

# Using Medicaid Accountable Care Initiatives to Improve Care for People with Serious Behavioral Health Conditions



Prepared by Wendy Holt and Richard Dougherty of DMA Health Strategies and Chuck Ingoglia and Rebecca Farley David of the National Council for Behavioral Health.

© 2017

## ABOUT NATIONAL COUNCIL

The **National Council for Behavioral Health** is the unifying voice of America's health care organizations that deliver mental health and addictions treatment and services. Together with our 2,900 member organizations serving over 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery. The National Council helped introduce [Mental Health First Aid USA](#) and more than 1 million Americans have been trained.

## ABOUT DMA HEALTH STRATEGIES

DMA Health Strategies (DMA) provides effective, data driven strategies to support health systems change and quality improvement. Its work includes strategic planning, change management and quality improvement with public and private behavioral health organizations across the country. DMA is committed to improving our nation's mental health and substance use disorder services by providing the best possible consulting services to its healthcare leaders. Since 1987, DMA has provided services that combine experience in management, organizational behavior, research methods, public policy, and systems analysis. DMA has assisted public and private agencies that offer mental health, substance abuse, medical, child welfare, and intellectual disability services. Much of its work has involved the design, procurement and implementation of managed behavioral healthcare and blended funding initiatives for states and counties. These projects have involved Medicaid, Title IV, and state and local funds for the delivery of health care to people with disabilities, special needs children, children in foster care, and individuals with mental illness and/or addictions. DMA is a leader in the implementation of self-directed care and its work also includes quality improvement collaboratives and performance measurement in publicly funded healthcare systems.



# Contents

- I. Context and Purpose ..... 1**
- II. New and Emerging 1115 Demonstration Models.....2**
  - A. Introduction ..... 2
  - B. Accountable Care Organizations (ACOs). ..... 2
  - C. Delivery System Reform Incentive Payment (DSRIP) Waivers. .... 4
  - D. Cost-effective, Accountable Care for Population Health ..... 4
- III. Key Aspects of ACO Design ..... 5**
  - A. Primary Goal of ACOs ..... 5
  - B. Service Population..... 5
  - C. Scope of Services Provided ..... 5
  - D. ACO Lead Entity ..... 6
  - E. Payment Arrangements..... 6
  - F. Data Sharing ..... 7
- IV. Waiver or Contract Recommendations for Accountable Medicaid Services.....8**
  - A. Enrollment/Attribution ..... 8
  - B. Access to Services..... 9
    - 1. Outreach ..... 9
    - 2. Inclusion of Behavioral Health Providers in ACOs ..... 10
    - 3. Benefits and Services ..... 11
    - 4. Medical Care for People with SED, SMI, and SUD ..... 12
    - 5. Social Determinants of Health ..... 13
    - 6. Network Standards..... 13

C.	Service Authorization.....	15
1.	Authorization of Services .....	16
2.	Authorization of Medications.....	16
3.	Appeal .....	17
D.	Care Coordination.....	18
E.	Information Management .....	20
1.	Capabilities for Sharing Population Information.....	21
2.	Capabilities for Sharing Individual Client Information.....	21
3.	Capabilities to Share Behavioral Health Information.....	22
F.	ACO Governance .....	22
G.	Financing and Shared Savings.....	23
H.	Quality .....	24
1.	Quality Measures for Behavioral Health.....	25
2.	Quality Measures for People with SED, SMI and serious SUD.....	25
3.	Cultural Competency.....	26
I.	Oversight .....	26
J.	Conclusion .....	27
<b>Appendix A: Performance Measures .....</b>		<b>28</b>
A.	Well Established Measures.....	29
1.	Measures of Behavioral Health Service.....	29
2.	Measures of primary and medical care relevant for people with behavioral health problems .....	31
3.	Administrative Measures.....	33
4.	Measures of Potential Benefit .....	33
B.	Sources for Performance Measures.....	35
1.	National Sources.....	35
2.	State Sources.....	36
3.	Other Sources of Measures .....	37
<b>Appendix B: Summary of Medicaid Managed Care Final Rules .....</b>		<b>38</b>
A.	Overview of Medicaid Parity Regulations for Managed Care .....	38
1.	Design and Payment .....	38
2.	Plan Standards .....	38
3.	Consumer and Provider Rights and Enforcement.....	39
B.	Selected Provisions of the Medicaid Managed Care Final Rule.....	40
1.	Enrollment and Consumer Choice.....	40
2.	Networks .....	41
3.	Service Authorization .....	42
4.	Appeals .....	42
5.	Care Coordination .....	43
6.	Stakeholder Input on LTSS.....	44
7.	Cultural Competency.....	44
8.	Quality Improvement .....	44
9.	Regulatory Oversight.....	45
<b>Endnotes .....</b>		<b>47</b>

# I. Context and Purpose

Since 2014, many states have increased their use of value-based purchasing and have begun redesigning health systems to include payment reforms and build upon local provider networks, assigning them responsibility for managing their patients' care. The Accountable Care Organization (ACO) model is an approach by many public and private health systems to incentivize cost effectiveness and quality improvement. This paper addresses the design and operational features for ACOs that are necessary to ensure that they provide early identification and treatment of behavioral health conditions as well as effective care for people with complex behavioral health conditions.

Today's ACOs are operating in the context of two federal regulations with a particular impact on care delivery in Medicaid. In 2016, Centers for Medicare and Medicaid Services (CMS) issued the Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP (PFR), which applies provisions of the Mental Health Parity and Addictions Equity Act (MHPAEA) to Medicaid managed care organizations, Medicaid alternative benefit plans (ABPs), and the Children's Health Insurance Program<sup>1</sup>. Previously, parity laws applied to Medicaid managed care only to the extent that behavioral health services were included in the managed care benefit. The PFR requires states to amend their state plans, if necessary, to provide Medicaid behavioral health services at parity with medical/surgical services for Medicaid managed care, ABP, and CHIP beneficiaries, as well as for any behavioral health services provided outside of these programs in the fee-for-service system.

Also in 2016, for the first time in 14 years, CMS revised regulations for Medicaid managed care. This rule sets standards that protect Medicaid enrollees served through managed care in a number of ways, including establishing an expansive medical necessity standard. It also requires health care plans to provide information to assist consumers in making informed choices between managed care organizations (MCOs); states to establish time and distance standards for plan provider networks; Medicaid health plans to spend at least 85% of payments on services and quality improvement; health plans to address the special needs of people who need or use Long Term Services and Supports (LTSS); and states to draft, implement and update a comprehensive quality plan for managed care every three years. (The provisions of these two new regulations with particular relevance for Medicaid enrollees with behavioral health needs are summarized in Appendix B.)

Both CMS and the states increasingly recognize behavioral health services as a critical component of care for Medicaid members. While some Medicaid ACOs do not include behavioral health services, many require behavioral health services and providers to be included and measure the quality of behavioral health care as part of performance incentives. Some go further, and provide the option for inclusion of non-medical community services that are of significance for Medicaid members.

This paper primarily addresses the ACO model and how it can be used to best meet the needs of children with serious emotional disturbance (SED) and adults with serious mental illness (SMI) and/or serious substance use disorder (SUD). The paper is a resource for administrators, providers, health advocates and others in states that are considering health system reforms for their public and private health systems. It draws upon what has been learned about Medicaid ACOs and makes recommendations about how states can ensure that their Medicaid health system addresses the behavioral health needs of all their members.

## II. New and Emerging 1115 Demonstration Models

### A. Introduction

Section 1115 Waivers are a key tool allowing states to design alternative ways to deliver Medicaid services that differ from federal program rules, including by implementing ACOs. Section 1115 initiatives waive specified rules so that states can conduct experimental, pilot, or demonstration projects that are consistent with the objectives of the Medicaid program. Most demonstration models discussed here use 1115 Waivers. These waivers are required to be budget neutral, meaning that federal spending under the waiver should not exceed expected federal spending if the waiver was not in place.

Even with increasing enrollment of Medicaid beneficiaries into managed care, the costs of health care and coverage have continued to rise, while quality and outcomes are not increasing. In response, all sectors of the health care system have had to redouble their commitment to achieving the Triple Aim: improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. There is now a concerted effort across private and public payers to move toward alternative payment methods that reduce incentives for overuse and increase incentives for quality and outcomes. This approach has produced new models for organizing and financing service delivery. Two are of particular relevance here: ACOs and Delivery System Reform Incentive Payments (DSRIP).

### B. Accountable Care Organizations (ACOs)

According to the Kaiser Commission on Medicaid and the Uninsured, an ACO is “...a provider-run organization in which the participating providers are collectively responsible for the care of an enrolled population, and may also share in any savings associated with improvements in the quality and efficiency of the care they provide.”<sup>2</sup>

This model was first used by commercial plans and then gained more widespread use in Medicare. Payment reform efforts and 1115 Waiver authority have significantly expanded the focus on ACOs in Medicaid; the discussion here will concentrate on Medicaid ACO models. With a goal to cultivate and expand provider-run ACOs, states are developing strategies for bundled payments, and some are pursuing incentives around the total cost of care. To ensure that financial incentives do not result in failure to provide needed care or provision of low-quality care, payment also depends on achieving goals for quality of care and client satisfaction. ACOs that fail to meet quality standards may lose a share of the savings they would otherwise be entitled to. Monitoring ACOs' performance requires considerable data collection and reporting capacity across participating providers. In addition, achieving well-coordinated, safe and effective care requires well developed health information systems capable of interoperability and information exchange between ACO partners.<sup>3</sup>

Medicaid ACOs generally use two value-based payment structures: capitated budgets and shared savings.

- **Capitated Budgets:** Like MCOs, many ACOs are paid a capitated per patient per month rate for a specific group of patients, and have full financial risk for their costs of care.<sup>4</sup> Large provider systems may serve as ACOs, but in many cases, an MCO partners with a group of providers to form an ACO, since the MCOs have the utilization management and claims payment infrastructure needed to take on the role of serving as payer.<sup>5</sup> In Oregon, a regional care coordination organization plays this role.<sup>6</sup> Enrollees are prospectively assigned to capitated budget ACOs, and the Medicaid enrollees participating in capitated budget ACOs vary considerably based on state design.<sup>7</sup>

- **Shared Savings:** Similar to the Medicare ACO model, Medicaid ACO providers can share in savings in the total cost of care (TCOC) of their attributed members. Most Medicaid enrollees in shared savings models who access primary care through an ACO provider are retrospectively attributed to the ACO based on their primary care provider's affiliation. As a result, the costs and quality of their care are counted in ACO results.<sup>8</sup> The ACO is responsible for the TCOC whether services are provided inside or outside of the ACO, thereby promoting development of its ability to manage and coordinate care with its different providers. Indeed, through retrospective assignment, the ACO may not know all of the Medicaid members that will be attributed to their organization. Savings are calculated against a predetermined baseline of expected expenditures. In some cases, providers may also share part of the excess cost if expenditures exceed the baseline.<sup>9</sup> Shared Savings model ACOs are almost always solely provider organizations since insurance licensure is generally not required under this type of reimbursement and the attribution approach.

ACOs are entities that include providers as part of a formal organization that bears risk and shares savings among members. They must have sufficient capital to cushion possible losses. In higher-risk, fully capitated models, some provider groups are partnering with insurers to access capital.<sup>10</sup>

ACOs vary in the services they are expected to manage. As of January 2017, four state Medicaid ACO models covered only physical health services, and a fifth had the option to cover behavioral health services. Five others included behavioral health, with some of them including long-term services and supports (LTSS), dental, and sometimes even housing or other social services. To date, Medicaid ACOs have had impressive results. For example:

- Oregon Coordinated Care Organizations (CCOs) have achieved significant improvements on a number of dimensions, while successfully holding cost growth to the required 2% target.
  - As of mid-year 2016, 9 of 16 CCOs met the follow-up after hospitalization for mental illness target of 79.9%;
  - On average, 16.3% of members (ages 12+) had appropriate screening and intervention for alcohol or other substance abuse, exceeding the 2016 benchmark of 12.0%;
  - 63.3% of children received follow-up care after being prescribed ADHD medication, exceeding the 2015 national Medicaid 90th percentile of 53.0%; and
  - 17.7% of members (ages 13+) had two or more additional services for alcohol or other drug dependence within 30 days of their initial treatment, exceeding the 2014 national Medicaid median of 11.3%.<sup>11</sup>
- Through 2015, Minnesota's Integrated Health Plans (IHPs) have helped the state save \$156 million. Increased integration of behavioral health services and community partnerships were among the drivers of success.<sup>12</sup>
- Launched in 2014, the Vermont Medicaid Shared Savings Program (VMSSP) reported \$14.6 million in savings in the first year.<sup>13</sup>
- Colorado reported that its Accountable Care Collaboratives (ACC) generated net savings of \$29 to \$33 million during FY 2014, its third year of operation.<sup>14</sup>

## C. Delivery System Reform Incentive Payment (DSRIP) Waivers

DSRIP is a payment method built into some waiver programs that provides states with funding to support the investments needed to contain total health care costs over the life of the 1115 waiver. Examples include New York, Texas, Washington and Massachusetts. Recognizing the up-front investments that many delivery systems need, DSRIP waivers allow states to receive a portion of their future savings in the initial years of the waiver. States can use DSRIP payments to support hospitals, community mental health centers and other behavioral health providers in changing how they provide care to Medicaid beneficiaries. So far, there are relatively few DSRIP waivers in place, though others are in the pipeline. The overarching goal of these programs is to achieve measurable improvements in quality of care and population health through transforming payment and delivery systems. All current DSRIP programs include public hospitals, with some including private hospitals and two including non-hospital providers. DSRIP initiatives are multi-year performance-based incentive programs and come with the requirement to achieve significant improvements in future years on reduced levels of federal match. Required performance generally focuses first on achieving infrastructure development benchmarks, then system redesign goals, followed by clinical outcome improvements, and finally improved population health outcomes. Measures of clinical and population health outcomes may require providers to develop substantial new reporting capacity.<sup>15</sup>

## D. Cost-effective, Accountable Care for Population Health

Overall, these new Medicaid payment models explicitly focus on changes in the provision of care that should be of great value to enrollees with disabilities, mental illnesses, addictions and other complex conditions. Nonetheless, states must use caution as they initiate system change to ensure that providers and other organizations are able to systematically build their capacity for improved care coordination in ways that maintain the existing behavioral health service system and sustain relationships between Medicaid members with complex behavioral health conditions and their providers. To achieve the longer-term goals of population health improvement will require effective delivery systems for people with the most serious behavioral health conditions, but also health education and cross sector actions to address many of the social factors leading to poor health.

