

Considerations for Integrating Behavioral Health Services within Medicaid Accountable Care Organizations

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IN BRIEF

Medicaid accountable care organizations (ACOs) have the potential to improve health care quality and control rising costs, particularly for complex, high-need beneficiaries. Given the prevalence of behavioral health conditions among this population and the related cost implications, coordinating behavioral health services within Medicaid ACOs may help states to dramatically improve quality of care and reap significant savings from avoidable emergency room and inpatient utilization. This brief, made possible by The Commonwealth Fund, outlines considerations to guide state Medicaid agencies in successfully integrating behavioral health services within ACOs.

In recent years, there has been growing recognition of the impact of behavioral health comorbidities on overall health care costs and utilization, particularly in Medicaid where behavioral health conditions are more than twice as prevalent as in the general population.¹ Average health care costs for Medicaid beneficiaries with common chronic conditions increase by three and a half times, and hospitalization rates by four times due to co-occurring mental illness or substance use disorders.² As the largest single source of funding for public mental health services, Medicaid finances more than one-quarter of the nation's spending for behavioral health care, further driving the imperative for more cost-effective care delivery models.³

Accountable care organizations (ACO) that target Medicaid populations have been launched in Oregon, Minnesota, and other states to encourage shared accountability at the provider level for the cost and quality of health care services. Given the significant behavioral health needs of the newly insured Medicaid population,⁴ there is an even greater interest among states, health plans, and providers to integrate behavioral health services within existing Medicaid ACOs.

There are multiple integration approaches that ACOs can take to support the care needs of these populations. The federal Center for Integrated Health Solutions has mapped out several models that states can consider, with varying levels of service and payment integration – from basic coordination of services between primary care to co-location of services at a primary care, specialty, and/or behavioral health setting (see Exhibit 1).⁵ Medicaid ACO models are generally flexible in the approach used, leaving it up to providers to determine which is most appropriate.

EXHIBIT 1. SAMHSA-HRSA’s Center for Integrated Care: Six Levels of Collaboration/Integration

COORDINATED Key Element: Communication		CO-LOCATED Key Element: Physical Proximity		INTEGRATED Key Element: Practice Change	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care, and other health care providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
<ul style="list-style-type: none"> • Have separate systems • Communicate about cases only rarely and under compelling circumstances • Communicate, driven by provider need • May never meet in person • Have limited understanding of each other’s roles 	<ul style="list-style-type: none"> • Have separate systems • Communicate periodically about shared patients • Communicate, driven by specific patient issues • May meet as part of a larger community • Appreciate each other’s roles as resources 	<ul style="list-style-type: none"> • Have separate systems • Communicate regularly about share patients, by phone or e-mail • Collaborate, driven by need for each other’s services and more reliable referral • Meet occasionally to discuss cases due to close proximity • Feel part of a larger yet ill-defined team 	<ul style="list-style-type: none"> • Share some systems, like scheduling or medical records • Communicate in person as needed • Collaborate, driven by need for consultation and coordinated plans for difficult patients • Have regular face-to-face interactions about some patients • Have a basic understanding of roles and culture 	<ul style="list-style-type: none"> • Actively seek system solutions together or develop work-arounds • Communicate frequently in person • Collaborate, driven by desire to be a member of the care team • Have regular team meetings to discuss overall patient care and specific patient issues • Have an in-depth understanding of roles and culture 	<ul style="list-style-type: none"> • Have resolved most or all system issues • Communicate consistently at the system, team, and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blur or blend

B. Heath, P. Wise Romero, and K. Reynolds. *A Review and Proposed Standard Framework for Levels of Integrated Healthcare*. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.

Behavioral health providers transitioning to integrated care models will need to enhance their relationships with physical health providers and payers. They will also have to build the administrative infrastructure to support scheduling, billing, and medical record functionality. Existing provider alliances, like Medicaid ACOs, can potentially help behavioral health providers in making the transition to an integrated approach whereby behavioral health services are coordinated and even co-located with primary care and specialty services.⁶ There is a significant opportunity for shared savings for Medicaid ACOs that can successfully coordinate care across systems for complex, high-need populations.

This brief outlines considerations for states in fostering the integration of behavioral health services within Medicaid ACO models. It addresses decisions around financial strategies, data sharing, and quality measurement. It also identifies policy levers for promoting alignment with existing behavioral health initiatives and helping providers overcome barriers to integration. As Medicaid ACOs expand

their scope of accountability for these and broader social services (such as housing) and move toward becoming totally accountable care organizations (TACOs),⁷ it will be important to identify approaches that support the participation – and accountability – of behavioral health providers.

