advanced medical home classification requires on-site access to behavioral health care providers, behavioral health screening protocols, and protocols to address positive screens) • Standards for member attribution to medical homes • Clinical care standards Currently, RCCOs and PCMPs are not at financial risk for improving quality and lower costs.
Performance measurement and results	Key performance indicators for RCCOs and PCMPs include or have included: emergency room (ER) visits, 30-day all-cause hospital readmissions, high-cost imaging, and well-child visits, and post-partum care.

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Colorado: Accountable Care Collaborative	
	ACC annual reports have reported reductions in ER visits, hospital admissions and readmissions, and use of high-cost imaging services. Net savings have been attributed to the program dating back to state fiscal year 2013.[1]
Key references and websites	[1]"Creating a Culture of Change: Accountable Care Collaborative, 2014 Annual Report," Colorado Department of Health Care Policy & Financing. Available from: https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%202014%20Annual%20Report.pdf. See also: https://www.colorado.gov/pacific/hcpf/accountablecarecollaborative
Active as of:	March 2015

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Florida: Magellan Complete Care Serious Mental Illness Specialty Plan	
Basic Information	
Brief program description	Florida's Medicaid managed care program includes a specialty plan designed exclusively for beneficiaries diagnosed with or in treatment for severe mental illness (SMI). The specialty plan is offered by Connecticut-based Magellan Complete Care and aims to better coordinate physical and mental health care for high-cost beneficiaries.
Geographic area	Regions 2, 4-7, and 9-11. These regions cover the following counties: • Region 2 - Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington • Region 4 - Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia • Region 5 - Pasco and Pinellas • Region 6 - Hardee, Highlands, Hillsborough, Manatee and Polk • Region 7 - Brevard, Orange, Osceola, and Seminole • Region 9 - Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties • Region 10 - Broward • Region 11 - Miami-Dade and Monroe
Covered populations	Medicaid beneficiaries with SMI
Implementation date	July 2014 in Miami-Dade/Monroe and Broward counties; rolled out to other regions in August 2014 and September 2014
Pilot program?	No
Participating payers	Medicaid only
Program statistics	About 140,000 low income Floridians are expected to be eligible and Magellan predicts about 20,000 will participate voluntarily in the first year

Key Organizations	Core Services/Responsibilities	Provider Information
Magellan	Comprehensive Medicaid benefit set, including physical health, mental health and substance abuse services, home health, pharmacy, dental, vision, and transportation. Benefit set does not include long-term care institutional services, institutional services for persons with developmental disabilities, or state hospital services. Additionally, while not a core service, the MCO also has relationships with community providers (e.g., housing, home-delivered meals, etc.), which primary care providers are encouraged to tap.	Magellan's Integrated Care Teams (ICTs) include: • Family members, caregivers, or representatives • Integrated Care Case Manager (RN or licensed mental health profession) • Health Guide (member advocate) • Primary behavioral health provider • Primary medical provider • Peer Support Specialist (certified individual who has

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Florida: Magellan Complete Care Serious Mental Illness Specialty Plan		
		lived with SMI and is in recovery) • Medical specialists for complex medical conditions • Magellan clinical pharmacist and medical director (participate as needed)

Physical Health/Behavioral Health Integration	
Integration mechanisms	The Integrated Care Case Manager assesses each member identified as "high risk", develops an integrated plan to coordinate care, provides face-to-face coordination as necessary, is actively involved with the member at times of care transitions, and works to ensure communication between the individual, providers, and all members of the care team. Beyond the care team, Magellan also supports a group of "Provider Support Specialists", licensed clinicians who work with providers and provider groups on quality issues, data analytics, and practice transformation activities to facilitate the integration of primary care and behavioral health care.
Direction of integration	Two-way
Data sharing	Magellan Complete Care has a quality monitoring function using specific metrics related to their target population (unavailable). Magellan Complete Care shares appropriate data in support of these calculations with providers as appropriate and, from time to time, may request additional ad hoc data from providers to support these measures. The state (Forida's Agency for Health Care Administration) is currently developing a report for monitoring this program based on the encounter data submitted by Magellan.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	Amendment to state's existing 1115 research and demonstration waiver
Payment model	Capitation to Magellan set at 5 percent less per member, per month that would cost to treat beneficiaries in fee-for-service
Performance measurement and results	The state requires all MMA plans to collect and report on a list of performance measures on an annual basis. Magellan reported that it will be tracking the following measures beginning in late 2015: • Diabetes monitoring for members with diabetes and schizophrenia/bipolar disorder using anti-psychotic medications • Behavioral health and medical readmission rates • Adult access to preventive/ambulatory health services • Breast cancer screening • Cervical cancer screening • Use of appropriate medications for people with asthma

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Florida: Magellan Complete Care Serious Mental Illness Specialty Plan	
	• Lithium monitoring for members on Lithium
Key references and websites	http://www.magellancompletecareoffl.com/fl-site/about-complete-care/welcome.aspx http://www.magellancompletecareoffl.com/media/1019308/c-h1014rev1_specialty_plan_member_handbook_final.pdf
Active as of:	March 2015

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Iowa: Integrated Health Homes	
Basic Information	
Brief program description	The State of Iowa contracts with a behavioral health organization, Magellan Behavioral Health Care of Iowa, to administer the state's behavioral health homes initiative (Iowa has another health home initiative for chronic health conditions). Magellan contracts with community mental health centers, designated as Integrated Health Homes (IHHs), which in turn partner with Federally Qualified Health Centers (FQHCs) as physical health providers. Both Magellan and the IHHs provide care coordination services to enrollees.
Geographic area	Statewide
Covered populations	Medicaid-enrolled adults with serious mental illness (SMI) and children with severe emotional disturbances (SED)
Implementation date	Program began in 5 counties in July 2013; phased in statewide in 2014
Pilot program?	No
Participating payers	Medicaid only
Program statistics	Serves 11,500 adults and 9,800 children (as of January 2015) 40 participating providers (as of January 2015)

Key Organizations	Core Services/Responsibilities	Provider Information
Magellan Behavioral Health Care of Iowa	Administer IHH initiative: • Identify providers who meet IHH standards, • Educate and support IHH providers • Provide infrastructure and tools • Perform data analytics • Provide clinical guidelines • Provide technical tools for electronic exchange of health information • Maintain enrollment process	Integrated care nurse coordinator to manage transitions between providers
IHHs (community mental health centers with special designation)	• Provide behavioral health services to Medicaid-eligible and non-Medicaid eligible individuals. • Provide individuals who are eligible for IHH services with comprehensive care management, care coordination, health promotion, transitional care, patient and family support, referral to community and social support services	An IHH nurse, care coordinator, and a peer support specialist provide "on the ground" care coordination for members

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Iowa: Integrated Health Homes		
FQHCs	Partner with IHHs, sometimes opening a satellite office at the IHH	A medical nurse practitioner provides routine and preventive physical care.

Physical Health/Behavioral Health Integration	
Integration mechanisms	FQHC satellite office at IHH to provide routine and preventive physical care. Care manager to serve as communication hub for integrated care. Assessment of whole-person (i.e., physical and behavioral) health, and integrated care planning.
Direction of integration	Primary care integrated into behavioral health setting
Data sharing	IHHs are supposed to share data electronically (i.e., EMR data) between physical and behavioral health providers.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	ACA Section 2703 Health Homes; Health Home State Plan Amendment (SPA)
Payment model	IHHs receive tiered per member per month (PMPM) payments—$128 for standard beneficiaries and $348 for beneficiaries who receive intensive case management—plus incentive payments (pay for reporting in the first year, pay for performance the second year). IHHs are also eligible for a member outreach PMPM of $102, which is limited to three months per enrollee. Magellan receives an administrative fee for administering the program.
Performance measurement and results	Health homes will be evaluated through three sets of measures: 1) core measures developed by CMS, 2) state specific measures, and 3) evaluation measures. The CMS core measures include: • Adult body mass index • Screening for clinical depression and follow-up plan • Plan all-cause readmission rate • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Care transition–timely transmission of transition record • Initiation and engagement of alcohol and other drug dependence treatment • Chronic condition hospital admission composite–prevention quality indictor Evaluation measures include: • Hospital admissions • Emergency room visits