Achieving accountability and reducing future costs of health care services requires up-front investments in workforce skills, technology and care coordination, particularly in transitions between levels of care. It will require plans for health systems that build on the strengths of existing local providers and community agencies. States need to develop rate methodologies and contract requirements that ensure these investments occur and that their results are measured.

## III. Key Aspects of ACO Design

The primary goal for ACOs is to drive care coordination to the provider level to be carried out in collaboration with the client. ACO payments and standards are generally designed to incentivize and empower medical providers to undertake care planning and coordination based on their face-to-face relationship with clients. This requires care coordination with other providers through ACO network membership and partnership agreements. This chapter identifies some of the key design decisions that states must make, and provides examples from the first Medicaid ACOs.

### A. Primary Goal of ACOs

States must set goals for their ACOs. Aligning Medicaid ACOs with the priorities and measures used by Medicare and Commercial ACOs provides consistency for providers and makes it more likely that they will make progress on shared priorities. However, Medicaid members have special needs that are distinct from the Medicare and commercial populations. States need to ensure that ACOs will effectively address these needs. All states must find an appropriate balance between alignment with other payers and appropriate focus on the special needs of the Medicaid population. Vermont has emphasized aligning Medicaid and Exchange ACOs with existing ACOs for Medicare and commercial payers into an All-Payer model, which may lead to transformations that cut across the entire health system. In contrast, Oregon has developed specialized statewide Medicaid ACOs based in health plans with many contractual provisions focused on meeting the needs of the Medicaid population, and strengthening relationships with county-based health and preventive services.

### B. Service Population

States must decide which Medicaid members will be attributed to ACOs for measurement purposes. This is a different process than the customary enrollment methods associated with managed care and capitated financing. Capitated budget ACOs, and those that serve a specific geography, have members attributed or enrolled prospectively based on member selection, or when a specific geography is served, based on location of residence. Members are attributed to most shared savings ACOs retrospectively based on members' utilization of ACO services. One challenge in retrospective attribution is that providers in the ACO network don't always know whose care they are accountable for.

Capitated budget ACOs are generally restricted to Medicaid-only members, while some shared savings ACOs have also included people who have both Medicaid and Medicare coverage. Systems for these dually eligible consumers (Medicare and Medicaid) are challenging because Medicare savings (inpatient and pharmacy) accrue solely to Medicare or its MCOs; there has not been a mechanism for sharing that portion of savings with states except in some demonstration waivers. Thus, states have often had to develop two accountable care models. Illinois, for instance, has procured specialized Care Coordination Entities (CCEs) that serve children with complex medical needs or people who are elderly and disabled, and Accountable Care Entities (ACEs) that serve other Medicaid members.<sup>16</sup>

### C. Scope of Services Provided

As Medicaid programs have begun to incorporate accountable care strategies, they have often selected different sets of services to be managed. Medicaid services not included in the ACO are accessed with self or provider referrals using existing procedures. Colorado's Regional Care Coordination Organizations are geographically based providers delivering care coordination and practice support for Primary Care Medical Providers (PCMPs). The other states' ACOs all include physical health services, with some requiring or allowing provision of additional services, including behavioral health, dental, and LTSS. As an

example, Maine includes most Medicaid services in the TCOC for its Accountable Communities, but ACOs may elect to include adult family care homes, assisted living services, Day Health, HCBS Waiver Services, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Long Term Care, Nursing Facility, Personal Care, Private Duty Nursing, Children’s Private Non-Medical Institutions, and dental.<sup>17</sup>

With growing recognition of the significance of social determinants of health among the Medicaid population, states are increasingly expecting ACOs to establish strong collaborations with social services and community-based health-related services. Oregon’s CCOs are mandated to work with county health departments and other community organizations in their region, conducting regional health assessments and developing services to meet unaddressed needs. Minnesota requires ACOs to coordinate with county health services and has encouraged them to include community service providers in their governance boards. In fact, a county-based safety net ACO is considering leasing housing for homeless members. At least one ACO contract specifically allows ACOs to pay for non-medical care that would have an impact on members’ health.

## D. ACO Lead Entity

ACOs generally need a lead administrative and financial entity, which will contract with the state, submit bills, and accept payment on behalf of the ACO. Depending on the level of financial risk involved and the scope of reporting required, some states have designated MCOs (or the equivalent) to lead ACOs, making MCOs responsible for developing shared savings arrangements with providers and working together toward desired quality outcomes and cost targets. This also would allow the ACO to operate under the MCO’s licensure as a managed care organization. Other states have excluded MCOs from participating in ACOs. In these states, providers organize and lead ACOs in each region or community. For instance, Illinois allows a wide range of entities to serve as the legal entity responsible for contracting with the state, including a Medicaid-enrolled provider, a non-Medicaid enrolled provider, or a local governmental non-Medicaid authority, and the ACO lead can be a for-profit provider.<sup>18</sup> Minnesota has defined “virtual ACOs” as physician groups without hospital participation that serve smaller numbers of members and carry no risk. Finally, some ACOs are geographically based. The ACO is required to serve a specific catchment area, often with considerable coordination with county public health and other community organizations. When ACOs are led by providers, they are usually considered to be exempt from insurance or managed care licensure. However, in some states, ACOs may need to obtain licensure in part because of the level of risk involved in the financing.<sup>19</sup> A discussion of legal issues related to ACOs is beyond the scope of this document; additional information is available from *The ACO Handbook: A Guide to Accountable Care Organizations, Second Edition*.<sup>20</sup>

## E. Payment Arrangements

Most ACOs are funded with capitated budgets, some sort of shared savings, or performance incentives.

- CMS requires that capitated budgets be actuarially sound, with any expected savings built into the payment method. This form of payment provides both the state and the ACO with greater certainty on the program’s costs. Any savings beyond those built into the capitated budget will automatically be retained by the plan; however, there is an expectation that the plan will have shared savings arrangements with its component providers.
- Shared savings are based on a projection of what costs would be in the absence of the ACO. At the end of the period, actual costs are compared to this cost projection; if the agreed upon savings are realized, they will be shared between the ACO and the state. Some ACOs, primarily health plans and larger ACOs, also take on risk for exceeding expected costs and are expected to absorb a share of any overage.

- All models link payment to performance. ACOs must establish measures of quality care provision, report on baseline performance, and achieve a certain minimum improvement or reach an established goal in subsequent years. In some ACOs, the amount paid for performance is based on a small withholding from the capitated budget.

In addition to incentivizing efficient and effective provision of care, ACO models may incentivize other potential outcomes, based on the payment model. When ACOs can influence what clients they serve, capitated budgets incentivize them to serve low-cost clients, whose average cost is less than the capitation payment. In contrast, shared savings payments incentivize providers to serve high-cost patients whose costs they can reduce.

The Medicaid landscape is currently dominated by managed care, with 77% of Medicaid members across the country enrolled in a managed care plan in 2014.<sup>21</sup> Making changes to these insurance markets will be challenged from consumer advocacy, health policy, financial and political perspectives. As a result, states must be very clear about the boundaries of these new Accountable Care Organizations and clarify how ACOs and MCOs will relate to each other in the marketplace. When MCOs are the ACO lead entity, they are expected to develop shared savings arrangements with provider members. If MCOs are not an ACO participant, but have provider-led ACOs in their network, those ACOs may be able to lower costs for the MCO. States are empowered by the Medicaid managed care final regulation to require their MCOs to participate in value based purchasing and delivery system reform, and should determine whether MCOs are required to share their savings with ACOs.<sup>22</sup> For example, Minnesota MCOs are required to share savings with ACOs in their networks, while New Jersey allows ACOs and MCOs to negotiate their own shared savings agreements.

## F. Data Sharing

Through their utilization management and claims systems, MCOs have access to utilization and cost information on all the services in their benefit package. This information can help them identify members who could benefit from care coordination or those whose costs of care could be reduced without threatening quality, and also provide real-time or timely information on which providers are serving a specific member. With care coordination being pushed down to the provider level, providers in ACOs need access to this kind of information. Some ACOs are developing shared electronic health records (EHRs) among their participating organizations to provide such information. In ACOs with large networks, this may provide most of the information care coordinators need. However, smaller ACOs will need to be able to get information on their patients served outside of the ACO network. States have developed different arrangements to share relevant claims information from their own systems with ACOs. The state may do this by requiring MCOs to share data from their claims or Utilization Management systems, contracting an IT service to produce and disseminate the state's own data, or producing and sharing the reports itself. States need to work closely with MCOs and providers to develop data collection and exchange protocols that are clearly understood, efficient, result in useful information and align with providers' other reporting requirements.

## IV. Waiver or Contract Recommendations for Accountable Medicaid Services

This chapter addresses specific health system design and performance requirements for ACOs; specifically, the key ACO functions that should be considered for Medicaid members with behavioral health conditions based upon different levels of financial accountability and risk. Whatever its level of risk, an ACO's individual, family and community health outcomes should be frequently, regularly and publicly reviewed during implementation.

### A. Enrollment/Attribution

States have a number of options for determining which Medicaid members an ACO will serve, whether participation is mandatory or optional, and how long members remain eligible. Many states attribute members based on their use of a primary care practice that is part of the ACO. Members retrospectively attributed to an ACO may not be aware that they are enrolled in an ACO. Nonetheless, it is important that they be informed of their participation and their rights within it.

States should:

- *When members are required to select an ACO*, provide outreach and enrollment assistance tailored for people with SMI or serious SUD to help them select an ACO and a primary care provider. Behavioral health providers should be considered to perform some of this outreach.<sup>23</sup>
- *When members are assigned to an ACO*, clearly notify enrollees when they have been assigned, and provide information about what an ACO does and their options to opt out or change ACOs.<sup>24</sup>
- *When members opt out of an ACO*, provide outreach and assistance to enroll in another managed care plan or ACO and to select other primary care and behavioral health providers, if necessary.
- Specify member rights to change ACOs.

#### Examples

- Illinois' specialized Care Coordination Entity (CCE) for Children with Complex Medical Needs determines eligibility based on children's scores on clinical risk grouping software, and it intends to develop a clinical screening tool for children who do not have sufficient claims to use the grouper.<sup>25</sup> Children are eligible for three years, and must then be reassessed for eligibility. While CCEs can target particular conditions, they must accept any child meeting eligibility standards. Participation in a CCE is voluntary, and the family has the option to drop out or change the CCE without cause during the first 90 days of enrollment. Thereafter, the child is locked in to his or her selected CCE for 12 months until the annual enrollment period.
- In addition to attribution based on primary care utilization, Maine attributes members to ACOs if they have had three or more ED visits with a hospital that is part of an ACO.<sup>26</sup>
- Colorado Medicaid members are not enrolled with a Primary Care Medical Provider (PCMP) if they have a clear pattern of use with a provider who does not serve as a PCMP. Members without a provider relationship are enrolled with the Regional Care Coordination Organization, which is responsible for connecting them with a PCMP.<sup>27</sup>

## B. Access to Services

A number of dimensions of ACO design and functioning have bearing on access for Medicaid members with SED, SMI and/or serious SUD. These include: outreach to members who are disengaged from the service system; participation and inclusion of behavioral health providers in the ACO; participation in capitated budget ACO networks; and the scope of services for which the ACO is accountable. Access to primary and medical care is an important issue for this population, as much as their behavioral health care.

### 1. Outreach

Many people with complex behavioral health conditions are not engaged in a primary care relationship, and some are not engaged in ongoing behavioral health treatment. Outreach and engagement services must be built into any service system for these members. ACOs do not have a natural incentive to reach out to unengaged Medicaid members. Provider-led ACOs will have members assigned retrospectively based on their use of ACO services. It will be much easier for them to serve motivated patients who regularly participate in care. Capitated budget ACOs will generally receive a capitation payment whether a member uses services or not. They might actively reach out to those unengaged members who frequently use crisis care, emergency care, detoxification and inpatient care to move them toward less costly use of services, but they do not have a financial incentive to reach out to those who are simply going without care. For this reason, it is important for states to build in requirements or incentives for ACOs to assertively reach out to all their members and work to engage them in ongoing care.

States should:

- Establish a clear requirement for ACOs to serve members who are unengaged in behavioral or medical care, and continue to reach out to them creatively and assertively.
- Require ACOs to purchase services from or establish partnerships with community behavioral health providers who provide “assertive outreach” to engage people with SMI or SUD who are not regularly participating in treatment.
- Include measures of primary care and behavioral health penetration as quality goals to incentivize outreach to underserved populations. Even better, measure penetration for specific populations, including unengaged people with behavioral health or other underserved conditions.
- Permit and encourage the use of behavioral health peers and community health workers to perform outreach and engagement.
- When providers continue to be paid fee-for-service, reimburse for the work of behavioral health peers and community health workers performing outreach and engagement.
- Incorporate outreach and engagement as an expected component of care coordination.

### Examples

- Minnesota specifically allows ACOs to use community health workers, navigators and peer counselors.
- In Oregon, a CCO’s payment is based on members’ ratings of access to care, the rate of adolescent well-care visits, and emergency department utilization. Though not considered in quality payments, Oregon requires ACOs to report a number of additional measures, some of which are stratified for people with mental health diagnoses. These measures address aspects

of behavioral health care as well as access to medical and dental care. Several of these measures are also stratified for people with SMI, ensuring that the care received by these groups is well monitored, and disparities in access and quality between people with mental health issues and those without is addressed.