Considerations for Integrating Physical and Behavioral Health Services within Medicaid ACOs

Minnesota, Maine, and Vermont are defining program requirements for their Medicaid ACO programs to encourage the integrated delivery and payment of physical and behavioral health services. These states recognize these five focus areas as keys to program success:

1. *Financial incentives and sustainability;*
2. *Confidentiality of data sharing and provider supports for health information exchange;*
3. *Quality measurement;*
4. *Alignment with existing behavioral health initiatives; and*
5. *Potential regulatory and policy levers to overcome barriers to integration.*

The following sections address each of these issues.

1. Financial Incentives and Sustainability

States have an opportunity through Medicaid ACOs to create shared accountability among physical and behavioral health providers. They can do so through care delivery transformation efforts tied to a range of payment mechanisms that align incentives across stakeholders.

Hennepin Health, a safety-net ACO in Minnesota, has successfully integrated medical services with behavioral health services (and other county-funded and social services). The ACO receives a capitated payment, which encourages providers to work with one another to coordinate care for patients, thereby reducing duplicative and costly treatments and maximizing providers' net income.

It may be helpful for states to maintain some flexibility in ACO payment methodologies to ensure that financial incentives support the level of service integration being pursued. States can either require ACOs to share savings with behavioral health providers, or leave it up to the ACOs to determine the appropriate financial incentives to encourage the full participation of behavioral health providers. In some cases, a shared savings payment tied to a set of cost and quality measures may be sufficient to propel providers to coordinate physical and behavioral health services. For ACOs that have stakeholder support for global capitation, this approach may encourage ongoing coordination of integrated services, despite potentially decreasing opportunities for savings over time as ACOs become more cost-effective.

Oregon is now using regional Coordinated Care Organizations to manage both physical and behavioral health benefits for Medicaid beneficiaries under a global budget, a transition that was feasible since the Oregon Health Authority consolidates purchasing for both Medicaid and behavioral health services. Alternatively, Maine will include behavioral health services within the total cost of care (TCOC) calculations for its Accountable Communities (AC) to promote shared accountability across historically siloed primary care and behavioral health providers. To be eligible for shared savings, an AC's average TCOC for the performance year must be below benchmark by at least two percent while also achieving quality performance on 15 core measures. Paired with financial incentives, these

metrics can help incentivize behavioral health providers to collaborate with other providers for targeted AC populations. Global payments may therefore be more appropriate for organizations that already have behavioral health services within their network, while shared savings may be better for organizations looking to transition to a more integrated model.

Massachusetts, as part of its Primary Care Payment Reform initiative, has embedded behavioral health services within its three-tiered payment system, including: (1) comprehensive primary care per member per month (PMPM) payments for an optional set of behavioral health services; (2) quality incentive payments based on 23 quality measures including four related to behavioral health; and (3) shared savings payments based on cost savings on non-primary care services, including select behavioral health services. Essentially, the PMPM rate would increase for providers based on the level of behavioral health integration they support.

The trend toward moving behavioral health services from fee-for-service payment into managed care should help to remove some of the barriers associated with integrating these services into ACOs, particularly in carve-out states. For example, in New York State, behavioral health will be managed: (1) by Medicaid managed care organizations (MCOs) that qualify to provide the full array of behavioral health and substance use disorder services including those formerly carved out of the state's Medicaid managed care benefit package; (2) by MCOs in partnership with a behavioral health organization (BHO); or (3) through Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs.⁸

Given the newly defined roles for MCOs in the behavioral health arena, opportunities are emerging for states to encourage plans to promote closer integration at the point of care via Medicaid ACOs. States can leverage these new partnerships to promote integration within an ACO model where MCOs can promote coordination between primary care and behavioral health services through enhanced payment models. It is worth noting that different provider types have varying abilities to assume risk, and that support from ACOs may be helpful to assist providers in moving gradually toward a shared savings model.

2. Confidentiality of Data Sharing and Provider Supports for Health Information Exchange

In order to coordinate care across primary and behavioral health services for a given patient, providers require timely access to shared patient information including patient diagnosis, appointment scheduling, care treatment plan, prescribed medications, and other clinical information. Inter-operability challenges often pose significant barriers to such data exchange, given that behavioral health providers typically document information differently than physical health providers. This makes it difficult to exchange and interpret shared data.