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Iowa: Integrated Health Homes	
	• Skilled nursing facility admissions The State of Iowa has published a separate report on its health home, which suggests that: • Use of emergency departments dropped 16 percent between pre-IHH and post-IHH timeframes • Mental health admissions dropped 18 percent between pre-IHH and post-IHH timeframes • Demonstrated improvement in Quality Caregiver Survey (QCS) results—tracking medical, school, family, economic, psychological, and legal issues • Positive shift in favor of greater school attendance for pediatric IHH members • Strong member satisfaction rating for adults and pediatric IHH members[1]
Key references and websites	[1] "Integrated Health Home Initiative (IHH): Report to Community," Magellan Healthcare (January 2015). Available from: http://www.magellanofiowa.com/media/970231/2014_ihh_report_to_the_community_final_1-19-15.pdf. See also: http://dhs.iowa.gov/ime/providers/integrated-home-health
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Kansas: KanCare Health Homes for Serious Mental Illness	
Basic Information	
Brief program description	Kansas contracts with three KanCare managed care organizations (MCOs) to serve as "lead entities (LEs)" to administer its health home initiative. LEs contract with community providers called "health home partners (HHPs)" to provide some of the six core health homes services. Many different types of community providers can qualify as HHPs. Current HHPs include each of the state's 26 community mental health centers, several county health departments, and many of the state's larger safety net clinics.
Geographic area	Statewide – there can be multiple HHPs in a given geographic region
Covered populations	Medicaid enrollees (adults and children) with serious mental illness (SMI); enrollees are assigned to a health home unless they opt out
Implementation date	August 2014
Pilot program?	No
Participating payers	Medicaid only
Program statistics	An estimated 36,000 Medicaid beneficiaries have SMI and are eligible for assignment to a health home

Key Organizations	Core Services/Responsibilities	Provider Information
MCOs (serving as LEs)	Health home services – comprehensive care management, care coordination and health promotion, comprehensive transitional care from institutional to community-based settings, individual and family support, referral to community and social supports, use of HIT to link services.	• Psychiatrist • Nurse Care Coordinator (RN, APRN, BSN, or LPN) • Physician (MD/DO)
HHPs	Health home services – comprehensive care management, care coordination and health promotion, comprehensive transitional care from institutional to community-based settings, individual and family support, referral to community and social supports, use of HIT to link services.	• Psychiatrist • Nurse Care Coordinator (RN, APRN, BSN, or LPN) • Physician (MD/DO) • Social Worker/Care Coordinator (BSW, BS/BA in related field, mental health or intellectual/developmentally disabled targeted case manager, or substance use disorder person centered case manager) • Peer Support Specialist/Peer Mentor/Recovery Advocate (Certified Peer Support Specialist/Mentor)
More information: Some services are provided jointly by the MCO and HHP, and some services are provided only by the MCO. The contracts between LEs		

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Kansas: KanCare Health Homes for Serious Mental Illness
and HHPs spell out which entities are providing core services and how payments are divided.

Physical Health/Behavioral Health Integration	
Integration mechanisms	Integration occurs mainly through increased communication among providers so that a member's medical, behavioral health, and social service needs are addressed comprehensively. The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires in order to facilitate optimum member health status. Comprehensive assessment of individuals' physical, behavioral and social needs, and development of an integration health action plan to address clinical and non-clinical needs.
Direction of integration	Two-way integration, depending on the nature of the HHP (physical health or behavioral health provider)
Data sharing	All LEs and HHPs must implement an Electronic Health Record (EHR) to facilitate sharing patient information across health settings. LEs and HHPs have to connect to one of two certified Health Information Exchanges (HIEs) in the state.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	ACA Section 2703 Health Homes; Health Home State Plan Amendment (SPA)
Payment model	State pays risk-adjusted (four levels), per member per month (PMPM) payment to MCO to provide health homes for each person assigned to the health home program. The MCOs sign agreements with different HHPs to help provide health home services. Payment from the MCO to the HHP depends on contract between MCO and HHP.
Performance measurement and results	Health homes will be evaluated through three sets of measures: 1) core measures developed by CMS, 2) state specific measures, and 3) evaluation measures. The CMS core measures include: • Adult body mass index • Screening for clinical depression and follow-up plan • Plan all-cause readmission rate • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Care transition–timely transmission of transition record • Initiation and engagement of alcohol and other drug dependence treatment • Chronic condition hospital admission composite–prevention quality indictor Evaluation measures include:

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Kansas: KanCare Health Homes for Serious Mental Illness	
	• Hospital admissions • Emergency room visits • Skilled nursing facility admissions Additionally, a state program manual published in October 2014 noted that a quality sub-group made up of a variety of stakeholders has been formed to develop quality goals and measures to assess the model. This quality program will incorporate federally mandated reporting on: hospital admission, chronic disease management, coordination of care, program implementation, processes and lessons learned quality and clinical outcomes, cost savings and admissions to skilled nursing facilities.[1]
Key references and websites	[1] "KanCare Health Homes Program Manual – Serious Mental Illness (SMI)," KanCare (October 1, 2014). Available from: http://www.kancare.ks.gov/health_home/download/KanCare_Health_Homes_Program_Manual_SMI.pdf. See also: http://www.kancare.ks.gov/health_home.htm
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Maine: MaineCare's Behavioral Health Homes Program	
Basic Information	
Brief program description	One of two health home initiatives in Maine, the behavioral health homes initiative is focused on beneficiaries with severe and persistent mental illness or serious emotional disturbances. It involves partnerships between licensed community mental health providers ("behavioral health home organizations" or BHHOs) and one or more enhanced primary care practices ("health home practices" or HHPs).
Geographic area	Statewide
Covered populations	Medicaid-eligible adults with severe and persistent mental illness (SPMI) and children with severe emotional disturbances (SED); individuals who are eligible for these services can opt out
Implementation date	April 2014
Pilot program?	No
Participating payers	Medicaid only
Program statistics	25 BHHOs (as of October 2014) and 170 HHPs (as of July 2014)

Key Organizations	Core Services/Responsibilities	Provider Information
BHHOs	Health home services – comprehensive care management, care coordination, health promotion, transitional care, patient and family support, referral to community and social support services	Psychiatric consultant, nurse care manager (RN, LPN, LSW, or other appropriately licensed clinical staff), clinical team leader (mental health professional), peer support specialist, health home coordinator, medical consultant
HHPs	Primary care services, care coordination with BHHO partners	Primary care provider, care manager (RN, LPN, LSW, or other appropriately licensed clinical staff), support staff, data manager

Physical Health/Behavioral Health Integration	
Integration mechanisms	BHHOs/HHPs have protocols for regular and systematized communication/collaboration across agencies and providers. BHHOs complete baseline assessments of their behavioral-physical health integration capacity during their first years of participation. BHHOs implement one or more specific improvements to integrate care. BHHOs are required to conduct an assessment of individual's medical, behavioral, social, residential, educational, vocational and other related needs; and to develop a comprehensive plan of care to meet individuals' physical and behavioral health goals.
Direction of integration	Primary care integrated into behavioral health setting
Data sharing	BHHOs (within 24 months) and HHPs must have EHRs.

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Maine: MaineCare's Behavioral Health Homes Program	
Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	ACA Section 2703 Health Homes; Health Home State Plan Amendment (SPA)
Payment model	Both BHHOs and HHPs receive per member per month (PMPM) payments for health home services provided to enrolled members: $329 for individuals with SED and $372 for individuals with SMI (includes $15 PMPM pass-through for HHPs).
Performance measurement and results	Health homes will be evaluated through three sets of measures: 1) core measures developed by CMS, 2) state specific measures, and 3) evaluation measures. The CMS core measures include: • Adult body mass index • Screening for clinical depression and follow-up plan • Plan all-cause readmission rate • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Care transition–timely transmission of transition record • Initiation and engagement of alcohol and other drug dependence treatment • Chronic condition hospital admission composite–prevention quality indictor Evaluation measures include: • Hospital admissions • Emergency room visits • Skilled nursing facility admissions According to the MaineCare Behavioral Health Homes – Quality Strategy, selected quality measures[1] will be used to identify improved outcomes in five goal areas: • Goal 1: Reduce Inefficient Healthcare Spending • Goal 2: Improve Chronic Disease Management • Goal 3: Promote Wellness and Prevention • Goal 4: Promote Recovery and Effective Management of Behavioral Health Conditions • Goal 5: Promote Improved Experience of Care for Consumers/ Families
Key references and websites	[1] "MaineCare Behavioral Health Homes – Quality Strategy (November 2013)." Available from: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/HH/Behavorial%20HH/BHH_quality_measures.pdf.

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Maine: MaineCare's Behavioral Health Homes Program	
	See also: http://www.maine.gov/dhhs/oms/vbp/health-homes/stageb.html.
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Maryland: Maryland Health Home Program	
Basic Information	
Brief program description	In Maryland, Psychiatric Rehabilitation Programs (PRP), Mobile Treatment Service (MTS) providers, and Opioid Treatment Programs that are enrolled Medicaid are eligible to become Health Homes. Maryland's Health Homes program targets populations with behavioral health needs who are at high risk for additional chronic conditions, offering them enhanced care coordination and support services from providers from whom they regularly receive care.
Geographic area	Statewide
Covered populations	• Medicaid-enrolled adults with either a serious and persistent mental illness (SPMI), or an opioid substance use disorder (SUD) and risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use. • Medicaid-enrolled children and adolescents with serious emotional disturbance (SED).
Implementation date	October 2013
Pilot program?	No
Participating payers	Medicaid only
Program statistics	• 4,330 adults and 375 youth (December 2014) • 70 health homes (December 2014)

Key Organizations	Core Services/Responsibilities	Provider Information
Community behavioral health agencies that have obtained or are in the process obtaining Commission on Accreditation of Rehabilitation Facilities' (CARF) Health Homes Standards and The Joint Commission's Behavioral Health Homes Certification	Health home services – comprehensive care management, care coordination, health promotion, transitional care, patient and family support, referral to community and social support services	Health Home staff team includes: a director (0.5 FTE per 125 enrollees), care manager (0.5 FTE per 125 enrollees), physician or nurse practitioner consultant (1.5 hours per enrollee per 12 months), and administrative support staff. A dedicated care manager is assigned to each participant.