## *2. Inclusion of Behavioral Health Providers in ACOs*

Behavioral health is a known driver of Medicaid expenditures, and community mental health and addiction treatment providers are uniquely qualified to address the special needs of people with complex behavioral health conditions. For this reason, states should define a formal role for providers serving Medicaid members with complex behavioral health conditions. CMS has prohibited behavioral health providers from serving as lead entities for ACOs; however, as listed below, there are a number of approaches that states can take to include community mental health and addiction treatment providers in ACOs.

States can:

- Require or incentivize ACOs to include behavioral health and other community providers used by people with complex conditions as members of the ACO, participating in shared savings.
- Require ACOs to include one or more community behavioral health providers on their governance body.
- Establish a role for community behavioral health providers as the source for specialized care coordination for people with complex behavioral health needs, either within an ACO or as an entity with which an ACO must collaborate.
- Require or incentivize ACOs to collaborate with community behavioral health providers serving their members.
- Require ACOs to develop an advisory group or groups representing community behavioral health providers and members with SED, SMI and serious SUD.

### Examples

- Maine requires an Accountable Community to include at least one provider for behavioral health, one for chronic conditions, and one for developmental disabilities, if there is such a provider in its service area.
- Minnesota's ACO program requires its Integrated Health Plans (IHPs) to "demonstrate how formal and informal partnerships with community-based organizations, social service agencies, counties, public health resources, etc. are included in the care delivery model." IHPs are encouraged to propose mechanisms to incorporate these organizations directly into the payment model and are awarded bonus points for doing so.<sup>28</sup>
- Minnesota's IHPs must have a Medicaid-enrolled provider to serve as the entity that receives payments or pays cost sharing, but non-profits, a county, or group of counties can be part of the IHP. Illinois allows a wider range of organizations to serve as a lead entity of a CCE, including health care organizations, non-health organizations, governmental entities and for-profit providers. Maine allows any provider judged through an application process to be willing and qualified to be a lead entity for an Accountable Community (AC).

- Massachusetts' Medicaid agency will select community behavioral health providers on a competitive basis to serve as Behavioral Health Community Partners, and its ACOs must contract with the Behavioral Health Community Partners serving its catchment area. Behavioral Health Community Partners will be paid separately on a capitated basis for providing enhanced care coordination for members with SMI and serious SUD. In addition, Behavioral Health Community Partners will receive up to \$450,000 in DSRIP funding to support infrastructure development needed to fulfill their care management responsibilities for ACO members.

### 3. Benefits and Services

States must decide on the scope of services that ACOs will be responsible for providing, as well as the scope of services for whose total costs they will be accountable. Some states focus solely on medical care in ACOs, while most at least make it optional for ACOs to include behavioral health, or plan to phase it in over time. Long-term services and supports are less frequently included. Oregon's initiative is the most inclusive, comprising medical, behavioral health and dental services.

Any service boundaries established between ACOs and other entities should not become an impediment to access for members who need those services. On the other hand, ACOs will have a financial incentive to substitute external services for those services which the ACO pays or is otherwise accountable. States should both require ACO care coordination to facilitate access to excluded services, as well as control or monitor access to excluded services to prevent inappropriate cost shifting.

In regard to inclusion of behavioral health, states should:

- Promote access to both medical and behavioral health care for members with SED, SMI and serious SUD by including or phasing in inclusion of Medicaid behavioral health services in those services expected to be delivered by ACOs as well as in the TCOC.
- Allow behavioral health homes, behavioral case management or care coordination providers, and integrated primary care case management practices to participate in ACOs, and award bonus points for ACO applicants that have included them.
- Provide extra points for ACO applicants based on their plans to share savings with behavioral health providers, or establish other financial incentives for managed behavioral health care organizations or participating behavioral health providers.
- When inclusion of behavioral health is optional for ACOs, provide bonus points for ACOs that opt to include them.
- Establish financial incentives and quality measures related to effective identification and treatment of behavioral health problems.
- If ACOs are not yet ready to manage behavioral health services, phase those services in over time.

In regard to inclusion of behavioral health LTSS in ACOs, states should:

- Require ACOs to provide Medicaid-financed behavioral health LTSS and be accountable for total costs.
- Assess early experience with including LTSS in ACOs. Based on results, consider braiding funding for non-Medicaid LTSS into ACOs or otherwise aligning provision of Medicaid and non-Medicaid LTSS.

- Provide extra points for ACO applicants based on their plans to manage behavioral health LTSS for people with SMI.
- Provide extra points for ACO applicants based on their plans to share savings or establish other financial incentives for participating behavioral health LTSS providers based on improving community tenure and participation for people with SMI.
- Consider calculating and sharing savings from reductions in institutional care with organizations responsible for managing behavioral health LTSS.
- If behavioral health LTSS are provided outside of ACOs, require them to develop protocols to coordinate referrals to LTSS.
- Monitor use of LTSS to identify access problems or cost shifting from ACOs to LTSS.

#### Examples

- The Maine Accountable Community Initiative builds on its health homes and behavioral health homes by requiring any Health Home Practice's partner(s), such as a Care Coordination Team or a Behavioral Health Home Organization, to participate in the AC.
- The TCOC for Massachusetts ACOs will eventually include physical health, behavioral health and LTSS.

#### *4. Medical Care for People with SED, SMI and SUD*

The flexibility inherent in the ACO model empowers states to eliminate or address barriers to effective medical care for people with SED, SMI and serious SUD.

States should:

- Establish incentives for ACOs' primary care practices to treat this high-risk group.
- Eliminate any regulatory barriers to the provision of co-located primary and behavioral health care, such as conflicting licensing regulations for primary and behavioral health facilities and restrictions on same-day billing of more than one service.
- Encourage ACOs to compensate primary care providers for the extra time spent working with members with mental health or substance use problems.
- Encourage ACOs to use peers and behavioral health care managers to assist members with behavioral health conditions to get medical care.
- Allow ACOs to use their reimbursement to pay for the expenses of self-management programs to address physical and mental wellness, including smoking cessation and weight loss, for individuals with SED, SMI and SUD.
- Develop measures to monitor the provision of medical care for members with SED, SMI or SUD.

## 5. Social Determinants of Health

In addition to considering the inclusion of community service providers in ACOs, ACOs should be attentive to a member's social needs in service planning and care coordination.

States should:

- Require ACOs to be knowledgeable about the needs of the community and have relationships with organizations that address members' social needs.<sup>29</sup> If ACOs need additional time to develop this capacity, expectations should be phased in.
- Require ACOs to complete a needs assessment and community health improvement plan that engages community-based organizations and populations served.<sup>30</sup>
- Require that ACOs demonstrate progress in implementing community health improvement plans.<sup>31</sup>

### Examples

- Oregon Care Coordination Organizations must conduct a needs assessment and implement a community health improvement plan.<sup>32</sup>
- Minnesota requires its ACOs to "Demonstrate how formal and informal partnerships with community-based organizations, social service agencies, counties, public health resources, etc., are included in the care delivery model. Responders are encouraged to propose mechanisms to incorporate these organizations directly into the payment model."<sup>33</sup>
- Minnesota's ACO assessment tool guides practices toward the goal of formalized partnerships with community agencies supported by an infrastructure where partners plan together, measure outcomes together, and share information together.<sup>34</sup>

## 6. Network Standards

States set network standards for adequacy, credentialing, travel time/distance and time from request to appointment for its MCOs, and with implementation of the Medicaid managed care final regulation, CMS must approve them. States will need to determine how these standards apply to ACOs. ACOs led by health plans will likely adhere to similar standards. Provider-led ACOs will have a group of providers participating in the ACO, may have a network of providers partnering in other ways, and their members will also have access to the providers participating in the larger Medicaid system. In such cases, states will have to consider what kinds of network standards ACO participants and/or partners should meet. For people with complex behavioral health problems, standards for access to primary care, behavioral health services, and peer support services should all be addressed.

In regard to primary care, states should:

- Require ACOs to offer members a choice of primary care providers.<sup>35</sup>
- Require ACOs to contract with or include both integrated primary care practices (such as community health centers) that currently treat individuals with SED, SMI and SUD, and behavioral health providers with co-located primary care.
- Require ACOs to develop plans to increase the network of primary care providers who are

prepared to welcome and serve people with SED, SMI and SUD.

- Prohibit ACOs from excluding or discriminating against providers that serve high-risk populations.
- Require or incentivize ACOs to contract with or include all willing physicians in their service area who are certified and willing to administer buprenorphine, unless they do not meet other minimum standards.
- Require ACOs to set a standard for the number of complex cases that a primary care practice offering care coordination can appropriately carry.
- Set appointment access standards for ACOs that are aligned with those that the state sets for MCOs.
- Prohibit ACOs from setting rules for payment that inhibit co-location and integration of primary care and behavioral health care, such as prohibiting billing of two services on the same day.

In regard to behavioral health providers, states should:

- Require ACOs to include community mental health and addiction providers as partners or affiliates and recognize the state's licensing standards for mental health and SUD services as necessary and sufficient for credentialing.
- To expand their networks, require ACOs to develop streamlined methods to credential<sup>36</sup> Master's-level behavioral health clinicians who are not yet licensed or have three years of experience, including substance abuse counselors, direct care and peer/recovery staff.
- Require ACOs to include providers with expertise in the needs of children subjected to abuse and/or neglect.
- Require ACOs to offer members with SED, SMI, or SUD a choice of community providers and a choice of case managers.<sup>37</sup>
- Limit ACOs' ability to build duplicative behavioral health services that could threaten the continued viability of community behavioral health organizations.
- Require or incentivize ACOs to credential and contract with community behavioral health providers as an organization, rather than only with licensed staff.
- Require or incentivize ACOs to recognize state SUD credentials for non-Master's trained counselors.
- Require ACOs to use certain specialized behavioral health services, such as mobile crisis teams, that require a sufficient volume to succeed.
- Establish expectations or contractual requirements for ACOs to coordinate with services provided outside of the Medicaid system, such as those provided by a state or county MH, SUD, or developmental disabilities agency.
- Encourage appropriate use of telehealth services for psychiatry and other hard-to-access behavioral health providers.<sup>38</sup>
- Set appointment access standards for ACOs that are aligned with those that the state sets for MCOs.

For global budget ACOs with a provider network, states should:

- Require ACOs to make provisions for members with complex conditions who wish to continue care with a provider who is not in the ACO, including:
  - Inviting the provider to apply for participation.
  - Executing a single case agreement with the provider.
  - Allowing an extended 6- to 12-month transition period for the member to find an in-network provider.
- Allow ACO members to get behavioral health services outside of the ACO, at least initially. Restrict access to ACO providers only when the program has operated for a number of years and meets robust network adequacy standards.<sup>39</sup>
- Establish network adequacy standards that are at least as robust as those established by the state for its MCOs.

In regard to peer services, states should:

- Score ACO applicants' experience developing and purchasing peer service models.
- If the state has peer-run service organizations, require ACOs to develop appropriate business relationships with peer/recovery organizations, providing modified payment and additional management support when necessary.

### Examples

- In Maine's Accountable Communities, members retain their right to choose providers.<sup>40</sup>
- Illinois allows CCE enrollees to switch primary care providers within the CCE once per month.<sup>41</sup>
- Illinois sets a contractual limit on the number of children with complex medical needs assigned to a medical home. It also requires CCEs to propose, monitor and maintain ratios for maximum enrollees per primary care provider, pediatric specialty provider, dental provider and behavioral health provider.<sup>42</sup>

## C. Service Authorization

ACOs are intended to drive clinical decisions closer to the clinician and the patient. By participating in financial rewards from shared savings and performance, physicians are incentivized to deliver services at the right time and in the right amount. If carried out as intended, this should result in a smaller role for utilization management staff and a larger role for primary care practices regarding referrals and follow-up. In addition, the focus on medical homes emphasizes team-based care planning for people with complex conditions who may need social supports. Since community mental health and addiction treatment providers are experienced in working with clients to develop individualized person-centered treatment plans, they should have an important role in behavioral health service planning.

While Medicaid members continue to have a choice in providers within and outside the ACO, there may be some incentives for ACOs to refer within the ACO network. During the service planning process, members must receive clear information on their rights to a choice of providers and solutions if they are steered away from their preferences for type of service or for provider.

Medical necessity criteria and service authorization practices are non-quantitative treatment limits, subject to federal parity requirements, and as a result, behavioral health benefits must be managed similarly to medical/surgical benefits in Medicaid plans to which the parity regulations apply (that is, Medicaid managed care and the Medicaid expansion Alternative Benefit Plans). For administrative simplicity and improved access to services, states should consider applying parity across all Medicaid plans and populations. (See Appendix B for an overview of key aspects of the Medicaid Parity regulations.)

### *1. Authorization of Services*

States should (and depending on the type of Medicaid plan in question, under federal parity laws may be required to):

- Develop methods to monitor implementation of the expansive medical necessity definition introduced by the Medicaid managed care final regulation.
- If behavioral health services are not included in the ACO, ensure that they are authorized and managed no more stringently than medical services.
- When behavioral health services are included in the ACO, require ACOs to prepare a parity compliance plan for state approval that includes specific assurances that mental health and SUD services are administered at parity with medical services.
- Require ACOs to staff any service authorization functions with behavioral health professionals experienced in care for disabled populations who are able to discuss treatment plans with provider clinicians on a peer-to-peer basis.
- Allow ACOs to purchase services, including non-medical services, outside the standard benefit when they save money and produce better outcomes.
- Require ACOs to allow billing for more than one behavioral health or primary care service on the same day (to allow members to use time and transportation efficiently).
- Require ACOs to individualize authorization decisions rather than implement de facto maximum lengths of stay in a specific service.<sup>43</sup>
- Require that ACOs' guidelines for placement or discharge consider homelessness, lack of family supports, and coexisting medical conditions.<sup>44</sup>
- Monitor lengths of stay, utilization, and appeals indicators to identify patterns of overly-restrictive authorization practices.

### *2. Authorization of Medications*

In regard to psychotropic and SUD medication treatment, states should:

- Require ACOs to establish policies to waive any fail-first processes or formulary limitations for services or medications for members with SMI or SUD whose current service plan is demonstrated to keep them stable.
- Do not allow ACOs to impose time limits on medications used for treating opioid or alcohol dependence.