To support seamless data exchange across these providers, additional fields – including medical disorders, screenings, health risks and expanded medication lists – need to be incorporated into behavioral health software programs. Efforts to standardize patient data across providers are underway nationwide through support of shared care/treatment plans, particularly for patients in patient-centered medical homes (PCMH) and health homes. Although states, including Rhode Island,

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have begun training care team staff on using standardized health assessments to support transitions of care between PCMH and health home providers, there is much work yet to be done.

Electronic infrastructure hurdles: Another challenge to data exchange is that behavioral health providers typically do not have access to advanced electronic infrastructure and are mostly excluded from meaningful use and related incentive payment programs. While the uptake of electronic medical records (EMR) by medical providers has risen significantly in recent years,⁹ use is dramatically lower among behavioral health providers and only a small proportion are connected to Health Information Exchanges (HIE), relative to their counterparts in the physical health arena.¹⁰ Smaller behavioral health providers may be overburdened by the process of implementing an EMR and can be priced out of the market for such products given the substantial financial investments required. They may also lack the workforce to support system implementation, including staff familiar with system requirements for data exchange and interoperability.

Participation in Medicaid ACOs can provide financial supports to help behavioral health providers in securing the necessary systems to allow for information exchange with other treating providers. State-driven strategies to support provider-level data exchange include EMR adoption incentives for specialty mental health and addiction providers, which some states are beginning to provide. While the majority of behavioral health providers remain excluded from meaningful use payments, there has been a legislative push by states like Rhode Island and Pennsylvania toward policies that would add mental health providers to EMR incentives.¹¹ Federal changes like the inclusion of core mental health and substance abuse information in the standards for Continuity of Care Documents, could also result in EMR and HIE vendors developing more comprehensive products for providers and care teams.¹² Recognizing this gap in access and capacity for information technology (IT) among behavioral providers, several states with ACO programs, including Minnesota, Maine, and Vermont, have recently released RFPs, under their respective State Innovation Model (SIM) initiatives, to build up this data-sharing capacity. In addition to funding for IT/EMR adoption, these requests include supports such as training on various technologies and learning collaboratives with other providers to re-define operational workflows and facilitate implementation of data-sharing tools within behavioral health practices.

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Information exchange privacy issues: Behavioral health and/or substance abuse providers also face issues with sharing sensitive patient information. Federal regulation through 42 CFR Part II is designed to protect the confidentiality of alcohol and drug treatment records. Given that additional patient consent is required (beyond the standard HIPAA framework) before such information can be shared between treating providers, this regulation can lead to fragmented and incomplete patient records. Such requirements apply to information shared between federally assisted alcohol and drug abuse programs (or “Part 2 Providers” as they are termed) and general medical care facilities. The distinction, however, between these two types of providers is increasingly difficult to discern in the context of comprehensive care providers such as federally qualified health centers (FQHCs), PCMHs, and health homes. Lack of clarity and understanding around this provision has led some providers to avoid data sharing for fear of liability associated with misinterpreting and possibly incorrectly implementing the law.

Many states are encountering obstacles in using HIE and all-payer claims databases to facilitate data sharing with ACOs and behavioral health providers within 42 CFR Part II requirements. In many cases, HIEs and clinical registries do not have the functionality to accommodate the consent and re-disclosure protocols required under 42 CFR Part II. As a result, Vermont’s HIE, for example, currently does not accept substance abuse treatment information from any type of provider. Oregon is pursuing the inclusion of all behavioral health claims in its All Payer All Claims (APAC) database. However, data have not yet been integrated due to questions around the potential need for legislation to require “Part 2 providers” that do not have patient consent to submit patient data to CCOs and commercial health carriers, which would then re-submit to the APAC. States like Oregon may need to consider alternative mechanisms for analyzing cost and utilization trends related to substance abuse treatment in all-payer claims databases, given the potential gaps in information for such patients.

3. Quality Measurement

Accountability for quality metrics is a key lever that states can use in ACO programs to encourage greater coordination between physical and behavioral health. As detailed below, leading states are tying payments to performance on select quality measures that reflect improved quality of care.