Physical Health/Behavioral Health Integration	
Integration mechanisms	Health home team conducts an initial biopsychosocial assessment and develops an individualized treatment plan. Care coordinators facilitate communication across providers.
Direction of integration	Primary care integrated into behavioral health setting
Data sharing	eMedicaid Health Homes tool used for Health Homes intake, service reporting, outcomes reporting, and basic care

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Maryland: Maryland Health Home Program	
	management. Health Home providers must enroll with the Chesapeake Regional Information System for Our Patients (CRISP) to participate in CRISP's encounter notification system and pharmacy monitoring capability. CRISP notifies Health Homes in real time when a participant is encountered at Maryland hospitals.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	ACA Section 2703 Health Homes; Health Home State Plan Amendment (SPA)
Payment model	Per member per month (PMPM) payment to home health providers of $98.87, as of 2013
Performance measurement and results	Health homes will be evaluated through three sets of measures: 1) core measures developed by CMS, 2) state specific measures, and 3) evaluation measures. The CMS core measures include: • Adult body mass index • Screening for clinical depression and follow-up plan • Plan all-cause readmission rate • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Care transition–timely transmission of transition record • Initiation and engagement of alcohol and other drug dependence treatment • Chronic condition hospital admission composite–prevention quality indictor Evaluation measures include: • Hospital admissions • Emergency room visits • Skilled nursing facility admissions The Hilltop Institute is conducting a yet-to-be published evaluation of Maryland's health home program. State goals for the program include:[1] • Improving disease-related care for chronic conditions • Improving outcomes for persons with mental illness and/or opioid substance use disorders

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Maryland: Maryland Health Home Program	
	• Improving preventive care • Reducing utilization associated with avoidable hospitalization/ER usage • Reducing emergency room visits for chronic health home participants • Reducing hospital admissions for chronic health home participants • Reducing skilled nursing admissions for chronic health home participants
Key references and websites	[1] "Health Home Goals and Outcome Measures – Maryland Health Homes (February 2014)." Available from: http://dhmh.maryland.gov/bhd/Documents/HealthHomeGoalsandMeasures.pdf. See also: http://dhmh.maryland.gov/bhd/sitepages/health%20homes.aspx
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Massachusetts: Massachusetts Behavioral Health Partnership	
Basic Information	
Brief program description	In 2012, the Commonwealth of Massachusetts signed a five-year contract with the Massachusetts Behavioral Health Partnership (MBHP), a ValueOptions company, to provide integrated physical and behavioral health programs, management support services, and behavioral health specialty services to people enrolled in MassHealth's Primary Care Clinician (PCC) Plan. Individuals enrolled in MassHealth's PCC plan receive behavioral health services through the state's contract with ValueOptions and medical services from PCCs on a fee-for-service basis.
Geographic area	Statewide
Covered populations	MassHealth PCC plan members – note that MassHealth members with disabilities and other medically complex care needs are more likely to enroll in the PCC plan rather than with a MassHealth MCO.
Implementation date	MBHP has provided (1) a comprehensive set of managed behavioral health services and (2) quality improvement and network management for behavioral health and primary care clinicians to the Commonwealth since 1996. MBHP's new contract to provide managed behavioral health services, care coordination, medical/behavioral health integration services, and technology to enable system transformation started in October 2012.
Pilot program?	No
Participating payers	Medicaid only
Program statistics	Works with 360,000+ MassHealth members statewide

Key Organizations	Core Services/Responsibilities	Provider Information
MBHP (ValueOptions)	• Outpatient mental health services, outpatient substance use disorder services, diversionary services, emergency services for individuals in crisis, inpatient services for acute mental health or substance use disorders • Care management and care coordination services for all members • "Integrated care management" for high-need, high-cost enrollees • Management support services to primary care clinicians (PCCs) program – MBHP monitors, measures, and analyzes health care provided to members by PCCs with a panel size of 180 or more members	• MBHP network has 1,200+ behavioral health providers statewide • MBHP's expanded care management team includes "integrated, local care teams" and "an added internist to enrich medical leadership" and capacity to identify members who can benefit from care management through analytics. • MBHP also works through "practice-based care management partners" at major health care delivery systems and behavioral health networks.

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Massachusetts: Massachusetts Behavioral Health Partnership		
	• Promotion of integrated physical and behavioral health services	
PCCs	Provision of primary care services	MBHP works with 380+ primary care practices throughout the state

Physical Health/Behavioral Health Integration	
Integration mechanisms	New member engagement center, special health needs assessment for members, integrated care management program, enhanced network management activities with primary care and behavioral health providers
Direction of integration	Two-way: program aims to integrate physical health services into the specialty behavioral health system and at the same time work to increase behavioral health capacity within the physical health system.
Data sharing	MBHP provides a "shared technology platform" enabling comprehensive assessments and care plans accessible all service providers; member interventions tracked at the member/provider/program levels; and availability of quantitative outcome measures.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	1115 waiver
Payment model	Capitation with additional financial incentives for documented achievements in quality of care and service delivery
Performance measurement and results	MBHPs Quality Management Program Evaluation for 2013[1] included the following measures: • Member, PCC, and behavioral health provider satisfaction • Member grievances and Member appeals • Member safety • Timely access to behavioral health appointments • Timely access to MBHP Clinical and Community Relations staff • Availability of behavioral health network providers • Ability of behavioral health network providers to meet cultural and linguistic needs and preferences of our Members • Coordination of behavioral health care with medical care • Preventive behavioral health care • Health record documentation • Provider use of behavioral health clinical practice guidelines

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Massachusetts: Massachusetts Behavioral Health Partnership	
	According to the report, for 2013, 98% of all goals were met.
Key references and websites	[1]Massachusetts Behavioral Health Partnership. "2014 Quality Management Program: Behavioral Health Provider Summary." Available from: http://www.masspartnership.com/pdf/2014QualityManagementProgramProviderSummary.pdf. See also: https://www.masspartnership.com/index2.aspx http://www.valueoptions.com/company/Products_and_Services/PSD/Massachusetts.pdf
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Minnesota: Hennepin Health	
Basic Information	
Brief program description	Hennepin Health is a county-based safety-net accountable care organization in Minnesota serving Minnesota's Medicaid expansion population in Hennepin County. Hennepin Health is a partnership of four organizations: the Hennepin County Human Services and Public Health Department; Hennepin County Medical Center (a Level 1 trauma center and medium-sized public hospital and safety-net medical system; NorthPoint Health and Wellness Center (a federally qualified health center); and Metropolitan Health Plan (a non-profit, county-run health maintenance organization). The goal of the partnership is to increase the use of preventive care, and reduce preventable hospital admissions and emergency department (ED) visits, by integrating health care and social services for this safety-net population.
Geographic area	Hennepin County (Minneapolis and surrounding suburban communities)
Covered populations	Medicaid-eligible, childless adults (age 21-64) with incomes under 133 percent of Federal Poverty Level (FPL) (75 percent FPL prior to 2014) who are not certified as disabled. Hennepin Health is the default enrollment for individuals in Hennepin county who are newly eligible for Medicaid and do not select another health plan.
Implementation date	January 2012
Pilot program?	No. Hennepin Health is often called a "Medicaid demonstration project" but has no set end date.
Participating payers	Medicaid only
Program statistics	Approximately 10,000 enrollees as of February 2015. Of the approximately 5,000 members who sought medical care during January 2012 – June 2013, 90 percent had a diagnosis of a mental illness and 60 percent had a major psychiatric diagnosis.

Key Organizations	Core Services/Responsibilities	Provider Information
Hennepin Health ACO Partners: • Hennepin County Medical Center (HCMC) • Hennepin County Human Services and Public Health Department (HSPHD) • Metropolitan Health Plan • NorthPoint Health and Wellness Center	• Full Medicaid benefits to the enrolled population, including behavioral health services such as individual counseling, support groups, and outpatient psychiatric care; • Interdisciplinary clinical care planning, coordination, and resource navigation; and • Targeted social services for mental health/chemical dependency services, work support, housing assistance, and financial support services.	The Hennepin Health network includes: • Primary care clinics made up of family practice and internal medicine physicians and physician assistants, • Mental and chemical health clinics and providers, • Hospitals and urgent care providers, • Specialty providers, • Walk-in clinics, • Eye care providers, • Pharmacies, and • Dental providers. Clinic Care Coordination teams located in primary care clinics include registered nurse care coordinators, clinical

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Minnesota: Hennepin Health		
		social workers, and community health workers.