### 3. Appeals

The ability to appeal denials of service is a critical right. Given the significance of specialized services, specific mediations, and existing treatment relationships in effectively managing a client's condition, appeals must provide timely resolution of service denials. Because people with SMI or SUD may have difficulty advocating for themselves, the process must be easy to access and understand. States should ensure that adding an ACO does not complicate or delay response to appeals beyond the standards set by the Medicaid managed care final regulation.

States should:

- Require ACOs that are paid on a risk basis to provide the same internal appeals rights as MCOs.
- Ensure denial notices clearly specify what types of appeals the ACO can address, and what types of appeals must be considered by the state Medicaid agency.<sup>45</sup>
- Clearly specify how members can appeal authorization decisions of ACOs that are not paid on a risk basis. This may mean that a member appeals to an ACO or to an MCO, but not both, before accessing a state fair hearing.
- Require ACOs to develop a method for members to register disagreement with a care plan developed by their primary care or behavioral health team, and promptly resolve the matter.
- Fully inform or require ACOs to fully inform members of their rights in an easily readable format. Include rights to grievances and appeals, to change health care providers, to use a provider outside of the ACO<sup>46</sup>, to be treated in the least restrictive setting, to have expedited reviews when the situation is urgent or an emergency, and to consent to all treatment.<sup>47</sup>
- Review notices to ensure that they are easy to understand for the literacy levels and language groups commonly found in the covered population.
- Allow family members, friends, advocates, or providers to assist the client during the appeals process.
- Ensure that the requirements of the appeals process do not impose difficult barriers for persons of low income.
- Require ACOs to record and report grievances and their resolution to the Medicaid agency.<sup>48</sup> Monitor responses to appeals to ensure that timelines are consistently met and procedures followed.
- Analyze appeals and complaints to identify and address any systemic issues.
- Develop a process for monitoring and sanctioning ACOs (such as limiting incentive payments) if their rate of grievances or response to grievances is not acceptable.<sup>49</sup>
- Use the independent beneficiary support system required by the Medicaid managed care final regulation to assist ACO consumers to pursue appeals.<sup>50</sup>
- Establish statewide requirements for quality of care complaints pertaining to ACOs.

## Examples

- Oregon's CCO contract establishes services, including behavioral health counseling, that must be available by member self-referral, without prior approval required. When prior approval is required, it must be provided within standards for timeliness, not to exceed 14 calendar days following receipt of the request for service. In circumstances when the 14-day timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, an expedited service authorization decision must be made within 3 business days after receipt of the request for service. Written notice of any denial must provide information about the members' right to submit a grievance and how to do so.<sup>51</sup>

## **D. Care Coordination**

Service planning and care coordination are the core services envisioned in implementing accountable care. Whether from medical home policies, rules for home- and community-based services under Medicaid, or existing state policies, most ACOs are required to ensure that service planning be person-centered, culturally competent, and consider a member's living situation and social needs. In addition, behavioral health service planning should be recovery oriented. States are also emphasizing improvements in care transitions, expecting that providers collaborating in an ACO framework will be able to better execute supported transitions from one level of care to another. There is also an expectation that service plans for people with complex conditions will be developed by a team with competencies in the types of services and supports they need. Once service plans have been developed, members will need ongoing assistance accessing and coordinating services. This might include face-to-face assistance in community settings that could be delivered by paraprofessionals or peers, as well as assistance coordinating between providers those services that might be delivered by a clinician. ACOs have many ways to organize care in order to meet these expectations, and states are providing ACOs with considerable flexibility to do so.

However, truly delivering person-centered and well-coordinated care is more than a matter of re-organizing planning and care processes. It requires learning about the scope of behavioral health LTSS for people with SED, SMI and serious SUD, which are more intense and provided for longer durations than acute mental health services. It also requires a significant shift in how medical professionals share decision making with clients, and how medical professionals work with behavioral health clinicians and with a range of paraprofessionals delivering navigation, case management and peer support. Workforce training and development as well as continued attention to business processes and teamwork are necessary to make these changes. In many cases, ACOs will need to make upfront investments in information technology, training, and hiring additional care coordination staff whose services may not be fully billable.

States often have developed care coordination capacity through pre-existing Medicaid person-centered care initiatives, including primary care medical homes, home- and community-based waiver programs, and children's systems of care. States may elect to exclude behavioral health care coordination from ACOs and build upon this existing capacity. For example, states might require that ACOs contract with dedicated programs, such as Illinois' Coordinated Care Entities for special populations, or make referrals to a pre-existing specialized program, such as Colorado's regional Medicaid Behavioral Health Organizations. It is imperative that states determine how these initiatives relate to each other and to ACOs, especially when a member might get services from more than one. Providers also need clear instructions on how to bill when they deliver service planning in more than one initiative.

## States should:

- Require ACOs to incorporate person-centered planning and shared decision making between health care professionals and patients as a foundation for care coordination and service authorizations.
- Require ACOs to use specialized care coordinators who have worked with people with SED, SMI, or serious SUD.
- Establish caseload ratios (clients per care coordinator) or require ACOs to document and assess the appropriateness of the care coordinator to client ratios that they implement.
- Require ACOs to use staff with lived experience of behavioral health challenges to support clients and participate in treatment planning and care coordination.
- Require ACOs to use person-centered planning that puts a focus on recovery and hope, and uses motivational enhancement approaches.
- Require ACOs to delegate service planning for members with SED, SMI and serious SUD to community mental health or addiction treatment providers, or actively include these providers in service planning led by others.
- Require ACOs to include other key providers, caregivers and natural supports in treatment planning.
- Require ACO treatment planning to include plans for community-based support services for members with complex needs, such as co-occurring substance abuse, medical conditions, and/or housing problems.
- Require ACOs to provide face-to-face care coordination for children with SED and adults with SMI. This may include community case managers who assist in accessing and coordinating social support services, such as housing, education, and income support, that may fall outside of covered benefits.
- Require ACOs to track and follow up on individuals after discharge from an inpatient or other 24-hour setting, and assist them in accessing needed community services or establish incentives for them to do so.
- Require ACOs to consider and develop plans for offering members incentives for healthy behaviors and preventive care.
- Require ACOs to develop efficient and effective information systems to document and monitor the implementation of treatment plans for people with complex conditions, including services outside of the benefit.
- Require ACOs to identify how care coordination will interface with and not duplicate other forms of person-centered planning in the Medicaid system.
- Require ACOs to establish liaisons and negotiate protocols with state agencies, such as the mental health authority, the single state agency for SUDs, the child welfare agency and correctional agencies, to coordinate treatment planning, discharge and other key aspects of care for shared clients.

- Protocols must be consistent between ACOs and health plans in order to be efficient for state agency staff who must interact with more than one service delivery model.
- If these agencies pay for services that constitute a portion of the continuum of care for individuals with SED, SMI, or SUD, protocols should address managing both access to and transition from these services.
- Require ACOs to develop and implement care transition plans for members who move to another ACO or another form of coverage.<sup>52</sup>
- Include consumer and caregiver representatives in the ACO selection process to help rate applicants' implementation plans for recovery orientation and person-centeredness.
- Implement new workforce training efforts to support the development of person-centered planning skills and formation of multidisciplinary teams, including:
  - Training for peer workers based on the role that they will fill;
  - Training for medical professionals on working with peer staff;
  - The state's preferred model for person-centered planning;
  - Motivational interviewing;
  - Behavioral health and suicide prevention; and
  - Cultural competency.

### Examples

- Illinois' proposal for CCEs asks applicants to describe any incentives they will allow primary care providers and other providers to use to encourage healthy behaviors and patient engagement in preventive care.<sup>53</sup>
- Illinois also requests CCE applicants to outline their proposed care coordinator-to-enrollee ratios, including how ratios may differ based on risk level and on the needs of the enrollees they are assigned.<sup>54</sup>
- Minnesota provides a self-assessment tool for ACOs and their participating providers to guide next steps in implementing care coordination and related functions.<sup>55</sup>

## **E. Information Management**

ACOs and state Medicaid agencies both have important information management functions to perform in an accountable care initiative. These include population and individual health data exchanges and analytics. When an ACO is led by a health plan and paid on a fully capitated basis, the plan has the information needed to inform providers about care their members are getting elsewhere. ACOs who have claims payment responsibilities for some of the services will need to report those data to the states. This will need to be merged with claims data on other services from the state Medicaid agency. Accountability requires that these data are compiled and shared in a timely way between the state and ACO, as well as within the ACOs. Making these data accessible for health providers, consumers and the public should be a requirement for a truly accountable health system.

## 1. Capabilities for Sharing Population Information

States should:

- Have the capacity to produce and share actionable data at both the population and client level for ACOs. These data could include on at least a quarterly basis:
  - Attributed member roster
  - Utilization reports, including ER visits, inpatient hospital readmissions, and high-cost imaging services
  - Actual TCOC broken out by practice and service category
  - Performance on quality measures
- Have a portal available to ACO providers allowing them to inquire on the utilization history of their attributed members and download claims.

## 2. Capabilities for Sharing Individual Client Information

In turn, ACOs' providers must have the capacity to share information with other providers on individuals cared for by both, as well as to manage care for their attributed population to attain cost and quality targets.

States should:

- Require ACOs to demonstrate appropriate administrative and information system capacity to carry out each of their responsibilities. If they cannot demonstrate this capacity, then implementation should be phased in or delayed.
- Require ACOs to have EHR access with the capacity for computerized provider order entry (CPOE) and referral and referral tracking capacity.
- Require ACOs to use their EHR for clinical decision support tools, such as reminders; care plans and flow sheets; and guidelines based on conditions specific to the consumer or condition.
- Require ACOs to use their EHR to generate and share summary care records and electronically track patient/client consent to release health information.
- Provide bonus points for ACO applicants with EHRs that both send and query information to and from affiliated organizations.
- Provide bonus points for ACO applicants that coordinate or integrate data from multiple sources, including clinical and financial, or have data warehouse(s) and analysis software that can aggregate information from multiple sources, including external data sources.
- Provide bonus points to applicants who have dedicated staff whose primary responsibilities include interpreting and understanding data.

### 3. Capabilities to Share Behavioral Health Information

Behavioral health providers have generally received less technical and financial assistance than medical providers in implementing EHRs, and may lack sufficient financial resources to invest in them. In many states, medical and behavioral health providers have an incomplete understanding or have received insufficient information about the rules governing privacy of patient behavioral health information.

States should:

- Provide state or obtain federal financial support to assist community behavioral health organizations to build the IT and other infrastructure necessary to coordinate care with health system providers. Many states are using Delivery System Reform Incentive Payments (DSRIP) as a part of 1115 Waivers for these investments.
- Develop strong and standardized protocols for sharing information between behavioral health and medical providers that meet state and federal privacy standards. States should educate and work with providers to fully understand and implement these standards.

## F. ACO Governance

The ACO's governing body and staff should represent the partners to set a vision, develop strategic and business plans and data sharing agreements, and administer the financing and shared risk. Some states require or encourage that certain kinds of health care providers and other organizations be represented in the governing body. In addition to participation on the governing body, behavioral health providers and ACO members can have other relevant roles as part of advisory groups or quality improvement teams.

States should:

- Require ACO governing bodies to have meaningful voting representation of members, caregivers, and community providers, including behavioral health providers.<sup>56</sup>
- Award extra points to applicants that have taken concrete steps to fully incorporate consumer and peer voices and include peer services in their planned scope of services.
- Monitor and promote ACO investment of resources to fully incorporate consumer and peer voices and services.
- Require ACOs to include behavioral health consumers on an advisory board or governance body.
- Establish a statewide advisory group that includes family and consumer representatives and robust representation of members with significant behavioral health conditions, or require each ACO to create their own.
- Involve families and consumers in planning and implementing ACOs and other forms of managed care in meaningful ways.
- Require each ACO to present an annual report to their governing boards and to share with staff on the satisfaction of members, including stratified samples for people with mental health and/or substance abuse claims, using methods that ensure high response rates and valid data, such as surveys and interviews of consumers.
- Require ACOs to stratify complaints and grievance data and include data for behavioral health issues and for clients with SED, SMI and SUD.

## Examples

- Minnesota’s ACO assessment tool gives its highest rating to a governing body composition that is representative of the community served, and includes patient family representatives, providers, payers, behavioral health social services, local public health, and education.
- Illinois’ CCE application asks for a description of the applicant’s plan for consumer input into the operations and management of the program.<sup>57</sup>
- Maine requires that Accountable Communities include two MaineCare members in governance.
- Minnesota’s IHP RFP requires applicants to “Demonstrate how the IHP will meaningfully engage patients and families as partners in the care they receive, as well as in organizational quality improvement activities and leadership roles.”<sup>58</sup>

## **G. Financing and Shared Savings**

Attention to behavioral health has increased because states are increasingly aware that members with behavioral health conditions who also have a chronic condition cost considerably more on average than members with just a chronic condition. There is also considerable evidence that provision of behavioral health services for people with both behavioral and chronic conditions lowers these average costs. In many states, community mental health and addiction providers who primarily serve patients paid by the public sector receive relatively low rates that do not fully cover their costs. In addition to limiting their ability to invest in infrastructure, constrained financial resources can limit community behavioral health providers’ ability to share risk. States need to design their financing models to take these factors into account.

States should:

- Establish financing incentives that are large enough so that the ACO focuses on and promotes high-quality, coordinated and cost-effective care.
- Consider exclusion of catastrophic cases costing more than a set maximum in calculation of actual expenses.
- Consider strategies to phase in accountability for certain measures and costs as ACOs gain experience and financial stability.
  - Phase in performance expectations
  - Gradually increase funds at risk for performance
  - Gradually increase savings expectations and amount at risk for exceeding costs
- Include behavioral health costs in the total cost of care, and measure the quality of behavioral health services to ensure that ACOs pay attention to behavioral health. (This incentivizes ACOs to include lower-cost services provided by unlicensed staff, when they promote access, quality, and outcomes.)
- Stratify behavioral health and medical health components of ACO cost projections so that the relative contributions of each can be measured.
- Stratify the costs of members with SED, SMI and serious SUD as compared to other ACO members so that the relative savings of each can be measured.