EXHIBIT 2: Behavioral Health-Related Measures used in Medicaid ACO Metrics in Select States

Program/State	Behavioral Health-Related Measures ¹³
Accountable Communities (Maine)	Shared savings are contingent on performance on 18 measures, including the following two related to behavioral health services: <ul style="list-style-type: none"> • Rate of initiation and engagement of alcohol and other drug dependence treatment; and • Rate of follow-up within seven days of hospitalization for mental illness.
Primary Care Payment Reform Initiative (Massachusetts)	Providers are eligible to receive an annual incentive payment based on their performance on 23 quality measures, including the following four behavioral health-related measures: <ul style="list-style-type: none"> • Rate of depression screening; • Rate of follow up after hospitalization for mental illness; • Rate of initiation of alcohol/drug dependence treatment; and • ADHD medication management for children.
Integrated Health Partnerships (Minnesota)	Shared savings is calculated based on a weighted score that includes performance on eight clinical quality measures, including: <ul style="list-style-type: none"> • Depression remission at six months.
Coordinated Care Organizations (Oregon)	Within a global budget framework, CCOs are required to track: <ul style="list-style-type: none"> • Screening and follow-up for members diagnosed with clinical depression.
Medicaid ACO Shared Savings Pilot (Vermont)	Providers who demonstrate successful integration and improve behavioral and physical health care in the following two measures will be eligible for increased shared savings (based on Total Cost of Care calculations): <ul style="list-style-type: none"> • Rate of depression screening by 18 years of age; and • Rate of follow-up within seven days of hospitalization for mental illness.

Some states have been broadening traditional measures to include relevant social outcomes. New York State, for example, is implementing measures related to social outcomes, including housing, employment, incarceration, and social connectedness, in its effort to integrate behavioral health

services in managed care. While specific measures may vary from state to state, most Medicaid ACO programs are beginning to make shared savings payments contingent on meeting specific behavioral health-related process and outcome measure targets.

4. Alignment with Existing Behavioral Health Initiatives

States across the country have already invested in a variety of efforts to integrate physical and behavioral health services, including Medicaid health homes. States can use these existing efforts as building blocks to foster behavioral health integration within ACO programs. States can leverage the data infrastructure, operational process flows, and working relationships that have developed across providers to serve these targeted populations when designing program elements for Medicaid ACOs.

Aligning with existing state efforts: New York State, for example, is seeking to scale up its health home program for complex patients to evolve into an ACO model. Its Medicaid health home program, which paid out approximately \$260 million in its first eight quarters, has helped behavioral health providers in the state collaborate more effectively with medical systems. New York’s health home entities are generally led by one provider, offering a single point of accountability. Health homes are required to: (1) create a comprehensive network to help beneficiaries connect with multiple ambulatory care sites; (2) support care management across physical and behavioral health services; and (3) create links to community supports and housing. The state’s approach to service integration, a tenet of its Medicaid Redesign Team’s Action Plan, includes moving the currently carved-out behavioral health care benefit into managed care.

Health homes offer expertise in developing systems for stratifying patient needs given the range and complexity of their target populations. Such systems can be incorporated into Medicaid ACOs that are accountable for a broad spectrum of patient needs. Health homes also have experience in training care team members on standardized, comprehensive health assessments. Health homes are strengthening relationships between primary care and behavioral health staff, which could prove fundamental to successfully integrating services within Medicaid ACOs.

Leveraging federal grant opportunities: Federal grant programs have been established to help initiate coordinated service delivery. These efforts can potentially be leveraged to support additional integration of behavioral health services. The Center for Medicaid and Medicare Innovation (the Innovation Center), for example, has launched two rounds of Health Care Innovation Awards (HCIA), with funding of more than \$1 billion awarded nationally, to test payment and service delivery models that aim to improve care and lower costs for Medicare, Medicaid, and Children’s Health Insurance Program enrollees. The Innovation Center is also supporting states, through SIM, in testing innovative approaches to integrate existing siloed services and ultimately achieve the Triple Aim of improved population health, enhanced patient care, and reduced costs.

These federal programs support improvements similar to those expected from integrating behavioral health services within Medicaid ACOs.¹⁴ Kitsap Mental Health Services, a behavioral health organization in Washington State, received approximately \$2 million under a federal HCIA award to pursue a new approach to integration. Kitsap is partnering with a community hospital

Leveraging Health Home Components

The key components of health homes that states can leverage when developing Medicaid ACOs include an evolving payment model and expanding provider networks. In New York, the transition from health home to ACO is focused around refining the payment model and ensuring that health home providers gradually prepare to assume risk. For health home models that are focused on a single practice or provider, the formation of provider networks that include behavioral health and social service providers is a critical first step toward balancing and sharing the financial risk for beneficiaries across providers in multiple

to implement multidisciplinary care teams that support a bi-directional integration model for behavioral health management and preventive care for patients. With anticipated savings from reduced emergency department and inpatient utilization estimated at \$5.8 million over three years, the state is considering how to further support these activities through its developing Medicaid ACO program. Several states that are pursuing Medicaid ACOs, including Washington, are using their statewide behavioral health integration efforts under SIM to incorporate additional services in their ACO models.