Physical Health/Behavioral Health Integration	
Integration mechanisms	Patients are stratified by risk tier based on past utilization to direct care coordination and interventions. Care for the highest-risk patients are transferred to HCMC's Coordinated Care Center to work with multidisciplinary care teams made up of a physicians, advanced practice providers, care coordinators, social workers, and psychologists. Pharmacists, chemical dependency counselors, and an addiction psychiatrist support the work of these teams. Care coordinators facilitate communication across teams. HCMC and NorthPoint Health and Wellness Center have embedded on-site psychologists, clinical social workers, and advanced practice nurses with medication management skills into their primary care practices.
Direction of integration	Behavioral health into primary care.
Data sharing	A unified electronic health record (EHR) shared by clinical providers, social service providers, health plan staff is under development – an integrated data warehouse for analytics and reporting exists.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	Accomplished under Minnesota's existing 1115 waiver authority.
Other state enabling legislation or regulations	State legislation (Minnesota Laws 2010, Art. 16, Sect. 19, M.S. §256B.0755) granting two counties the authority to develop and implement innovative health care delivery systems. State legislation expanded Medicaid benefits under the ACA to childless adults under 75 percent of the FPL.
Payment model	Full-risk, prospective, total cost of care payment model. Hennepin Health receives per member per month capitation from the state and therefore assumes full financial risk for Medicaid services for enrollees. Medical partners/providers (Hennepin County Medical Center, NorthPoint Health and Wellness Center, and county public health clinics) receive fee-for-service payments from Hennepin Health. Metropolitan Health Plan operates as the program's administrator on a fixed percentage of revenue. At the close of each year, any funds remaining are (1) distributed to partners to offset the cost of operating the model and (2) reinvested in projects (e.g., staff, data infrastructure) to further improve the model. Partners are at risk for losses if capitation payments received by Hennepin Health are insufficient to cover costs.
Performance measurement and results	Reported results:[1] • Decrease in ED visit of 9.1 percent (from 2012 to 2013) • Increase in primary care visits of 2.5 percent (from 2012 to 2013)[2] • Increase in outpatient visits of 3.3 percent (from 2012 to 2013)

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Minnesota: Hennepin Health	
	• Decrease in inpatient admissions (from 2012 to 2013)[2] • Stable hospitalizations(from 2012 to 2013) • Increase in the percentage of patients receiving optimal diabetes care from 8.6 percent to 10 percent (from second half of 2012 to second half of 2013) • Increase in the percentage of patients receiving optimal vascular care from 25.0 percent to 36.1 percent (from second half of 2012 to second half of 2013) • Increase in the percentage of patients receiving optimal asthma care from 10.6 percent to 13.8 percent (from last five months of 2012 to last five months of 2013) • In the last month of 2013, 87 percent of members reported being satisfied with their care.
Key references and websites	[1]Sandberg, Shana F. et al., "Hennepin Health: A Safety-Net Accountable Care Organization for the Expanded Medicaid Population." Health Affairs 33, No. 11 (2014). Available from: http://content.healthaffairs.org/content/33/11/1975.abstract. [2]Owen, Ross, "Hennepin Health Presentation." Hennepin University Partnership (2015). Available from: http://hup.umn.edu/docs/HennepinHealth-RossSlides.pdf. See also: Blewett, Lynn A. and Ross Owen., "Accountable Care for the Poor and Underserved: Minnesota's Hennepin Health Model." American Journal of Public Health 105, No. 4 (April 2015). Available from: http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2014.302432. http://www.hennepin.us/healthcare http://www.mhp4life.org/members/hennepin-health
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Minnesota: Preferred Integrated Network (PIN) Program	
Basic Information	
Brief program description	The Preferred Integrated Network (PIN) program is a public-private partnership between Dakota County (Minnesota) and a Medicaid Managed Care Organization (MCO) to coordinate physical and mental health care services for Medicaid-eligible adults under age 65 who have serious mental illness or children with emotional disturbances, including duals. The PIN is an option for individuals in Dakota County who voluntarily enroll in Minnesota's Special Needs BasicCare (SNBC) managed care program and select Medica as their health plan.
Geographic area	Dakota County
Covered populations	Medicaid beneficiaries, including duals, with serious mental illness
Implementation date	2009
Pilot program?	No
Participating payers	Currently Medicaid only (duals can enroll in the PIN but Medicare is no longer integrated in the product)
Program statistics	As of May 2012, there were 402 enrollees in PIN – of these enrollees, 373 were adults, and 271 were dually eligible.

Key Organizations	Core Services/Responsibilities	Provider Information
Medica (Medicaid MCO)	Assistance with enrollment into the PIN. Access to full continuum of medical and behavioral health services	Medica's network of physical and mental health providers and facilities.
Dakota County	Comprehensive assessments across physical health, mental health, and social service continuum. Care planning and care coordination tailored to enrollee's needs and preferences. Assistance in navigating available physical health services, mental health services, and social services.	A county "Wellness Navigator" acts as a single source of contact for each enrollee.

Physical Health/Behavioral Health Integration	
Integration mechanisms	Bluestone Physician Group provides "Clinic without Walls" services to PIN members at community-based mental health locations. Bluestone staff assess PIN members and provide county Wellness Navigators with recommendations on physical health interventions. Many other contracted providers of mental health clinic and case management also have other co-located physical health services.
Direction of integration	Two-way
Data sharing	Medica received a planning grant from the State of Minnesota to work with a consultant on data interoperability, but data exchange is still in development.

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Minnesota: Preferred Integrated Network (PIN) Program	
Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	Accomplished under Minnesota's existing 1115 waiver authority
Payment model	Capitation to Medica as a Medicaid MCO; county funding for program administration and Wellness Navigators
Performance measurement and results	Human Services Research Institute (HSRI) is currently completing an evaluation of the PIN program; the evaluation will be published sometime in the summer of 2015.
Key references and websites	Program does not have a website. HSRI and DesertVista Consulting. "Preferred Integrated Network (PIN) Program Evaluation." Presentation of Preliminary Results, Final Report. June, 2015. SHADAC obtained from Dakota County (has not been made available on the web yet).
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Minnesota: Southern Prairie Community Care (Integrated Health Partnerships Program)	
Basic Information	
Brief program description	Southern Prairie Community Care (SPCC) is a collaboration between 12 counties that share a similar mission: to enhance the quality of life for citizens through facilitating the integration of services and supports provided throughout their communities. SPCC is the first multi-county partnership to join Minnesota's Accountable Care Organization (ACO) demonstration in Medicaid, called the Integrated Health Partnerships (IHP) program. Under this contract with the State of Minnesota, the SPCC's total cost of care (TCOC) for Medicaid enrollees will be measured against targets for both cost and quality. Providers in SPCC's network can share in savings resulting from the program.
Geographic area	12 counties located in southwestern Minnesota (Chippewa, Cottonwood, Jackson, Kandiyohi, Lincoln, Lyon, Nobles, Murray, Redwood, Rock, Swift and Yellow Medicine)
Covered populations	All Medicaid enrollees, except duals. Target populations for SPCC include enrollees with: • Dual diagnoses – mental health and chemical dependency diagnoses and/or those who are mentally ill with co-occurring significant medical conditions • Uncontrolled diabetes management • Pre-diabetes and/or at high risk for diabetes • Frequent hospitalizations or emergency room (ER) visits
Implementation date	March 2014
Pilot program?	No
Participating payers	Medicaid only
Program statistics	As of April 2014, roughly 23,000 Medicaid beneficiaries were attributed to SPCC

Key Organizations	Core Services/Responsibilities	Provider Information
SPCC	• IHP core services include the full scope of Minnesota Health Care Program (MHCP)-covered services, ***excluding*** long-term care and waiver services, dental, durable medical equipment, transportation, foster care/child welfare, and mental health and chemical dependency services that are primarily intensive and residential. • SPCC is the first IHP to include mental health services to their TCOC calculation.	• SPCC's provider members include 27 area clinics, hospitals, public health, mental health centers, and area human services agencies. • CCTs include providers from across the spectrum of services to meet the specific needs of people with complex medical, behavioral health, and support needs.

Appendix: Catalog of Medicaid Initiatives Integrating Behavioral and Physical Health

Minnesota: Southern Prairie Community Care (Integrated Health Partnerships Program)		
	• Community Care Team (CCTs) services • Additionally, Southern Prairie has partnerships with county-based services (e.g., corrections, public health, housing, etc.)	