- States should ensure attention to behavioral health by establishing relevant quality measures and stratifying results for the behavioral health subpopulation whose use of services has the most influence on costs.
- Require or incentivize ACOs to use payment methods that reimburse community mental health and addiction providers for engagement, outreach and care coordination.
- Require ACOs to pay behavioral and primary care providers at rates that adequately cover their costs and are sufficient to maintain their participation in the network.
- Use ACOs and their ability to share savings to incentivize more behavioral health providers to participate in Medicaid.<sup>59</sup>
- Establish requirements or incentives for ACOs to share savings with behavioral health partners.
- Ensure that ACOs' proposed risk sharing arrangements do not exclude community behavioral health providers or providers with limited financial resources from participation.
- Require shared savings arrangements that appropriately account for the contribution of behavioral health and wellness services to improvements in overall physical health care.
- Make provisions for reinvestment of a portion of state or provider savings into strengthening the behavioral health system.

### Examples

- For Minnesota's IHPs, "Claims for an individual member that fall outside of pre-determined thresholds will be capped to adjust the PMPM results to exclude 'catastrophic cases' and better reflect the IHP's target population."<sup>60</sup>
- Maine's Accountable Communities provides a choice of two models:
  - Model I - requires minimum of 1,000 members and share up to 50% of savings, based on quality performance not to exceed 10% of benchmark TCOC. No downside risk in any of the three performance years.
  - Model II - requires minimum of 2,000 members and share up to 60% of savings, based on quality performance, not to exceed 15% of benchmark TCOC. No downside risk in first performance year. Liable for 40-60% of losses, based on quality performance, in years two and three, not to exceed 5% of benchmark TCOC in Year 2 and 10% of benchmark TCOC in Year 3.<sup>61</sup>

## H. Quality

ACOs are expected to have a robust quality improvement process involving providers and consumers to identify and drive improvement, particularly on the measures for which they are financially accountable. For this reason, states' choice of quality measures for behavioral health is consequential. This is particularly relevant to the subpopulation of members with the most complex behavioral health conditions and for members at risk of experiencing racial or ethnic disparities in access to and quality of care.

## 1. Quality Measures for Behavioral Health

There is considerable overlap in the quality measures states use for ACOs, though there is considerable variation in the ways they related these measures to payment. Some states use only a few measures; some use a larger number; and some tie only a few to performance payment, but require reporting on a large number of measures. Some states have combined related measures into a composite rating. A few states require ACOs to publish results of quality measures. Many include measures of screening and treatment for the most common behavioral health interventions, including depression, ADHD, and substance abuse. See Appendix A for a list of relevant quality measures, many of which are in current use by Medicaid ACOs.

States should:

- Incentivize early identification of behavioral health conditions through measures of behavioral health screening in primary care.
- Promote effective early intervention, psychoeducation, and health and wellness interventions.
- Promote appropriate medication treatment.

## 2. Quality Measures for People with SED, SMI and serious SUD

People with complex behavioral health conditions have special needs for behavioral health LTSS, and frequently do not have strong primary care relationships that would support effective care for chronic conditions. In order to focus attention on these aspects of ACO performance,

States should:

- Include significant financial incentives for ACOs to improve quality of care for people with SED, SMI and SUD.<sup>62</sup>
- If ACOs are bearing risk, use robust quality metrics for SMI, SUD and SED, and impose sanctions for failures to meet goals.<sup>63</sup>
  - Measure primary care provider opioid prescribing compliance with Prescription Drug Monitoring Program (PDMP) checks and submission, and with opioid prescribing guidelines.
  - Consider measures of the time that members with SED, SMI, and SUD spend living in the community, rather than restrictive inpatient settings, homelessness, or criminal justice system involvement.
  - Consider measures of the housing and employment status of members with SED, SMI, and SUD.
- Require ACOs to report additional indicators relevant for monitoring and quality improvement, beyond those for which they are financially accountable.
- Set expectations for improvements to access to primary care and to LTSS for the management of chronic medical conditions among individuals with SED, SMI and SUD.
- Allow ACOs to select some of the measures for which they will be accountable.

- Sponsor a learning collaborative with a focus on measures tailored to the health needs and risks of people with SED, SMI and SUD.

### Examples

- Illinois requires its CCEs to propose at least one Quality Measure to be used as a pay-for-performance measure that can best demonstrate successful care coordination.
- Oregon requires its CCOs to stratify certain behavioral health and medical care measures for members with mental health and members with SMI.

### *3. Cultural Competency*

The Medicaid managed care final regulation has recognized the significance of addressing racial and ethnic health disparities in the Medicaid program. State Medicaid agencies must better identify the racial and ethnic characteristics of their members and require their MCOs to develop a quality improvement plan that includes reduction of disparities. ACOs should also have access to these racial and ethnic data and be included in initiatives to reduce health care disparities.

States should:

- Improve the quality of ethnic and racial data about Medicaid members and identify priorities for disparities reduction.
- Share ethnic and racial data with ACOs and require them to develop a plan to reduce high-priority health care disparities.
- Have ACOs stratify key performance measures by racial and ethnic group.
- Work with ACOs in the state to develop culturally specific educational materials, and provide staff training on providing culturally appropriate services.
- Require MCOs to ensure availability of bilingual providers and trained interpreters in the languages used by at least 5% of Medicaid enrollees.

### Examples

- Oregon requires ACOs to stratify some of their quality measures by racial and ethnic group. It summarizes these data and posts the results online.

## **I. Oversight**

Most states' efforts are part of a waiver or a grant program which includes requirements for an evaluation process. These efforts should be coordinated with the state's own monitoring and oversight processes. In addition to analysis of utilization, cost and quality data, such processes should include efforts to get feedback from system stakeholders. States should make evaluation documents available to the public and work with stakeholders to address problems identified.

States should:

- Require Medicaid agencies to involve state mental health authorities and single-state agencies for substance abuse when developing performance specifications for access and quality of care of behavioral health services, especially for individuals with SED, SMI, and SUD.
- Designate a Medicaid staff member with training and experience in providing treatment for SED, SMI, and SUD to oversee the ACO's contractual requirements to provide behavioral health services. Ensure that staff capacity is sufficient to monitor the size and number of ACOs in the state.
- Require that the state Medicaid agency has right of approval over any ACO subcontract for management of behavioral health.
- Develop strategies for public review of performance measures and consumer, family, community and provider input for system change.
- Make best use of evaluation resources provided by waiver or grant funding.

### Examples

- Oregon's Health Policy Board serves as the policy-making and oversight body for the Oregon Health Authority. The nine Board members representing diverse aspects of the health system and community organizations are nominated by the Governor and confirmed by the Senate. In its role, it oversees the implementation of the CCOs, and has held public listening sessions over three months in 2016 as well as issued a survey for additional responses. From these sessions as well as reports of CCO results on all performance measures, the Board developed recommendations for priorities in the further development of CCOs.<sup>64</sup>
- Minnesota's efforts receive funding from the State Innovation Model (SIM) program, which requires a formative evaluation. Evaluation data was collected in 2015 from information about organizations participating in SIM activities; semi-structured qualitative interviews with over 200 individuals, including state leaders and staff, grantees, and contractors; review of state documents, grants and contracts; and results of a survey designed for providers to self-assess capabilities necessary for delivering accountable care. Progress was identified, as were barriers to sustainability.<sup>65</sup>

## J. Conclusion

This is a time of great change in the Medicaid health care system. There is much to be learned from the experience of first ACOs, and the experience of dual eligible demonstrations will provide valuable information. The early successes of many ACOs are encouraging, but states must carefully align and coordinate different care models arising from different phases of the path toward well-integrated care. There will likely continue to be a tension between focus on population health for the overall Medicaid population and the extra efforts needed to effectively provide care for individuals with complex behavioral and chronic care needs. States, providers, and advocates must carefully monitor care for this group and make adjustments when necessary.

## Appendix A: Performance Measures

This appendix provides a list of measures of particular value for people with behavioral health conditions, either because they directly measure aspects of behavioral health treatment, or because they address access to medical care or treatment for medical conditions for which this population is at high risk. This list includes many measures that are focused on people with SED, SMI, or serious SUD. It also includes preventive measures for behavioral health that can help ensure that mild, moderate or serious behavioral health conditions are promptly identified so that brief interventions or treatment can begin as soon as possible.

This list of measures has been compiled by review of widely accepted measurement sets, such as NCQA HEDIS, the National Quality Forum (NQF), the Medicaid Core Measures, and Medicare ACO Measures, as well as from review of those employed in many of the state ACO initiatives. In addition, some measures were drawn from SAMHSA's Quality Framework. This list is far too long to be adopted in its entirety. States need to select a balanced set of measures, and determine whether they should be tied to payment or incentives, or whether they should be used for monitoring and to inform further development of the ACO program.

States may find it helpful to consider selection criteria that Massachusetts developed for its Accountable Care Initiative. In selecting each measure, MA considered:

- Reliability, validity, drawn from nationally accepted standards of measures (wherever possible) and with broad impact;
- Alignment with other payers and CMS;
- Measures aspects of patient-centeredness, is patient-reported, or measures quality of life/ functionality;
- Existence of variation in performance on the measure that shows that there is opportunity for improvement (e.g., reduce provider-level variation, disparities);
- Working to attain improvement on the measure will promote co-management/coordination across spectrum of care; and
- Feasibility of data collection and measurement and minimization of administrative burden as much as possible.

In addition to these considerations, it is important to consider whether a measure appropriately incentivizes investment and attention on performance of key aspects of care for underserved populations with mental health and/or SUD. The measure's potential to incentivize undesirable patient/client selection practices such as creaming, skimping, and premature discharge of patients should also be considered, and such measures or payment rules revised or avoided.

States may also wish to use the Center for Health Care Strategies' *Medicaid Accountable Care Organization Quality Measurement Strategy Tool for States*, which provides a grid to help states rate potential measures on a range of criteria. (See <http://www.chcs.org/resource/medicaid-accountable-care-organization-quality-measurement-strategy-tool/>)

## A. Well Established Measures

This section provides well established measures for aspects of behavioral health services. They are well-defined and have proved both feasible to report and meaningful in monitoring utilization and quality of care. Most are widely used.

### 1. Measures of Behavioral Health Service

#### Access

- Timeliness of access to primary care and specialty care measured by surveys; e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients (Certified Community Behavioral Health Clinic demonstration program, SAMHSA)
- For ACOs with a network, analysis of compliance with geoaccess standards for behavioral health services

#### Preventive Care

- Bipolar disorder and major depression: appraisal for alcohol or chemical substance use (CQAIMH, SAMHSA)
- Mental and Physical Health Assessment within 60 days for children in state custody (OR)
- Screening for clinical depression and follow-up (NQF 0418)
- Percent of members receiving screening and brief counseling for substance use
- Diabetes screening of individuals with schizophrenia or bipolar disorder and antipsychotic use (HEDIS, NQF 1932)
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (NQF 0028)
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (NQF 2152)
- Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (NQF 1365)
- Adult Major Depressive Disorder: Suicide Risk Assessment (NQF 0104)

#### Service Utilization

- Percent of members using outpatient mental health care (HEDIS)
- Percent of members using intermediate mental health care (HEDIS)
- Percent of members using inpatient mental health care (HEDIS)
- Out-of-home placements for children and adults
- Percent of ACO-enrolled, Behavioral Health Community Partner-engaged members (up to age 64)

recommended by their care team to receive flexible services support who received such support (MassHealth, 2016)

- Hospital readmissions per 1,000 – hospital readmissions within 30 days for the same diagnosis, for members who were enrolled in the ACO for more than six months, compared to those not enrolled. Measure stratified for members with disabilities and adults and children without disabilities (CO, 2014)

### *Quality*

- Patient and family experience of care (CAHPS or other survey)
- Initiation and engagement of alcohol and other drug dependence treatment (HEDIS, NQF 0004)
- Follow-up care for children prescribed ADHD medication (HEDIS, NQF 0108)
- Antidepressant Medication Management - Acute Phase and Continuation Phase (HEDIS, NQF 0105)
- Screening for Clinical Depression and Follow-up Plan (NQF 0418)
- Consumer follow-up with standardized measure (PHQ-9): Depression Remission at 12 months (NQF 0710)
- Adherence to antipsychotic medications for individuals with schizophrenia (HEDIS)
- Adherence to mood stabilizers for individuals with bipolar I disorder (CMS, NQF 1880)
- Potentially Preventable Emergency Department Visits - Risk-adjusted ratio of observed to expected Emergency Department visits during the measurement period for ACO-attributed members (up to age 65) with a diagnosis of SMI or SUD who were hospitalized for treatment for a selected mental illness or substance use diagnosis that is either the primary or secondary diagnosis; measure calculated for both ACOs and Behavioral Health Community Partners (MassHealth, 2016)
- Plan All-Cause Readmission Rate (NQF 1768)
- Rehospitalization within 30 days - Risk-adjusted percentage of ACO attributed members (up to age 65) with a diagnosis of SMI or SUD who were hospitalized for treatment of selected mental illness or substance use diagnoses (regardless of primary or secondary diagnosis); measure calculated for both ACOs and Behavioral Health Community Partners (MassHealth, 2016)

### *Care Coordination*

- Percentage of ACO-attributed, Behavioral Health Community Partner-eligible members (up to age 65) who had at least one Behavioral Health Community Partner care coordination support during the measurement period (MassHealth, 2016)
- Percentage of Behavioral Health Community Partner-engaged members who were screened for Social Service needs (MassHealth, 2016)
- Post-discharge continued care plan 1) created; 2) transmitted to the next level of care provider on discharge (NQF 0557 & 0558)

- Follow-up after emergency department for alcohol or other dependence (NQF 2605)
- Percentage of members with follow-up within 7 days and 30 days of discharge from a mental health hospitalization (HEDIS, NQF 0576)
- Percentage of members with follow-up within 7 days and 30 days of discharge for a hospitalization for alcohol or chemical dependency detoxification (New York State, 2012)

### LTSS

- Percentage of people referred for LTSS who had a Care Plan within 90 days of referral (for LTSS providers) (MassHealth, 2016)
- People who make life choices, including housing, roommates, jobs and daily activities (National Core Indicators: Choice and Decision Making)
- People who have adequate transportation (CAHPS Home- and Community-Based Services Survey)
- People who need additional services and supports (CAHPS Home- and Community-Based Services Survey)
- People whose support workers come and leave when they are supposed to (CAHPS Home- and Community-Based Services Survey)

### *2. Measures of primary and medical care relevant for people with behavioral health problems*

Some of these measures may be used for all plan members. States should consider stratifying some of these measures for people identified with SED, SMI, and SUD. This can provide insight into the existence and the degree of any disparities in access and quality for people with complex behavioral health conditions. Oregon provides an example of such stratification in its semi-annual CCO metrics reports, defining mental health and SMI by diagnostic categories. Their reports are available from:

<https://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx>.