SAMHSA-HRSA's Center for Integrated Health Solutions has been promoting similar care coordination efforts by awarding more than \$26.2 million in grants to 100 community-based behavioral health organizations under its [Primary and Behavioral Health Care Integration](#) (PBHCI) grant program.¹⁵ Through this program, SAMHSA supports the integration of primary care services into publicly funded, community-based behavioral health settings. Awardees include Colorado's Aurora Comprehensive Community Mental Health Center, which partners with a local provider network to fully integrate primary care clinicians into local behavioral health care practices. This type of integration supports Colorado's broader vision for embedding behavioral health services in its Accountable Care Collaborative program.

5. Regulatory and Policy Levers to Overcome Potential Barriers to Integration

Current state regulations that often prohibit billing for primary care and behavioral health services on the same day are a common barrier to integration.¹⁶ In some cases, same-day billing practices can discourage providers from co-locating services, to the disadvantage of ACO beneficiaries who often need multiple services at any given time. While the federal government does not prohibit billing for two services on the same day,¹⁷ Medicaid reimbursement varies from [state to state](#). Currently only 28 state Medicaid programs allow reimbursement for two services by one provider organization. Some states may also need to confirm the use of appropriate coding to ensure that behavioral health specialists can bill on the same day for a patient who visits a physician for services secondary to a primary care diagnosis such as diabetes.¹⁸ Several states are modifying billing requirements, to allow for multiple visits on the same day, thereby encouraging ACO providers and patients to seek coordinated services as needed.

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An inadequate workforce is another common barrier impeding integration. Some states are developing standardized training and reimbursement protocols to use non-traditional health care providers as liaisons between previously siloed ACO providers, particularly in rural areas of the country with limited access to care. Oregon set up a Non-Traditional HealthCare Workforce Subcommittee to create standards for a statewide workforce of community health workers, personal navigators, and peer wellness specialists who are trained to support integration efforts within the state's CCOs.

States can provide on-the-ground resources to enhance the capacity of providers to transform care delivery at the practice level. Potential supports might include coaching through contractors and training curricula for multidisciplinary care team staff. States also have a role in engaging stakeholders in Medicaid ACOs by helping to incentivize behavioral health providers' participation and mitigating the fear of getting “lost” within a seemingly medically-driven model. Vermont, for example, included

representatives from mental health and substance abuse providers and consumers on the ACO's governing body and established a separate consumer advisory board. States can leverage mental health providers' existing relationships with community organizations and work with community mental health centers to promote the goal and benefits of integrated care. By enhancing stakeholder outreach and engagement, states can potentially collect feedback on new model development while building relationships across systems.

Conclusion

As states explore how to expand Medicaid ACOs to include behavioral health and, in some cases, social services, there are key opportunities to capitalize on existing building blocks for integration, including health homes, federal Healthcare Innovation Awards, and other federal and local initiatives.

The following considerations can help guide states in supporting the integration of services in Medicaid ACOs:

- Acknowledge differing provider capacity to assume downside financial risk among different provider types when designing financial strategies.
- Invest in mental health and substance abuse provider capacity building activities, including HIT and technical assistance, to enable them to participate in data-sharing activities.
- Include behavioral health measures and other relevant social outcome metrics across physical health quality incentive programs and in MCO contracts.
- Consider reorganization at the state agency level to further promote more integrated oversight and alignment across relevant behavioral health initiatives.
- Revise licensure and other regulatory frameworks that currently serve as barriers to provider-level integration and establish the integration of physical and behavioral health services as a core component of cross-cutting policy strategy.

Particular attention should be paid to program components that support behavioral health providers, including flexible payment mechanisms and data-sharing protocols that promote shared accountability and streamlined care delivery processes. Although financing such efforts can be challenging, there are grant programs, such as the Innovation Center's SIM grants and HCIA awards that states can leverage to maximize Medicaid ACO efforts to improve quality and bend the cost curve.

By linking payments to improvements in quality of behavioral health services and improved integration with medical services, ACOs encourage historically siloed providers to share timely information and coordinate patient care more effectively. State efforts to promote provider relationship building, support capacity building activities, implement payment reforms, and enable new billing practices will help further existing service integration efforts and pave the way for ACOs to become totally accountable for all facets of patient care.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

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