Physical Health/Behavioral Health Integration	
Integration mechanisms	SPCC assesses Medicaid enrollees for medical and psychosocial issues. Medicaid enrollees are identified by three levels of risk. Individuals identified as "intermediate risk" receive care coordination for 1-3 months, and individuals identified as "high risk" receive care coordination for 6-12 months to address complex medical and psychosocial issues. Individuals identified as "low risk" receive usual care. SPCC has started to embed field staff into member organizations and clinics.
Direction of integration	Two-way
Data sharing	Consultant built an SPCC "cross reference" data set based on Medicaid claims data to SPCC team could see key utilization data at a glance. SPCC is also a Minnesota State Innovation Model (SIM) e-Health grantee, meaning that it is engaged in developing and implementing a Health Information Exchange (HIE) to collect, analyze, and use clinical data across collaborating partners to improve outcomes.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	Minnesota used its existing 1115 wavier plus a State Plan Amendment (SPA) for changing fee-for-service payment methods.
Other state enabling legislation or regulations	2010 legislation mandating that the Minnesota Department of Human Services (DHS) develop a demonstration project to "test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement" (Minnesota Statutes §256B.0755).
Payment model	Shared savings only (no downside risk) based on performance vis-à-vis a TCOC benchmark and core set of clinical quality and patient experience measures. Shared savings are shared equally (50/50) with the state and SPCC in each year of the demonstration when a TCOC savings of 2% or greater is achieved. Savings are shared with SPCC primary care providers, area hospitals, mental health centers, and social service agencies.
Performance measurement and results	The state will use the Minnesota Statewide Quality Reporting and Measurement System measure specifications and reporting requirements, including all updates and modifications, as published by the Minnesota Department of Health (MDH)

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Minnesota: Southern Prairie Community Care (Integrated Health Partnerships Program)	
	Provider Measures • Optimal diabetes care composite (2011 specifications) • Optimal vascular care composite (2011 specifications) • Depression remission at six months • Optimal asthma care (Child/adolescent and Adults) • Patient experience (CG=CAHPS) • Major depression in adults in primary care: percentage of patients whose symptoms are reassessed by the use of a quantitative symptom assessment tool (such as PHQ-9) within six months of initiating treatment (ICSI). Hospital Measures • Heart failure • Pneumonia –Appropriate Care Composite • Home management plan for care for asthma • Patient experience (based on HCAHPS measures)
Key references and websites	http://www.southernprairie.org/
Active as of:	March 2015

Appendix: Catalog of Medicaid Initiatives Integrating Behavioral and Physical Health

Missouri: Community Mental Health Center Healthcare Homes	
Basic Information	
Brief program description	One of two Medicaid health home initiatives in Missouri, the Community Mental Health Center Health Homes initiative is focused exclusively on high-cost Medicaid beneficiaries with (1) serious mental illness, or with (2) other behavioral health problems combined with other chronic conditions or tobacco use. Only community mental health centers (CMHCs) are eligible to participate as health homes under this initiative. Missouri was the first state to amend their Medicaid state plan to implement healthcare homes.
Geographic area	Statewide
Covered populations	Medicaid beneficiaries (both adults and children) with: • Serious mental illness; or • Other behavioral health problems AND diabetes, chronic obstructive pulmonary disease (COPD)/asthma, cardiovascular disease, a Body Mass Index (BMI) greater than 25, developmental disabilities, or tobacco use
Implementation date	Program began in January 2012
Pilot program?	No
Participating payers	Medicaid only
Program statistics	Approximately 20,000 participants and 28 CMHCs comprised of 120 clinics/outreach offices as of November 2014

Key Organizations	Core Services/Responsibilities	Provider Information
CMHCs achieving NCQA Level 1 recognition (and 3 other state-developed standards)	CMHCs provide behavioral health services to Medicaid-eligible and non-Medicaid eligible individuals. Under the CMHC Healthcare Homes initiative, CMHCs also offer comprehensive care management, care coordination, health promotion, transitional care, patient and family support, referral to community and social support services, and use of health information technology to link services for Medicaid beneficiaries.	Health home teams within CMHCs are comprised of: • Nurse care managers (1 FTE per 250 enrollees) • Care coordinators (1 FTE per 500 enrollees) • Health home director (1 FTE per 500 enrollees) • Primary care physician consultant (1 hour per enrollee)

Appendix: Catalog of Medicaid Initiatives Integrating Behavioral and Physical Health

Missouri: Community Mental Health Center Healthcare Homes	
Physical Health/Behavioral Health Integration	
Integration mechanisms	Annual metabolic screenings, diabetes education, treatment per practices guidelines (e.g., heart disease, diabetes, smoking cessation, use of novel anti-psychotics), prevention, performance tracking through patient disease registry. Care coordination is tasked with facilitating communication across providers.
Direction of integration	Primary care integrated into behavioral health setting
Data sharing	• Access to Medicaid electronic health record (EHR) available to all Missouri Medicaid providers • Next day notification of Hospital Admissions and Emergency Department (ED) visits

Regulatory Authority and Performance Information	
Federal regulatory authority	ACA Section 2703 Health Homes, Medicaid State Plan Amendment (SPA) approved on October 20, 2011
Payment model	PMPM capitation paid to CMHCs for health home services; $78.74 PMPM in first year
Performance measurement and results	Health homes will be evaluated through three sets of measures: 1) core measures developed by CMS, 2) state specific measures, and 3) evaluation measures. The CMS core measures include: • Adult body mass index • Screening for clinical depression and follow-up plan • Plan all-cause readmission rate • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Care transition–timely transmission of transition record • Initiation and engagement of alcohol and other drug dependence treatment • Chronic condition hospital admission composite–prevention quality indictor Evaluation measures include: • Hospital admissions • Emergency room visits • Skilled nursing facility admissions In a 2014 presentation, it was noted that Missouri's health home program reported:[1] • Reductions in average blood pressures

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Missouri: Community Mental Health Center Healthcare Homes	
	• Reductions in low-density lipoprotein (LDL) cholesterol levels • Reductions in hemoglobin A1C levels • Reduction in percent of patients with at least 1 hospitalization • Estimated cost reduction of $76 PMPM, or $15.7 million, after 18 months
Key references and websites	[1]Spillman, Brenda C., Barbara Ormond and Elizabeth Richardson, The Urban Institute. "Medicaid Health Homes in Missouri: Review of Pre-existing State Initiatives and State Plan Amendments for the State's First Section 2703 Medicaid Health Homes." June 29, 2012. Available from: http://aspe.hhs.gov/daltcp/reports/2012/HHOption-MO.pdf. See also: Parks, Joe. "Integrating Primary Care and Behavioral Health," National Association of Medicaid Directors (November, 2014). Available from: http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/realizing_behavioral_health_integration_in_medicaid_parks.pdf. http://dmh.mo.gov/mentalillness/mohealthhomes.html
Active as of:	March 2015

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New Jersey: Behavioral Health Homes	
Basic Information	
Brief program description	New Jersey has two related health homes initiatives established with separate SPAs: one targets adults with severe mental illness, and one targets children with severe emotional disturbances. Because the child health homes initiative is focused more on case management than physical and behavioral health integration, this summary addresses only the adult health homes initiative. Only community mental health centers (CMHCs) are eligible to participate as adult behavioral health homes (BHHs) under this initiative.
Geographic area	Bergen County (most populous county of New Jersey)
Covered populations	Adults with severe mental illness, who are high-utilizers or at risk of high utilization
Implementation date	July 2014
Pilot program?	No
Participating payers	Medicaid only
Program statistics	Unclear

Key Organizations	Core Services/Responsibilities	Provider Information
BHHs (CMHCs)	Health home services – comprehensive care management, care coordination, health promotion, transitional care, patient and family support, referral to community and social support services	Health home teams are comprised of: a nurse care manager, a care coordinator, a wellness educator, a consulting psychiatrist, a consulting primary care physician, and support staff. Optional team members include: a nutritionist/dietitian, a peer specialist, a pharmacist, and a hospital liaison.
More information: Nurse care manager must be a registered nurse, care coordinator must be a licensed social worker or licensed practical nurse; primary care is required to be fully or partially co-located with the BHH (full-time or part-time clinic in the BHH) within 3 years of becoming a health home.		

Physical Health/Behavioral Health Integration	
Integration mechanisms	Assessment of consumer needs, development of care plan, coordination of care plan services, and ongoing assessment and revisions of care plan
Direction of integration	Primary care into behavioral health setting
Data sharing	Health homes are required to have an EHR

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New Jersey: Behavioral Health Homes	
Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	ACA Section 2703 Health Homes; Health Home State Plan Amendment (SPA)
Payment model	Per member per month payment to health home, tiered according to phases defined by clinical indicators, frequency of intervention, and defined duration. Engagement: $480 PMPM; Active: $401 PMPM; Maintenance: $120 PMPM.
Performance measurement and results	Health homes will be evaluated through three sets of measures: 1) core measures developed by CMS, 2) state specific measures, and 3) evaluation measures. The CMS core measures include: • Adult body mass index • Screening for clinical depression and follow-up plan • Plan all-cause readmission rate • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Care transition–timely transmission of transition record • Initiation and engagement of alcohol and other drug dependence treatment • Chronic condition hospital admission composite–prevention quality indictor Evaluation measures include: • Hospital admissions • Emergency room visits • Skilled nursing facility admissions The state plans to track: • All-cause 30-day hospital readmissions • Cost savings • Hospital admissions • ED visits • Skilled nursing admissions
Key references and websites	New Jersey SPA, available from: http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NJ/NJ-14-0005.pdf
Active as of:	March 2015