### *Access to Primary Care*

- Percent of members reporting a usual source of primary care
- Member visits to provider identified as the usual source of care (NQF)
- EPSDT Composite for children (HEDIS)
- EPSDT Composite for adolescents (HEDIS)
- Respect from providers (CAHPS)
- Difficulty speaking with provider due to language (CAHPS)
- Access to interpreter (CAHPS)
- Ratio of primary care providers to members by geographic area (Bailit, 2011)

### *Preventive Care and Wellness*

- Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-up (NQF 0421)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (NQF 0024)
- Adolescent well-care visit (HEDIS)
- Well child visits 3-6 yrs. (NQF 1516)
- Developmental screening in first 15 months of life (NQF 1448)
- Childhood Immunization Status (NQF 0038) Immunizations for Adolescents (NQF 1407)

### *Primary Care Utilization*

- Ambulatory Care - ED visits only (not for mental health or SUD and don't result in inpatient admission) (HEDIS)
- Risk-adjusted length of hospital stay (NQF)
- Return to ED within 7 days of hospital discharge (New Jersey, 2016)

### *Primary Care Quality*

- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (NQF 1932) and/or diabetes monitoring for individuals with schizophrenia and diabetes (HEDIS 2013)
- Percentage of patients treated for bipolar disorder who are assessed for diabetes within 16 weeks after initiating treatment with an atypical antipsychotic agent (CQAIMH, NQF 0003).
- Cardiovascular monitoring for individuals with schizophrenia and cardiovascular disease (HEDIS, 2013)
- Mortality rates for individuals with mental health and/or SU conditions

### *Care Coordination*

- Ambulatory Care Follow-up with assigned Primary Care Provider within 14 days of Inpatient Discharge (excluding deliveries and mental health or SUD discharges) (Illinois, 2013)
- Ambulatory Care Follow-up with a Provider within 14 days of ED visit (HEDIS)
- Medication Reconciliation Post-Discharge - The percentage of discharges during the first 11 months of the measurement year for patients 66 years of age and older for whom medications were reconciled on or within 30 days of discharge (NQF 0554)
- Percentage of ACO-enrolled, Behavioral Health Community Partner-assigned members with documentation of a comprehensive assessment and approval of a plan of care by primary care clinician or designee and member (or legally authorized representative, if appropriate) within 90 days of assignment to Behavioral Health Community Partner (MassHealth, 2016)
- Percentage of ACO-enrolled, Behavioral Health Community Partner-assigned members who had a

completed plan of care during the measurement period (MassHealth, 2016)

- Timely transmission of transition record - Percentage of discharges from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, of patients, regardless of age, for which a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge (NQF 0648)

### *3. Administrative Measures*

Some administrative measures pertain to ACOs as an organization, and others pertain to the capacity of individual providers, both behavioral health and primary care.

#### *ACO Level Measures*

- Percentage of authorization requests approved, modified or denied by service type (Bailit, 2011)
- Average length of time to make an authorization determination by service type (Bailit, 2011)
- Average time to payment of clean claims
- Per enrollee spending on physical health care and behavioral health care

#### *Practice Level Measures*

- Adoption of health information technology (NQF, 0488)
- Percent of practices that have adopted Electronic Health Records (EHRs) that can be accessed by primary and MH/SU care (Wash DSHS, 2010)
- Adoption and use of Medicaid e-prescribing in ambulatory settings (NQF 0486)
- Ability of providers with health information technology (HIT) to receive laboratory data electronically as discrete searchable data (NQF, 0489)

### *2. Measures of Potential Benefit*

The following are measures that are either not widely used or not yet well defined. Others rely on data extracted from EHRs, which can be burdensome or not feasible for providers whose systems are not well developed. Many of these are measures of significance, so states may consider developing their own protocols for a small number of such measures, or use them on a pilot basis to test their feasibility and utility.

#### *Recovery and Wellness Measures*

- Recovery-oriented measures for persons with SMI receiving mental health services (stability in family and living conditions, return to or stay in school, criminal/juvenile justice involvement, employment status (Illinois and Virginia Dual Demonstration, Zainulbhai et. al)
- Maintaining independent living status for members with SMI during the measurement period (CO BHOs, 2014)
- Increase in level of physical activity
- Weight loss

## ***Measures of Primary and Behavioral Health Integration for People with SED or SMI***

- Linkage to primary or specialty care for physical health (Bella et. al, 2009)
- Degree of MH/SU integration with primary care: % of health care homes with access to MH/SU/ primary care through a team, co-location, a system, or referrals (Wash DSHS, 2010)
- Evidence of comprehensive screening (in all three domains - physical, MH, SU) (Wash DSHS, 2010)
- Percentage of individuals screening positive who have further assessment in domain screened (Wash DSHS, 2010)
- Evidence of joint assessment, jointly developed plans of care (Bella et. al, 2009)
- Care plan collaboration across primary care, behavioral health, LTSS and social service providers - Percentage of ACO attributed members (up to age 65) identified for care management/care coordination with documentation of a care plan that:
  - Is developed by/shared with primary care, behavioral health, LTSS, and social service providers as applicable;
  - Addresses needs identified in relevant assessments/screenings; and
  - Is approved by member (or caregiver, if appropriate). (MassHealth, 2016)
- Linkage to community behavioral health for mental health (Bella et. al, 2009)

## ***Quality***

- Percent of members with SMI or functionality limiting SUD assigned to the ACO who are retained for six months
- Rate of diversions from inpatient care
- Rate of avoidable psychiatric readmissions
- Avoidable emergency department utilization (NQF) (Bella et. al, 2009) (Medi-Cal, 2010) (New Jersey, using New York University algorithm)
- ED Utilization for Ambulatory Care Sensitive Conditions (New Jersey)
- Improving or maintaining mental health over two years (CMS)
- Appropriateness of drug regime (number of prescriptions with contra-indicated doses or drug combinations) (Bella et. al, 2009)

## ***Primary Care***

- Medication Management for People with Asthma (NCQA)
- Comprehensive Diabetes Care (HEDIS)
- Cholesterol Management For Patients With Cardiovascular Conditions (HEDIS)

- Medication possession ratio (proportion of days a patient takes medication, based on the intervals between refills) (Oestrich & Clayton, 2009)
- Medication gap (average days between refill of prescription) (Oestrich & Clayton, 2009)
- Beneficiaries changed managed care plans within 60 days (Bailit, 2011)
- Care for Older Adult (COA), Advance Care Plan - Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (NCQA, NQF 0326)
- Percent of health home patients whose charts include documentation of physical and behavioral health needs (Rhode Island Health Home measures)

## B. Sources for Performance Measures

### 1. National Sources

The **National Quality Forum (NQF)** catalogs a broad group of measures and maintains a websearch tool including each of the measures it has endorsed, the steward of each, and the measure's specifications. We have specified the NQF number for those measures included at the time of publication. They can be looked up by number or title, and you can also search on more general terms. [https://www.qualityforum.org/Measures\\_Reports\\_Tools.aspx](https://www.qualityforum.org/Measures_Reports_Tools.aspx). Click on "QPS" within the Measures section on this page to get to the search tool.

**NCQA HEDIS** is a measure set widely used by private and Medicaid managed care plans. Accessed from <http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2018>.

**Medicaid Core Measures.** *2017 Core Set of Behavioral Health Measures for Medicaid and CHIP (Behavioral Health Core Set)*, accessed from <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2017-bh-core-set.pdf>. Further detail on the specifications for these measures is available from the following websites: <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html> (for children) and <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html> (for adults).

**Medicare ACO Measures.** These are available online at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality-Measures-Standards.html>

**SAMHSA's National Behavioral Health Quality Framework** <https://www.samhsa.gov/data/national-behavioral-health-quality-framework#exhibit1>

**Consumer Assessment of Healthcare Providers and Systems (CAHPS)** produces a variety of consumer surveys on different aspects the performance of a person's health plan experience. The *CAHPS Experience of Care and Health Outcomes (ECHO)* survey assesses patient experience with outpatient mental health or substance abuse services and administration through behavioral health care organizations or managed care plans. <https://www.ahrq.gov/cahps/surveys-guidance/echo/index.html>. CAHPS also has a Health Plan Survey, a Clinician & Group Survey for primary care, a home health survey, and an American Indian survey.

**Center for Quality Assessment and Improvement in Mental Health (CQAIMH)** conducts mental health services research and provides quality management services to improve community-based care for individuals with mental health and addictions disorders. Its webpage maintains a searchable directory of mental health measures. <http://www.cqaimh.org/NIMHQM.htm>

**National Core Indicators (NCI)** is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). <http://www.nationalcoreindicators.org/indicators/domain/individual-outcomes/choice-and-decision-making/>

## 2. State Sources

### Colorado

**Accountable Care Collaborative 2014 Annual Report**, Department of Health Care Policy and Financing <https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%202014%20Annual%20Report.pdf>

**BHO-HCPF Annual Performance Measures Scope Document (2014) Version 6** <https://www.colorado.gov/pacific/sites/default/files/BHO-HCPF%20Annual%20Performance%20Measures%20Scope%20Document%202014.pdf>

**Illinois Care Coordination Entities For Children with Complex Medical Needs Accessed Innovations Project** 2013-24-010 See Attachment B. Accessed from: <https://www.illinois.gov/hfs/SiteCollectionDocuments/CCMNSolicitation.pdf>

**MassHealth Delivery System Reform Incentive Payment Protocol** includes measurement sets applicable to 1) ACOs; 2) independent Behavioral Health Community Partners responsible for working with ACOs to serve people with mental health and SUD; and 3) independent LTSS Community Partners, responsible for working with ACOs to serve people with LTSS needs. All three are accountable for their own clientele on a number of these measures. Accessed from: <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/dsrip-protocol.docx>

**Oregon Health Authority**. This web page has a number of documents outlining some of Oregon's incentive measures for CCOs. Scroll down to CCO Measure Specification Sheets. Guidance Documents may also be of interest. <http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx>

**Minnesota Department of Human Services Health Care Administration**. *Request for Proposals for Qualified Grantee(s) to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration, 2016*. See Attachment F. [http://www.dhs.state.mn.us/main/groups/business\\_partners/documents/pub/dhs16\\_192599.pdf](http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_192599.pdf)

**New Jersey Medicaid ACO Demonstration Project: Quality Measures**, Accessed from: [http://www.nj.gov/humanservices/dmahs/info/NJ\\_Medicaid\\_ACO\\_Demonstration\\_Project\\_Quality\\_Metrics\\_4-18-16.pdf](http://www.nj.gov/humanservices/dmahs/info/NJ_Medicaid_ACO_Demonstration_Project_Quality_Metrics_4-18-16.pdf)

**New York State Health Home SPA (State Plan Amendment) for Individuals with Chronic Behavioral and Medical Health Conditions** - SPA # 12-11, 4.12.12 revised, Accessed from: [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/assessment\\_quality\\_measures/docs/statewide\\_hh\\_quality\\_measures.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/statewide_hh_quality_measures.pdf)

**Washington State Department of Social and Health Services, Behavioral Health and Primary Care Integration Collaborative**, *Vision for a System of Integrated Mental Health/Substance Use/Primary Care Treatment Services in Person-Centered Healthcare Homes: Discussion Draft, December 17, 2010*. Accessed from: <https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/Integration%20Discussion%20Distributed%2012-20-2010.pdf>

### *3. Other Sources of Measures*

Bailit Health Purchasing, LLC, (January 2011), **Monitoring Medi-Cal: Recommendations for Measuring the Performance of California's Medicaid Program**, California HealthCare Foundation. Accessed from: <http://www.chcf.org/publications/2011/01/monitoring-medical-recommendations-measuring-performance>

Bella, M., Somers, S.A., Llanos, K., (June 2009). **Provider Behavioral Health Services to Medicaid Managed Care Enrollees: Options for Improving the Organization and Delivery of Services**, The Medicaid Institute at the United Hospital Fund. <https://www.chcs.org/resource/providing-behavioral-health-services-to-medicare-managed-care-enrollees-options-for-improving-the-organization-and-delivery-of-services/>

**Center for Health Care Strategies**, *Medicaid Accountable Care Organization Quality Measurement Strategy Tool for States*, <http://www.chcs.org/resource/medicaid-accountable-care-organization-quality-measurement-strategy-tool/>

# Appendix B: Summary of Medicaid Managed Care Final Rules

This section provides an overview of the major provisions of the Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP (PFR) and discusses early efforts to enforce them. It also summarizes provisions of the Medicaid Managed Care Final Rule that have the greatest relevance for Medicaid enrollees with SED, SMI or serious SUD.

## A. Overview of Medicaid Parity Regulations for Managed Care

Inclusion of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) in the Affordable Care Act (ACA) in combination with the inclusion of mental health and SUD services as essential benefits was a significant step forward in expanding coverage of mental health and SUD in most health plans. However, Medicaid managed care plans initially were subject to parity regulations only if behavioral health benefits were included in the plan benefit. In 2016, CMS issued the Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP (PFR), which applies provisions of MHPAEA to Medicaid managed care organizations, Medicaid alternative benefit plans (ABPs), and the Children's Health Insurance Program (CHIP).<sup>66</sup>

The PFR establishes two standards for compliance:

- State must design and pay for benefits at parity; and
- Plans' standards for behavioral health network, payment and utilization management must be at parity with such standards for medical network, payment and utilization management.