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North Carolina: Community Care of North Carolina	
Basic Information	
Brief program description	The State of North Carolina contracts with Community Care of North Carolina (CCNC)—a not-for-profit organization—to administer North Carolina's statewide medical home and care management system. In this capacity, CCNC works through CCNC-affiliated networks, care managers, and primary care practices to promote primary care medical homes, deliver care management/coordination, lead statewide disease and population health initiatives, and address quality, utilization, and cost concerns in Medicaid. Local CCNC-affiliated networks are non-profit organizations (either independent non-profit organizations, components of academic health centers, federally qualified health centers, or public health departments) with their own leadership and staff, and board of directors. In 2010, the state provided an additional per member per month (PMPM) payment to CCNC to support the integration of behavioral health services into CCNC-affiliated primary care practices – the aim is to support these practices in becoming medical homes for Medicaid enrollees with behavioral health problems.
Geographic area	Statewide
Covered populations	Medicaid-eligible adults (including duals)
Implementation date	CCNC evolved from a small medical home pilot that began in the 1980's. A basic version of the current program was piloted in 7 rural counties in 1998; CCNC officially launched statewide in 2001, but focused on single chronic illnesses like asthma and diabetes. In 2005, CCNC incorporated aged, blind, and disabled (ABD) populations and began to focus on the treatment of multiple chronic illnesses. Behavioral health integration efforts began in 2010.
Pilot program?	No
Participating payers	Medicaid only, though CCNC is currently piloting a multi-payer approach in 7 counties.
Program statistics	As of May 2013, 14 CCNC networks covered all 100 counties in the state, serving 1.3 million enrollees. 4,500 primary care physicians in 1,400 practices participate in CCNC's network.

Key Organizations	Core Services/Responsibilities	Provider Information
CCNC central office	Statewide administrative responsibilities such as: • Informatics • Analytics • Identification of enrollees in need of care management • Training	At the central office, a psychiatrist directs the behavioral health initiatives and is supported by another psychiatrist/associate director, a behavioral health pharmacist, and a program manager.

Appendix: Catalog of Medicaid Initiatives Integrating Behavioral and Physical Health

North Carolina: Community Care of North Carolina		
	• Marketing	
CCNC networks (14 local non-profit organizations)	• Linking enrollees to primary care medical homes • Providing care coordination and care management • Monitoring medications • Assisting with care transitions and hospital discharge planning • Connecting enrollees to needed medical, behavioral, and social services • Conducting patient education • Support providers	Each CCNC network has a Clinical Director who is a physician, a Network Director who manages daily operations, Care Managers (typically RNs or social workers), and a pharmacist to assist with medical management. An enhanced per member per month (PMPM) payment for behavioral health integration allows each CCNC network to utilize the services of a Psychiatrist and Behavior Health Coordinator. 10 psychiatrists and 14 behavioral health coordinators have been added to CCNC's networks since 2010.
CCNC-affiliated primary care practices	Primary care services; medical home care	Primary care providers See note below on behavioral health professionals

Physical Health/Behavioral Health Integration	
Integration mechanisms	CCNC's behavioral health project includes: efforts to integrate and co-locate physical and mental health services in CCNC-affiliated primary care practices; participation in community-wide partnerships such as Project Lazarus (appropriate use of opiod pain medication); collaboration in Screening, Brief Intervention, Referral and Treatment (SBIRT) efforts for individuals at risk for tobacco, alcohol, or drug use problems; and the development of depression toolkits for primary care providers. [It is not clear based on information available to what extent behavioral health professionals have been integrated into CCNC-affiliated primary care practices.]
Direction of integration	Integration of behavioral health into primary care settings
Data sharing	CCNC has incorporated behavioral health "flags" in their existing electronic care management tool to identify members in need of assistance. A CCNC patient portal allows providers and case managers to view integrated medical records, including individuals' utilization of physical and behavioral health services and prescription drugs. North Carolina provides CCNC with access to Medicaid claims data. CCNC's Informatics Center provides reports on utilization, providers, diagnoses, costs, individual and population level care alerts, and other performance indicators. CCNC also receives real-time data on hospitalizations, emergency department (ED) visits, and provider referrals.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	CCNC was initially authorized through a 1915(b) managed care waiver, but is now authorized through a State Plan Amendment (SPA).

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North Carolina: Community Care of North Carolina	
Payment model	CCNC receives per member per month (PMPM) payment from the state. PMPM payment amounts are higher for ABD enrollees and lower for non-ABD enrollees. Payments were increased in 2010 to fund CCNC's behavioral health integration activities. CCNC sends a portion of PMPM payments to local CCNC networks to fund their activities. The state also pays each CCNC-affiliated practice a PMPM fee for enrollees (also higher for ABD enrollees and lower for non-ABD enrollees), in addition to fee-for-service payments for physical health services.
Performance measurement and results	Using claims analysis and chart reviews, a broad array of quality measures for diabetes, asthma, hypertension, cardiovascular disease, and heart failure are tracked. CCNC's affiliated primary care practices receive their quality results annually, with comparisons to various benchmarks (e.g., last year's results, network results, NCQA/HEDIS benchmarks). [At this time, quality measurement efforts do not appear to incorporate behavioral health metrics.] CCNC's cost savings/effectiveness has been evaluated by several third-party consultants over the years. Most recently, a 2011 Milliman report shows that CCNC reduced state Medicaid costs by nearly a billion dollars between 2007-2010 through care management, mainly through reductions in inpatient hospital admissions and emergency room visits. These results are not specific to CCNC's behavioral health integration activities.
Key references and websites	http://www.communitycarenc.com/
Active as of:	March 2015

Appendix: Catalog of Medicaid Initiatives Integrating Behavioral and Physical Health

Ohio: Health Homes	
Basic Information	
Brief program description	Ohio's health home program targets Medicaid beneficiaries with serious and persistent mental illness (SPMI). Community Behavioral Health Centers (CBHCs) are designated health home providers. Plans to expand beyond the five initial counties within a year appear to have been delayed.
Geographic area	5 counties (Adams, Butler, Lawrence, Lucas, and Scioto) counties
Covered populations	Medicaid-enrolled adults with serious mental illness (SMI) and Medicaid-enrolled children with serious emotional disturbances (SED)
Implementation date	October 2012
Pilot program?	No
Participating payers	Medicaid only
Program statistics	5 CBHCs with 19 clinics (as of April 2013); 14,221 enrollees (as of August 2013)

Key Organizations	Core Services/Responsibilities	Provider Information
CBHCs	Health home services – comprehensive care management, care coordination, health promotion, transitional care, patient and family support, referral to community and social support services; additionally, health homes are required to offer on-site community support services.	Health home team composition: • Health home team leader • Embedded primary care clinician • Care manager • Qualified health home specialist
More information: Health home team leader can be a licensed independent social worker, professional clinical counselor, independent marriage and family therapist, registered nurse with a master of science in nursing, certified nurse practitioner, clinical nurse specialist, psychologist or physician. An embedded primary care clinician can be a primary care physician, internist, family practice physician, pediatrician, gynecologist, obstetrician, certified nurse practitioner with primary care scope of practice, clinical nurse specialist with primary care scope of practice, or physician assistant. A care manager can be a licensed social worker, independent social worker, professional counselor, professional clinical counselor, marriage and family therapist, independent marriage and family therapist, registered nurse, certified nurse practitioner, clinical nurse specialist, psychologist or physician. A qualified health home specialist can be a pharmacist, licensed practical nurse; qualified mental health specialist with a four-year degree, two-year associate degree or commensurate experience; wellness coach; peer support specialist; certified tobacco treatment specialist, health educator or other qualified individual (e.g., community health worker with associate degree).		