### 1. Design and Payment

This rule sets a much more powerful standard for design and payment than previously applied to Medicaid, because it requires states to modify their State Plans if necessary to meet parity requirements, as well as to increase capitation rates paid to MCOs if compliance with parity, such as paying for additional services or removing limits on services provided, costs more. This final rule also dictates that long-term care services for mental health and SUDs be covered under parity protections.<sup>67</sup> States are required to ensure parity in access to mental health and SUD benefits in all service delivery systems, including MCOs, ABPs, CHIP and any other form of managed care, as well as when members receive medical/surgical benefits through managed care but MH/SUD benefits are fee-for-service.<sup>68</sup> CHIP state plans providing full Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage are deemed in compliance with parity requirements.<sup>69</sup> In most cases, the state is responsible for determining if the benefits provided through its managed care delivery system meets parity requirements.<sup>70</sup> They have until October 30, 2017 (18 months from the rule's publication) to document parity compliance and make this documentation available to the public.<sup>71</sup>

### 2. Plan Standards

The PFR establishes standards for parity between behavioral health and medical care in aspects of plan structure and operation, including lifetime or dollar limits on services; members' financial requirements (e.g., copayments, coinsurance, deductibles and out-of-pocket maximums); quantitative treatment limits and non-quantitative treatment limits. Parity is determined by comparing medical/surgical and behavioral health benefits within four classes of acute care benefits identified by the CMS regulations: inpatient, outpatient, prescription drugs and emergency care;<sup>72</sup> this final rule also dictates that long-term care

services for mental health and SUDs be covered under parity protections.<sup>73</sup>

- If MCOs provide behavioral health benefits in any classification, they must provide behavioral health benefits in every classification for which medical/surgical benefits are provided.<sup>74</sup>
- Aggregate lifetime and annual dollar limits that apply to more than one-third of medical/surgical benefits may be applied to mental health and substance abuse benefits.<sup>75</sup>
- Financial requirements (e.g., copayments, coinsurance, deductibles and out-of-pocket maximums) for mental health and substance abuse benefits cannot be more restrictive than the predominant financial requirements applied to substantially all medical/surgical benefits in the same classification (where “predominant” is defined as more than one-half of the payments expected for medical/surgical benefits provided in the class).<sup>76</sup>
- Cumulative financial requirements for behavioral health benefits cannot accumulate separately from medical/surgical benefits in the same classification.<sup>77</sup>
- Quantitative treatment limitations (e.g., day or visit limits) for mental health and substance abuse benefits cannot be more restrictive than the predominant quantitative treatment limitations applied to substantially all medical/surgical benefits in the same classification (where “substantially all” is defined as two-thirds of medical/surgical benefits calculated by the dollar value of the payments expected for medical/surgical benefits provided).<sup>78</sup>
- Non-quantitative treatment limitations (i.e., non-numeric limits on the scope or duration of benefits, such as prior authorization or fail-first policies), or NQTLs, are prohibited unless the processes and standards for applying the NQTL to behavioral health benefits are comparable to and applied no more stringently than the processes and standards as written and in use for medical/surgical benefits in the same classification.<sup>79</sup>

### 3. Consumer and Provider Rights and Enforcement

MCOs must provide beneficiaries and contracted providers access upon request to complete health plan documents (including network adequacy standards), criteria for medical necessity determination (even if proprietary), and the reason for any adverse benefit determination.<sup>80,81</sup> The National Council has published *Tips For Providers On Negotiating Managed Care Contracts To Improve Access To Mental Health And Addiction Care*. It includes specific recommendations for providers to negotiate contracts with MCOs that are consistent with parity requirements pertaining to communication; standing; access to plan documents, clinical criteria and claims data; network access; negotiated coverage modifications; denials implicating parity; and penalties for noncompliance.

To help states and plans ensure they are complying with parity regulations, the Departments of Health and Human Services, Labor, and Treasury have issued guidance on parity, including 44 FAQs and a compliance checklist.<sup>82</sup> SAMHSA has also released an issue brief summarizing best and promising practices for states to monitor and enforce parity compliance mental health and SUD.<sup>83,84</sup> A second National Council paper, *Tips For Improving Access To Mental Health And Addiction Care By Improving State Medicaid Contracts*, provides guidance for states on incorporating parity requirements into their contracts with MCOs.

## B. Selected Provisions of the Medicaid Managed Care Final Rule

### 1. Enrollment and Consumer Choice

The Medicaid Managed Care Final Rule establishes a number of protections and supports for members enrolled in a managed care plan or who could potentially enroll in a managed care plan. This includes:

- An Independent Beneficiary Support System
- Requirement for plans to provide necessary information to members
- Provision of certain rights for enrollees to disenroll, in part based on their current medical or LTSS providers.

#### *Independent Beneficiary Support System*

States must establish an independent beneficiary support system for potential managed care enrollees in plans whose contracts start on or after July 1, 2018. The system must provide assistance before and after enrollment by phone, internet and in person. Information provided must be readily accessible in terms of language and disability and in an easily understood format.<sup>85</sup> The system must offer:

- Personal choice counseling
- Information to help understand managed care
- Assistance on LTSS
- An access point for LTSS complaints and concerns
- Education on enrollee rights and responsibilities
- Assistance with grievances and appeals
- Review and oversight of data to identify and resolve LTSS issues
- Assistance to members in fulfilling requirements to maintain their Medicaid eligibility.

#### *Beneficiary Information from Plans*

The state must require plans to provide new enrollees with the following information in locally prevalent non-English languages, and in alternative formats upon request at no extra charge:

- An informational handbook with a summary of coverage and benefits; and
- Drug formulary information.

: Plans must also help enrollees and potential enrollees understand plan requirements and benefits.<sup>86</sup>

#### *Beneficiary Rights Regarding Automatic Enrollment*

If an enrollee does not select an MCO, the state must assign the enrollee to a plan that will preserve his or her existing provider relationships or in a plan with providers that have traditionally served Medicaid enrollees. Criteria including quality, family preferences and accessibility for people with physical disabilities may also be considered.<sup>87</sup>

**Discussion.** This provision does not speak to the strength of plan networks for serving people with SED, SMI and SUD, but it seems likely that states could take this into account in assigning such enrollees to health plans. However, this practice would raise the likelihood of creating adverse selection, where a plan that excelled in serving people with SMI would enroll a higher proportion of these high-cost members, increasing its costs compared to others.

If an enrollee is automatically enrolled into an MCO, the state must provide that member clear information about their right, within 90 days, to disenroll and either enroll into a different plan, or, if allowed, opt into the fee-for-service system. States must also review any disenrollment request denied by a plan.<sup>88</sup>

Enrollees using LTSS must be allowed to disenroll from their plan if they would have to change their residential, institutional or employment supports provider or if they would experience a disruption in their residence or employment as a result of the provider leaving the plan network.<sup>89</sup>

## 2. Networks

The Medicaid managed care final regulation establishes stronger requirements regarding information about network providers, network adequacy, how compliance with these standards must be monitored, and provision of continuity of care for enrollees transitioning into a plan.

### *Network Provider Directory*

States must require plan provider directories, with the online version updated within 30 days of notice by the provider.<sup>90</sup> The directory must specify:

- Whether the provider will accept new enrollees
- Linguistic capacities
- Status of completion of cultural competence training
- Physical accessibility for disabled populations.<sup>91</sup>

### *Network Adequacy Standards*

States must develop network adequacy standards that include time and distance standards for services, including adult and pediatric behavioral health and LTSS applicable to MCO contracts beginning on or after July 1, 2018. In developing these standards, states must consider expected utilization based on the population's health care needs; the number of network providers not accepting new patients; geographic location; and transportation. It must further consider the ability of providers to communicate with limited English-proficient enrollees in their preferred language, and ensure physical access, reasonable accommodations, culturally competent communication and accessible equipment for people with physical or mental disabilities. Finally, it can consider the availability of triage lines, screening systems, telemedicine and other technological options that affect need for providers.

The state must also establish standards for LTSS providers that travel to the enrollee to deliver services. The state must also consider elements of LTSS network adequacy that would support choice of provider, ensure health and welfare, support community integration, and other factors in the best interest of LTSS enrollees.<sup>92</sup>

Health plans that enroll American Indians/Alaska Natives (AI/AN) are required to demonstrate a sufficient network of AI/AN health care providers to ensure timely access for enrollees. They must pay non-AI/AN network providers at rates comparable to those for non-AI/AN providers, and in accordance with FQHC rates, Indian Health Service encounter rates, or state plan FFS rates, as applicable.<sup>93</sup>

### *Monitoring Systems*

The state must monitor access to determine the degree to which time and distance access standards are being met.<sup>94</sup> In addition, it must contract with an external quality review organization to validate past year network adequacy, according to a CMS-issued protocol.<sup>95</sup>

### *Exceptions*

Any exceptions to network adequacy standards must be based on the number of providers in the relevant specialty who practice in the service area. States must monitor access to these provider types and report results to CMS annually.<sup>96</sup>

### *Transitions Between Health Plans*

For enrollees transitioning from fee-for-service to managed care or between health plans, states must set policies that:

- Ensure that these members have access to services consistent with their previous access and permit them to retain their current provider for a state-specified period if the provider is not in the new plan's network.
- Ensure continuity of care when, without continued services, an enrollee would suffer a serious determinant to health or risk of hospitalization or institutionalization.<sup>97</sup>

### *3. Service Authorization*

Medicaid managed care final regulation sets special conditions for authorizing services for enrollees who require LTSS. For these members, states must:

- Ensure that plans authorize services in a manner that reflects their ongoing need for services.
- Require that plans allow only individuals with appropriate expertise in addressing the enrollees' medical, behavioral health or LTSS needs to deny or reduce authorization.
- Make expedited authorization decisions within 72 hours of request for services.<sup>98</sup>

### *4. Appeals*

The Medicaid managed care final regulation establishes a streamlined, two-step appeals process for service authorization denials.

- Plans are allowed only one level of internal appeal.
  - An enrollee has 60 days from the notice of adverse benefit determination to submit an internal appeal, and the plan must respond within 30 days.
  - Expedited appeals must be resolved within 72 hours from receipt of appeal (rather than 3 working days).

- Plans must provide enrollees reasonable access to and copies of documents, records and other information relevant to their claims, including medical necessity criteria and any processes, strategies, or evidentiary standards used by the plan to set coverage limits. These must be provided without charge and sufficiently in advance of the timeframe for resolution of appeal.<sup>99</sup>
- The plan must consider all information submitted by enrollees or their representatives in appeals.<sup>100</sup>
- The state may require plans, upon request, to provide assistance to enrollees receiving LTSS who are appealing adverse benefit determinations.<sup>101</sup>
- Plans must keep required records of appeals.<sup>102</sup>
- Enrollees must go through this initial level of appeal to proceed to a state fair hearing, which may be requested within 120 days from the date of resolution of an internal appeal.
  - Plans must implement a decision overturned by a state fair hearing within 72 hours of the plan's receipt of notice of the determination.
- States may provide the option for an external medical review by a practitioner independent of the state and the health plan, but they cannot be required before or used to deter a state fair hearing. They do not extend the time frames described above nor disrupt continuation of benefits during the appeal.<sup>103</sup>
- An enrollee may continue benefits during the appeals process if he or she requests continuation within 10 days of the plan termination notice and again within 10 calendar days of the internal appeal resolution notice.
- Plans may recoup the cost of the continued service if the enrollee loses the appeal to the extent that the state does so in fee-for-service.<sup>104</sup>
- States must review plan records of appeals as part of ongoing monitoring and oversight.

### 5. Care Coordination

The Medicaid managed care final regulation requires states to collect more information about the health care needs of its enrollees and requires plans to conduct a health risk assessment, and provide care coordination with a broad scope of services, with special requirements for those needing LTSS.

#### Identification of Special Health Care Needs

States must develop a mechanism for identifying enrollees who need LTSS or have special health care needs and share this health care need and demographic information with the MCO for each enrollee at the time of enrollment.<sup>105</sup>

#### Health Risk Assessment

MCOs must conduct a health risk assessment for new members within 90 days of enrollment and provide them with contact information for their care coordinator.<sup>106</sup>

## *Care Coordination*

MCOs must provide care coordination that ensures that managed care enrollees have access to ongoing sources of care appropriate to their needs, including behavioral health and LTSS. Coordination is defined to include coordination between settings; coordination with services provided outside the plan; and coordination with community and social support providers.<sup>107</sup> States must also require plans serving people with special health care needs to maintain coordination and continuity of care capabilities for them.

## *LTSS Service Planning*

Plans must develop a treatment or service plan for enrollees who need LTSS. Planning must be conducted by an LTSS service coordinator trained in person-centered planning, with participation by the member and in consultation with his or her providers. Plans must be reviewed at least annually, and must be considered when the health plan authorizes LTSS.<sup>108</sup>

## *6. Stakeholder Input on LTSS*

States are required to convene a stakeholder group and a member advisory committee to meaningfully engage them in development of LTSS services.

### *LTSS Stakeholder Group*

The state must create and maintain a stakeholder group to solicit and address the opinions of enrollees, people representing enrollees, providers and other stakeholders in the design, implementation and oversight of the states' LTSS program. The composition of the group and the frequency of its meetings must be sufficient to ensure meaningful engagement.

### *LTSS Member Advisory Committee*

The state must also create a member advisory committee that has a reasonably representative sample of the populations receiving LTSS.<sup>109</sup>

## *7. Cultural Competency*

States are required to provide plans with data on the races and ethnicities of their members, and plans must use this information to develop a disparities plan.

**Discussion.** This will require many states to put substantial effort into collecting more accurate information on races and ethnicities of Medicaid enrollees.

In turn, managed care entities are required to develop a plan to reduce health disparities based on age, race, ethnicity, sex, primary language and disability.<sup>110</sup>

## *8. Quality Improvement*

One of the most notable new requirements is for states to have a quality strategy for their managed care plans. Some of the requirements discussed above are a component of this plan.