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Ohio: Health Homes	
Physical Health/Behavioral Health Integration	
Integration mechanisms	Comprehensive assessment of physical health, behavioral health, long-term care and social needs; integrated care plan. Health homes must have communication plans to ensure communication between providers.
Direction of integration	Primary care integrated into behavioral health setting
Data sharing	CBHC must acquire or adopt an electronic health record (EHR) product within 12 months of receiving designation as a Health Home provider, and must use the EHR within 24 months. CBHC must participate in a statewide Health Information Exchange (HIE) once one is available.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	ACA Section 2703 Health Homes; Health Home State Plan Amendment (SPA)
Payment model	Monthly per member per month payment to CBHCs that covers all health home service components; plan to incorporate pay for performance in year 3 of the program
Performance measurement and results	Health homes will be evaluated through three sets of measures: 1) core measures developed by CMS, 2) state specific measures, and 3) evaluation measures. The CMS core measures include: • Adult body mass index • Screening for clinical depression and follow-up plan • Plan all-cause readmission rate • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Care transition–timely transmission of transition record • Initiation and engagement of alcohol and other drug dependence treatment • Chronic condition hospital admission composite–prevention quality indictor Evaluation measures include: • Hospital admissions • Emergency room visits • Skilled nursing facility admissions State-Selected Measures include:

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Ohio: Health Homes	
	• Asthma medication management • Cholesterol management • Comprehensive diabetes care — Hemoglobin A1c (HbA1c) level less than 7 percent • Comprehensive diabetes care — Cholesterol management/LDL screening • Smoking and tobacco cessation • Timeliness of prenatal care • Adolescent well-care visits • Adults' access to preventative/ambulatory health services • Appropriate treatment for children with upper respiratory infections • Inpatient and emergency department utilization • Medication reconciliation post-discharge
Key references and websites	http://mha.ohio.gov/Default.aspx?tabid=536
Active as of:	March 2015

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Oklahoma: Health Homes	
Basic Information	
Brief program description	Oklahoma has two related health homes initiatives established with separate State Plan Amendments (SPAs): one targets adults with severe mental illness, and one targets children with severe emotional disturbances. This summary provides a description of both health home initiatives. Only state certified community mental health centers (CMHCs) and other outpatient behavioral health providers are eligible to participate as health homes under these initiatives.
Geographic area	Statewide
Covered populations	Adults with severe mental illness and children with severe emotional disturbances
Implementation date	January 2015
Pilot program?	No
Participating payers	Medicaid only
Program statistics	19 adult health home providers; 21 child health home providers

Key Organizations	Core Services/Responsibilities	Provider Information
Certified CMHCs or outpatient behavioral health providers	Health home services – comprehensive care management, care coordination, health promotion, transitional care (from impatient to other settings and from pediatric to adult settings), individual and family support, referral to community and social support services	**Adult health homes** Health home teams for low-medium intensity adults are comprised of: a health home director, a nurse care manager, a consulting primary care provider, a psychiatric consultant, a certified behavioral health case manager, a wellness coach, and a medical assistant. Health home teams for high intensity adults are comprised of the positions above plus: two licensed behavioral health professionals, a substance abuse treatment specialist, and an employment specialist. **Child health homes** Health home teams for children are comprised of: a care coordinator, a project director, a psychiatric consultant, a nurse care manager, a family support provider, a youth/peer support specialist, and an administrative assistant.

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Oklahoma: Health Homes

Physical Health/Behavioral Health Integration	
Integration mechanisms	**Adult health homes** Assessment of service needs and development and implementation of a comprehensive care plan, including physical and mental health **Child health homes** Bio-psychosocial assessment of physical and psychological status and social functioning. Development and implementation of an individual care plan through wrap-around planning, including medical, social, vocational, educational and other support services
Direction of integration	Primary care into behavioral health setting
Data sharing	Health homes must meet initial HIT standards to begin a health home and must meet final standards within 18 months of becoming a health home, including utilizing an EHR that meets Meaningful Use standards or having a plan for when and how to implement it, joining an HIE and committing to sharing information with all providers. Health homes have access to a patient registry that aids in enrollment, reporting and tracking, identifying gaps in care and best treatment practices for members.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	ACA Section 2703 Health Homes; Health Home SPA
Payment model	**Adult health homes** Per member per month payment to health homes, according to the health home location (urban vs. rural) and tier of services provided to members: Tier I – Outreach and engagement services, can be billed for up to 3 months ($53.98 urban and rural); Tier II – Low-medium intensity enrollees ($127.35 urban, $146.76 rural); Tier III – High Intensity-Programs of Assertive Community Treatment (PACT) enrollees ($453.96 urban and rural) **Child health homes** Per member per month payment to health homes, according to the health home location (urban vs. rural) and tier of services provided to members: Tier I – Outreach and engagement services, can be billed for up to 3 months ($53.98 urban and rural); Tier II – Resource coordination services ($297.08 urban, $345.34 rural); Tier III – Wrap-around intensive care coordination services ($864.82 urban; $1,009.60 rural)
Performance measurement	Health homes will be evaluated through three sets of measures: 1) core measures developed by CMS, 2) state specific

Oklahoma: Health Homes	
and results	measures, and 3) evaluation measures. The CMS core measures include: • Adult body mass index • Screening for clinical depression and follow-up plan • Plan all-cause readmission rate • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Care transition–timely transmission of transition record • Initiation and engagement of alcohol and other drug dependence treatment • Chronic condition hospital admission composite–prevention quality indictor Evaluation measures include: • Hospital admissions • Emergency room visits • Skilled nursing facility admissions The state plans to track: • Avoidable hospital readmissions • Cost savings • Hospital admissions • ED visits • Skilled nursing admissions
Key references and websites	https://www.okhca.org/providers.aspx?id=16525
Active as of:	March 2015

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Rhode Island: Community Mental Health Organization Health Homes	
Basic Information	
Brief program description	One of two health home initiatives, the Community Mental Health Organization health homes initiative is focused exclusively on Medicaid beneficiaries with severe and persistent mental illness (SPMI). Only community mental health organizations (CMHOs) (including specialty mental health providers) are eligible to participate as health homes under this initiative.
Geographic area	Statewide
Covered populations	Medicaid beneficiaries with SPMI who have (1) had intensive psychiatric treatment, (2) experienced an episode of continuous, structured supportive residential care, or (3) had impaired roll functioning. They also must meet at least two of the following criteria for at least two years: • Be employed in a sheltered setting or have limited skills/work history • Require public financial assistance for out-of-hospital maintenance • Be unable to maintain personal social support system • Require help with basic living skills • Exhibit inappropriate social behavior that requires intervention by the mental health/judicial system
Implementation date	October 2011
Pilot program?	No
Participating payers	Medicaid only
Program statistics	• 7 CMHOs and 2 specialty mental health centers serve as health homes • Roughly 5,200 enrollees (as of November 2013)

Key Organizations	Core Services/Responsibilities	Provider Information
CMHOs/specialty mental health providers	Health home services – comprehensive care management, care coordination, health promotion, transitional care, patient and family support, referral to community and social support services	A total of up to 11.25 FTEs per 200 clients: Master's level team coordinator (1 FTE), psychiatrist (0.5 FTE), registered nurse (2.5 FTE), licensed and Master's level mental health professional (0.5 FTE), and community support professions including hospital liaison (1 FTE), community support care coordinators (5.5 FTE), peer specialist (0.25 FTE) Optional: Primary care physicians, pharmacists, substance abuse specialists, vocational/employment specialists,

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Rhode Island: Community Mental Health Organization Health Homes		
		community integration specialists, housing facilitators
More information: In Rhode Island, Medicaid-only individuals with SPMI are auto-enrolled in managed care with a behavioral health carve out.		

Physical Health/Behavioral Health Integration	
Integration mechanisms	Bio-psychosocial assessment of physical and psychological status and social functioning; integrated care planning
Direction of integration	Primary care integrated into behavioral health setting
Data sharing	Rhode Island received a grant to integrate behavioral healthcare data into its statewide Health Information Exchange (HIE) called CurrentCare. CMHOs implemented memorandums of understanding to access CurrentCare and enroll consumers. However, health homes continue to rely on enrollee data supplied to them by managed care organizations (MCOs) and the state (for dual eligibles).

Regulatory Authority and Performance Information	
Federal regulatory authority	ACA Section 2703 Health Homes; Health Home State Plan Amendment (SPA)
Payment model	Single, statewide monthly case rate ($444.21 per member per month) based on estimated costs of health home staff, health team composition, and caseload, paid directly to health homes
Performance measurement and results	Health homes will be evaluated through three sets of measures: 1) core measures developed by CMS, 2) state specific measures, and 3) evaluation measures. The CMS core measures include: • Adult body mass index • Screening for clinical depression and follow-up plan • Plan all-cause readmission rate • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Care transition–timely transmission of transition record • Initiation and engagement of alcohol and other drug dependence treatment • Chronic condition hospital admission composite–prevention quality indictor Evaluation measures include: • Hospital admissions • Emergency room visits • Skilled nursing facility admissions

Rhode Island: Community Mental Health Organization Health Homes	
	The state has also noted that six goals for the program include: • Improving care coordination; • Reducing preventable emergency department utilization; • Increasing preventive services utilization; • Improving the management of chronic conditions; • Improving transitions to community mental health organization services; and • Reducing hospital readmissions. Rhode Island also uses claims and CMHO encounter data, intake surveys of CMHO clients, and chart reviews to evaluate progress. The state also collects self-reported data from the Rhode Island Behavioral Health Online Database.
Key references and websites	Spillman, Brenda C., Barbara Ormond and Elizabeth Richardson, The Urban Institute. "Medicaid Health Homes in Rhode Island: Review of Pre-existing State Initiatives and State Plan Amendments for the State's First Section 2703 Medicaid Health Homes." May 3, 2012. Available from: http://aspe.hhs.gov/daltcp/reports/2012/HHOption-RI.pdf
Active as of:	March 2015

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Vermont: Vermont Blueprint for Health	
Basic Information	
Brief program description	The Vermont Blueprint for Health is a statewide multi-payer initiative that aims to turn primary care practices into patient-centered medical homes (PCMHs) that provide mental health services and to support community health teams (CHTs) offering multidisciplinary care coordination and support services. The Blueprint is increasing the capacity of the primary care system to treat mild to moderate behavioral health issues within the primary care system, as well as to collaborate with specialty mental health system for individuals with greater needs.
Geographic area	Statewide
Covered populations	All Medicaid beneficiaries plus state residents covered by other participating private payers or Medicare
Implementation date	Originally piloted in 2006, modified in 2007 and 2008, and expanded statewide in 2010.
Pilot program?	No
Participating payers	Medicaid, Medicare, 3 major commercial insurers (BlueCross, MVP, Cigna), and 2 large self-insured employers (IBM and the state)
Program statistics	• Attributed patients: 347,489 (12/2013) • Active PCMHs: 124 (12/2014) • Unique providers: 682 (12/2014) • Core CHT staff: 218 staff members/135 FTEs (12/2014)

Key Organizations	Core Services/Responsibilities	Provider Information
Administrative Entities in each of Vermont's Health Service Areas (HSAs) lead the Blueprint locally	Local implementation of the Blueprint, including: • Working with the community to determine the design and functions of CHTs, • Facilitating CHTs, • Coaching and facilitation to practices, CHTs, and other providers, and • Managing program finances.	Multidisciplinary CHTs (typically made up of nurse care coordinators, social works, counselors, dieticians, health educators, and others) coordinate patient care and link patients to medical and non-medical providers in the community.