### *Written Quality Strategy for Managed Care Entity Services*

States must develop and implement a written quality strategy for assessing and improving the quality of all care and services delivered by a managed care entity by July 2018. It must be posted publicly to get

input before it is submitted to CMS and updated every three years. The strategy must include:

- Network adequacy standards
- Measurable goals and objectives for continuous quality improvement that take into account the health status of all participating populations
- Quality and performance standards
- State or federally required performance improvement projects
- A state transition of care policy.

### *Quality Improvement*

MCOs are required to conduct an ongoing comprehensive quality assessment and performance improvement program (QAPI), including

- Performance improvement projects
- Performance measurement
- Mechanisms to identify underutilization and overutilization
- Assessment of the quality and appropriateness of care for enrollees with special needs, including LTSS, if covered
- Assessment of LTSS must include assessment of transition care and whether the enrollee received the services and supports in his or her treatment plan<sup>111</sup>
- Annual external quality reviews.

### *External Quality Review*

- States must arrange for external review of quality for each contractor, which should validate performance measurement data associated with PIPs and with state performance measures; and
- Recommend how the state can better target its quality strategy on quality, timeliness and access to services.<sup>112</sup>

## *9. Regulatory Oversight*

States must fulfill greater requirements for monitoring of managed care.

### *Monitoring Systems*

States must establish monitoring systems that address all aspects of the state's managed care programs, including:

- Appeals and grievances
- Claims management
- Enrollee materials and customer service

- Information systems
- Marketing
- Medical management
- Network management
- Availability and accessibility of services.

### *Performance Improvement*

States must use required reporting and many specified sources of data to improve performance of managed care entities (MCOs).<sup>113</sup>

### *Annual Report*

States must submit an annual report to CMS, due within 180 days after each contract year, summarizing

- Each plan's performance on a wide variety of functions.
- Performance of the other parts of the state's managed care system, including its beneficiary support system.

States must post this report on the state's website.<sup>114</sup>

### *CMS approval of MCO contracts*

States must submit all managed care entity contracts to CMS for prior approval before contracting.

### *Readiness Reviews for New Programs*

States must conduct both a desk and an onsite review at least three months before implementation for new programs, or management of new populations for contracts starting on or after July, 2017.

### ***Services Provided in "Institutions for Mental Disease"***

Citing the high prevalence of mental health and SUDs among Medicaid beneficiaries, CMS will now permit MCOs to include within the scope of their capitation payment from the state certain services that might otherwise be subject to the Institutions for Mental Disease (IMD) payment exclusion. The rule allows MCOs to utilize IMD services for stays of up to 15 days in a month, if those services are medically necessary, cost effective and used "in lieu of" more costly services such as hospitalization.

## Endnotes

- 1 Centers for Medicare & Medicaid Services. (2016). *Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP*. Retrieved from <https://www.medicare.gov/medicaid/benefits/downloads/fact-sheet-cms-2333-f.pdf>
- 2 Kaiser Commission on Medicaid and the Uninsured. (2012). *Emerging Medicaid Accountable Care Organizations: The Role of Managed Care*. Retrieved from <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8319.pdf>
- 3 Center for Health Care Strategies, Inc. (2017). *Medicaid Accountable Care Organizations: State Update*. Retrieved from <http://www.chcs.org/media/ACO-Fact-Sheet-01-30-17.pdf>
- 4 Center for Health Care Strategies, Inc. (2017). *Medicaid Accountable Care Organizations: State Update*. Retrieved from <http://www.chcs.org/media/ACO-Fact-Sheet-01-30-17.pdf>
- 5 Mandros, A. (2015). Why Medicaid ACO Models Seem Confusing. *Open Minds*. Retrieved from <https://www.openminds.com/market-intelligence/executive-briefings/why-medicare-aco-models-seem-confusing/>
- 6 Mahadevan, R. & Houston, R. (2015). *Supporting Social Service Delivery through Medicaid Accountable Care Organizations: Early State Efforts*. Retrieved from [http://www.chcs.org/media/Supporting-Social-Service-Delivery-Final\\_0212151.pdf](http://www.chcs.org/media/Supporting-Social-Service-Delivery-Final_0212151.pdf)
- 7 Mandros, A. (2015). Why Medicaid ACO Models Seem Confusing. *Open Minds*. Retrieved from <https://www.openminds.com/market-intelligence/executive-briefings/why-medicare-aco-models-seem-confusing/>
- 8 Mandros, A. (2015). Why Medicaid ACO Models Seem Confusing. *Open Minds*. Retrieved from <https://www.openminds.com/market-intelligence/executive-briefings/why-medicare-aco-models-seem-confusing/>
- 9 Center for Health Care Strategies, Inc. (2017). *Medicaid Accountable Care Organizations: State Update*. Retrieved from <http://www.chcs.org/media/ACO-Fact-Sheet-01-30-17.pdf>
- 10 Ries, D. K. (2011). ACO Mission: Behavioral Healthcare Under the Medicare Shared Savings Program. *The ABA Health eSource*. Retrieved from [https://www.americanbar.org/newsletter/publications/aba\\_health\\_esource\\_home/aba\\_health\\_law\\_esource\\_1106\\_aco\\_ries.html](https://www.americanbar.org/newsletter/publications/aba_health_esource_home/aba_health_law_esource_1106_aco_ries.html)
- 11 Oregon Health Authority. (2017). *Oregon's Health System Transformation: CCO Metrics 2016 Mid-Year Report*. Retrieved from [https://www.oregon.gov/oha/Metrics/Documents/2016\\_Mid-Year\\_Report.pdf](https://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf)
- 12 Minnesota Department of Human Services. (2017). *Integrated Health Partnerships improve health, reduce the cost of care*. Retrieved from <https://mn.gov/dhs/media/news?id=1053-286364>
- 13 Lloyd, J., Houston, R., & McGinnis, T. (2015). *Medicaid Accountable Care Organization Programs: State Profiles*. Retrieved from <http://www.chcs.org/media/Medicaid-Accountable-Care-Organization-Programs-State-Profiles-1115.pdf>
- 14 Colorado Department of Health Care Policy and Financing. (2014). *Accountable Care Collaborative: 2014 Annual Report*. Retrieved from <https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%202014%20Annual%20Report.pdf>
- 15 Gates, A., Rudowitz, R., & Guyer, J. (2014). *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*. Retrieved from <http://kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/>
- 16 Illinois Department of Healthcare and Family Services, (2014) The Path to Transformation: Illinois 1115 Waiver Proposal.
- 17 *MaineCare's Accountable Community Initiative* accessed from [http://www.maine.gov/dhhs/oms/pdfs\\_doc/vbp/AC/2015%20AC%20Pres%20for%20VBP%20Site.pdf](http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/2015%20AC%20Pres%20for%20VBP%20Site.pdf) on May 1, 2017.
- 18 State of Illinois. (2013). Solicitation for Care Coordination Entities For Children with Complex Medical Needs Accessed Innovations Project – 2013-24-010 from <https://www.illinois.gov/hfs/SiteCollectionDocuments/CCMNSolicitation.pdf> on April 30, 2017.
- 19 Schaff, M. F., Leone, A. M. & Mack, G. D. (2015). *The ACO Handbook: A Guide to Accountable Care Organizations*, "Chapter 13, How State Law Issues May Affect ACOs." Second Edition. American Health Lawyers Association. Accessed from <http://www.lexisnexis.com/store/images/Supplements/Ch%2013%20ACO%20Handbook%20Sample.pdf> on April 30, 2017.
- 20 Pavarini, P. A. & Nauman, R. D. (2015). *The ACO Handbook: A Guide to Accountable Care Organizations*, Second Edition, American Health Lawyers Association.

- 21 Henry J. Kaiser Family Foundation. (2014). State Health Facts, Timeframe. accessed from <http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> on April 30, 2017.
- 22 Paradise, J. & Musumeci, M. (2016). *CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions*, The Kaiser Commission on Medicaid and the Uninsured, accessed from <http://files.kff.org/attachment/CMSs-Final-Rule-on-Medicaid-Managed-Care> on February 15, 2017.
- 23 Families USA. (2013). *Accountable Care Organizations (ACOs) in Medicaid: Challenges and Opportunities for Advocates*, accessed from <http://familiesusa.org/product/accountable-care-organizations-acos-medicaid-challenges-and-opportunities-advocates> on February 21, 2017.
- 24 Ibid.
- 25 State of Illinois, 2013.
- 26 Maine Department of Health and Human Services, 2015.
- 27 Colorado Department of Health Care Policy and Planning, *Supporting a Culture of Coverage Accountable Care Collaborative : 2015 Annual Report*.
- 28 Minnesota Department of Human Services Health Care Administration. (2016). *Request for Proposals for Qualified Grantee(s) to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration*.
- 29 Families USA, 2013.
- 30 Ibid.
- 31 Ibid.
- 32 Ibid.
- 33 Minnesota Department of Human Services Health Care Administration, 2016.
- 34 Minnesota Department of Health. (2016). *Minnesota Accountable Health Model: Continuum of Accountability Assessment Tool*
- 35 Families USA, 2013.
- 36 In Minnesota, plans contracts with community behavioral providers contain quality assurance and supervisory standards that they accept in lieu of individual credentialing. Services are billed under a supervising professional's National Provider Identifier. Brand, R. & Venkatesh, M. (2010). *Comprehensive Coverage: The Minnesota Mix*, *National Council Magazine*, Issue 2, page 40-42.
- 37 Moss, S. (1998). *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers*, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Rockville, MD.
- 38 Rosenbaum, S. (2016). *Twenty-First Century Medicaid: The Final Managed Care Rule*, *HealthAffairs Blog*, accessed from <http://healthaffairs.org/blog/2016/05/05/twenty-first-century-medicaid-the-final-managed-care-rule/> on February 15, 2017.
- 39 Families USA, 2013.
- 40 *MaineCare's Accountable Community Initiative*
- 41 State of Illinois, 2013.
- 42 Ibid.
- 43 Moss, 1998.
- 44 Ibid.
- 45 Families USA, 2013.
- 46 Ibid.
- 47 Substance Abuse and Mental Health Services Administration, *Description of a Modern Addictions and Mental Health Service System*, August 11, 2010. From <https://www.samhsa.gov/healthreform/docs/AddictionMHSystemBrief.pdf> accessed 4/15/2011.
- 48 Families USA, 2013.
- 49 Ibid.
- 50 Ibid.

- 51 Oregon Health Authority. (2017). Oregon Health Plan Amended and Restated Health Plan Services Contract: Coordinated Care Organization (Sample) accessed from <https://multco.us/file/48279/download> on July 24, 2017.
- 52 Ibid.
- 53 State of Illinois, 2013.
- 54 Ibid.
- 55 Minnesota Department of Health, 2016.
- 56 Families USA, 2013.
- 57 State of Illinois, 2013.
- 58 Minnesota Department of Human Services Health Care Administration, 2016.
- 59 Families USA, 2013.
- 60 Minnesota Department of Human Services Health Care Administration, 2016.
- 61 Maine Department of Health and Human Services, 2015.
- 62 Families USA, 2013.
- 63 Ibid.
- 64 Website of the Oregon Health Policy Board, accessed from <http://www.oregon.gov/oha/OHPB/Pages/members.aspx> on May 2, 2017.
- 65 State Health Access Data Assistance Center. (2016). *Evaluation Of The Minnesota Accountable Health Model: First Annual Report, Executive Summary*
- 66 Centers for Medicare & Medicaid Services. (2016). *Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP*
- 67 Ibid.
- 68 Ibid.
- 69 Ibid.
- 70 Centers for Medicare & Medicaid Services. (2016). *Frequently Asked Questions: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP*. Retrieved from <https://www.medicaid.gov/medicaid/benefits/downloads/faq-cms-2333-f.pdf>
- 71 Ibid.
- 72 Centers for Medicare & Medicaid Services. (2017). *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*. Retrieved from <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>
- 73 Centers for Medicare & Medicaid Services. (2016). *Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP*
- 74 Centers for Medicare & Medicaid Services. (2017). *Parity Compliance Toolkit*
- 75 Ibid.
- 76 Ibid.
- 77 Ibid.
- 78 Ibid.
- 79 Ibid.
- 80 Centers for Medicare & Medicaid Services. (2016). *Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP*.
- 81 Ingoglia, C., Farley, R., Parks, J., Ellis, A. & Bendat, M. (2016). *Protecting Consumer Access to Mental Health and Addiction Care in Managed Medicaid Plans*, The National Council.
- 82 Executive Office of the President of the United States. (2016). *The Mental Health & Substance Use Disorder Parity Task Force: Final Report*. Retrieved from <https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf>
- 83 Ibid.

- 84 Substance Abuse and Mental Health Services Administration. (2016). *Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States*. Retrieved from <http://store.samhsa.gov/product/SMA16-4983>
- 85 Paradise, J. and Musumeci, M. (2016). *CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions*, The Kaiser Commission on Medicaid and the Uninsured, accessed from <http://files.kff.org/attachment/CMSs-Final-Rule-on-Medicaid-Managed-Care> on February 15, 2017.
- 86 Ibid.
- 87 Ibid.
- 88 Ibid.
- 89 Ibid.
- 90 Ibid.
- 91 Ibid.
- 92 Ibid.
- 93 Ibid.
- 94 Rosenbaum, S. (2016). Twenty-First Century Medicaid: The Final Managed Care Rule, *HealthAffairs Blog*, accessed from <http://healthaffairs.org/blog/2016/05/05/twenty-first-century-medicare-the-final-managed-care-rule/> on February 15, 2017.
- 95 Paradise, J. and Musumeci, M. (2016).
- 96 Ibid.
- 97 Ibid.
- 98 Ibid.
- 99 Ibid.
- 100 Ibid.
- 101 Rosenbaum, S., 2016.
- 102 Paradise, J. and Musumeci, M. (2016).
- 103 Ibid.
- 104 Ibid.
- 105 Ibid.
- 106 Ibid.
- 107 Ibid.
- 108 Ibid.
- 109 Ibid.
- 110 Ibid.
- 111 Ibid.
- 112 Ibid.
- 113 Ibid.
- 114 Ibid.