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Vermont: Vermont Blueprint for Health		
Primary care practices that are recognized as PCMHs by the National Committee for Quality Assurance (NCQA)	Provision of primary care services, along with the following: • Providing comprehensive prevention and disease screening for his or her patients and managing his or her patients' chronic conditions by coordinating care, • Enabling patients to have access to personal health information through a secure medium, such as through the Internet, consistent with federal health information technology standards, • Using a uniform assessment tool provided by the Blueprint in assessing a patient's health, • Collaborating with community health teams, including by developing and implementing a comprehensive plan for participating patients, • Ensuring access to a patient's medical records by the community health team members in a manner compliant with federal and state law, and • Meeting regularly with the community health team to ensure integration of a participating patient's care.	Generally, primary care physicians, nurse practitioners, and physician assistants. One of the goals of the Blueprint is to support PCMHs in providing "advanced primary care", including providing primary care and behavioral health team-based care.
More information: Generally, the Blueprint Administrative Entity is the local community hospital, though in some cases it is the Federally Qualified Health Center (FQHC) or Community Mental Health Center, based on the characteristics of the HSA. Each Administrative Entity hires a Blueprint Project Manager, a local leader in the community and surrounding area.		

Physical Health/Behavioral Health Integration	
Integration mechanisms	Beyond the work of the core CHTs, CHT "extenders", employed by the state and placed throughout the state in field district offices/medical sites, are available to provide additional care management support to beneficiaries of Medicaid or Medicaid who are high risk and high cost (high ED usage, avoidable admissions/readmissions, multiple specialists). The state identifies these cases through a risk-stratification process and through practitioner referrals. Extenders are integrated with Blueprint CHTs.
Direction of integration	Integrating the treatment of behavioral health into the primary care setting.
Data sharing	The Blueprint and Vermont Information Technology Leaders (VITL) work to provide connectivity from electronic health records (EHRs) to the Vermont Health Information Exchange (VHIE). They also assist Blueprint practices with improving the quality of data in their EHRs and the VHIE. EHRs are used to risk-stratify patients that need attention. Clinicians can

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Vermont: Vermont Blueprint for Health	
	view a patient's comprehensive clinical record at the point of care through VITLAccess.

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	Section 1115 waiver authorizes Medicaid funding; CMS Multipayer Advanced Primary Care Practice Demonstration authorizes Medicare funds
Other state enabling legislation or regulations	Vermont Act 48 of 2011 required the state to pilot payment reforms moving away from volume-based incentives toward unified budgets and eventually a single-payer system.
Payment model	Two specific funding streams: • **Transformation payments.** The state makes Per Patient Per Month (PPPM) payments directly to primary care practices with NCQA-PCMH recognition. This payment is quality-based and is in addition to traditional fee-for-service payments. • **Capacity payments.** All insurers share the cost for core CHT members through capacity payments to Administrative Entities. Total support is provided at the rate of $70,000 (~1.0 FTE) / 4000 patients, which amounts to about $1.50 per patient per month.
Performance measurement and results	Key results include:[1] • Fewer hospitalizations for Medicaid insured children (23.9 vs 33.3 in control group), for Medicaid insured adults (137.8 vs. 149.4 in control group), and for commercially insured adults (47.1 vs. 53.4 in control group) • Fewer ED visits for Medicaid insured children (521 vs 485.1 in control group), and for commercially insured adults (205.1 vs 214.7 in control group) • Increase in primary care visits for Medicaid adults and commercially insured children • Increase in breast cancer screening in commercially insured adults (78.5 vs 77.1 in control group) • Increase in cervical cancer screenings in in Medicaid insured adults (59.6 vs 55.3 in control group) and commercially insured adults (68.8 vs 67 in control group) • Increase in adolescent well-care visits in commercially insured participants (59.8 vs 53.2 in control group) • Total annual expenditures in 2012 were reduced by: $200 for each Medicaid insured participant in the 1-17 age group, $447 for each Medicaid insured participant in the 18-64 age group, $386 (19%) for each commercially insured participant in the 1-17 age group, and $586 (11%) for each commercially insured participant in the 18-64 age group.
Key references and websites	[1]"Vermont Blueprint for Health, 2013 Annual Report," Department of Vermont Health Access (January 2014). Available from: http://blueprintforhealth.vermont.gov/reports_and_analytics/annual_reports. See also: http://blueprintforhealth.vermont.gov/
Active as of:	March 2015

West Virginia: Health Homes	
Basic Information	
Brief program description	West Virginia's health home program is currently open to Medicaid beneficiaries of any age with bi-polar disorder who are

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West Virginia: Health Homes	
	at risk of or are infected with hepatitis types B and/or C. It is limited in geographic scope to six counties with the largest bi-polar population. Approved behavioral health homes currently include federally qualified health centers (FQHCs), other specialty care centers, and community mental health centers.
Geographic area	6 counties (Wayne, Cabell, Putnam, Kanawha, Raleigh and Mercer) counties
Covered populations	Medicaid-enrolled individuals who are at risk for hepatitis type B or type C
Implementation date	July 2014
Pilot program?	No
Participating payers	Medicaid only
Program statistics	8 health home providers (as of March 2015)

Key Organizations	Core Services/Responsibilities	Provider Information
Certified health home providers	Health home services – comprehensive care management, care coordination, health promotion, transitional care, patient and family support, referral to community and social support services	Health home team composition: • Team leader/primary care provider • Behavioral health specialist • Registered nurse (RN) • Care manager • Care coordinator Additional optional team members include: • Pharmacists, social workers, mental health workers, health educators, community health workers, lay educators and peer support • Medical specialists, such as gastroenterologists, hepatologists and infectious disease specialists
More information: Health home team leader must be a primary care provider, either a physician or an advanced practice nurse. A behavioral health specialist must be a master's degree-level licensed psychologist, professional counselor or social worker. A care manager must be a registered nurse or a licensed clinical social worker. A care coordinator must have a bachelor's degree in social science with relevant experience, and this role may be filled by another existing team member (e.g., RN or care manager).		

Physical Health/Behavioral Health Integration

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West Virginia: Health Homes	
Integration mechanisms	Comprehensive assessment of medical, mental health, substance abuse and social service needs; integrated care plan addressing behavioral health, rehabilitative, long-term care and social service needs
Direction of integration	Behavioral health integrated into primary care setting
Data sharing	Health homes must use an electronic health record (EHR) system that qualifies for Meaningful Use, allowing access to patients' health information and care plan to the interdisciplinary team. Health homes also may access the state's Health Information Exchange (HIE).

Regulatory Authority and Performance Information	
Federal regulatory authority or funding source	ACA Section 2703 Health Homes; Health Home State Plan Amendment (SPA)
Payment model	Per member per month payment to health home teams, tiered according to whether the individual requires standard or intensive service (Level I – Standard Service: $51 per member per month; Level II – Intensive Service: additional $229.50 per member per year)
Performance measurement and results	Health homes will be evaluated through three sets of measures: 1) core measures developed by CMS, 2) state specific measures, and 3) evaluation measures. The CMS core measures include: • Adult body mass index • Screening for clinical depression and follow-up plan • Plan all-cause readmission rate • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Care transition–timely transmission of transition record • Initiation and engagement of alcohol and other drug dependence treatment • Chronic condition hospital admission composite–prevention quality indictor Evaluation measures include: • Hospital admissions • Emergency room visits • Skilled nursing facility admissions The state plans to track: • Total readmissions within 30 days of a hospital discharge

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West Virginia: Health Homes	
	• Total cost of care vs. similar beneficiaries not enrolled in health homes • Hospital admissions • ED visits • Skilled nursing admissions
Key references and websites	http://www.dhhr.wv.gov/bms/HH/Pages/default.aspx
Active as of:	March 2015