CHCS Center for
Health Care Strategies, Inc.

Building Community-Based Behavioral Health and Long-Term Care Provider Readiness for Payment Reform

By Sarah Kinsler, MPH [*]

IN BRIEF

This brief examines the competencies necessary for community-based behavioral health and long-term care providers to successfully participate in alternative payment models, discusses the barriers these providers face, and explores how states, the federal government, and private organizations can increase providers' readiness to participate in payment reform activities. It is based on literature review and key informant interviews with a mix of national and state-based experts and practitioners, including researchers from think tanks, federal and state officials, provider association leaders, and providers.

P ayers, providers, and state and federal governments have collectively recognized that payment and delivery system reforms are critical to achieve the Triple Aim of improved health, improved patient experience and quality, and reduced cost.[1] Participation in payment reform — sometimes called value-based payment or alternative payment methodologies — has increased dramatically as a result: In 2015, 38 percent of health care payments were value-based, with 23 percent of those in models that include shared savings or shared risk (Exhibit 1); as of 2016, 57 percent of health care payments were value-based, with 29 percent in models that include shared savings or shared risk.[2]

As participation in alternative payment methodologies grows, payers and providers are increasingly realizing that partnerships with community-based behavioral health and long-term care providers are essential to achieving Triple Aim goals, including realizing savings from payment reform efforts.[3,4,5,6] Evidence suggests partnerships between the medical care system and community-based behavioral health and long-term care can support improved population health and decreased medical costs through models like behavioral health-primary care integration.[7,8,9] These partnerships also support care transitions, avert preventable admissions and readmissions, and provide services that help individuals live at home rather than institutional settings.[10] States have been at the forefront of

What are Community-Based Behavioral Health and Long-Term Care Providers?

This brief refers to community-based providers, a collection of provider types that includes, but is not limited to:

- Community mental health centers
- Private outpatient mental health providers
- Outpatient substance use disorder treatment providers
- Home health agencies
- Visiting Nurse Associations
- Area Agencies on Aging
- Centers for Independent Living

---

* Author Sarah Kinsler is a Health Policy Advisor at Vermont's Green Mountain Care Board. She developed this brief as a graduate student at The Dartmouth Institute for Health Policy and Clinical Practice. The contents are the author's alone and do not reflect the views of the State of Vermont.

efforts to launch value-based payment for behavioral health and long-term care providers, with active programs in states like

Maine, Massachusetts, New York, and Tennessee.[18,19] State Medicaid programs in particular stand to benefit significantly from efforts to improve outcomes and reduce overall costs for individuals who use these services. Behavioral health conditions are more prevalent among Medicaid beneficiaries[20] and are particularly common among high-cost Medicaid beneficiaries.[21] State Medicaid programs also bear the majority of long-term care costs (see sidebar).[22]

Despite this evidence, uptake of payment reform efforts and the realization of payment reform goals may be constrained by providers' readiness to participate in reforms. This is especially true where payment models include shared financial risk — which holds providers accountable for cost above a pre-specified goal and may require that they reimburse insurers for part or all of any overage — participation in which may endanger participating providers' ability to provide care and stay financially solvent. Readiness can be a particular barrier for community-based behavioral health and long-term services and supports providers, who face unique challenges to participating in payment reform efforts, including: (1) business competencies and financial readiness; (2) technology; (3) quality measurement; and (4) care siloes and communication barriers.

This brief considers the necessary competencies for community-based behavioral health and long-term care providers to successfully participate in alternative payment models, discusses the barriers these providers face, and explores how states, the federal government, and private organizations can increase providers' readiness to participate in payment reform activities. It is accompanied by two case studies highlighting examples where public and private organizations partnered to increase community-based behavioral health and long-term services and supports provider readiness for payment reform. This brief is based on literature review and key informant interviews with a mix of national and state-based experts and practitioners, including researchers from think tanks, federal and state officials, provider association leaders, and providers.

Behavioral Health by the Numbers

- Nearly **one in five** U.S. adults have experienced mental illness in the prior year; just under **one in 12** had a substance use disorder (SUD) (2016 data).[11]

- Over **one in four** adult Medicaid beneficiaries have experienced mental illness in the prior year; more than **one in 10** had a SUD (2016 data).[12]

- An analysis by the Government Accountability Office found that among the five percent highest cost Medicaid beneficiaries, over 50 percent had mental health conditions, and 18-20 percent had SUDs.[13]

- Medical costs for people with both chronic medical conditions and behavioral health conditions have been shown to be **two to three times higher** than for people with only chronic medical conditions.[14]

Long-Term Care by the Numbers

- **Over eight million people in the United States use long-term care services**, including over six million served by community-based providers like home health agencies, hospice providers, and adult day programs (2012 data).[15]

- The cost of long-term services also contributes disproportionally to total health care costs in the U.S.: **$219.9 billion was spent on long-term care in 2012**, equal to eight percent of personal health care expenditures nationally.[16]

- The majority of long-term care costs — 61 percent in 2012 — are borne by state Medicaid programs.[17]

Defining Value-Based Payment Arrangements

Value-based payment (VBP) models tie provider payments to quality, cost, patient outcomes, or patient experience, rewarding providers for achieving program goals and sometimes withholding or reducing payment where performance goals are not met. There are several frameworks for VBP, but one commonly used model — created by the Department of Health and Human Services in collaboration with partners in the public, private, and nonprofit sectors — is the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model framework.[23] The LAN framework was designed by federal, state, and commercial payers to establish consistent terminology and to define the levels of risk in, or sophistication required for, types of VBP models. Exhibit 1 provides descriptions of provider payment models from the LAN Alternative Payment Model framework and reports the percentage of U.S. health care payments in each category. [24]

Exhibit 1. LAN Alternative Payment Model (APM) Framework[25,26]

Category 1: FFS payments not linked to quality. FFS payments are based on the number and units of service provided, without links to provider reporting or performance on quality.

Percentage of payments: 62 percent in 2015; 43 percent in 2016.

Category 2: FFS payments linked to quality and value. FFS payments are adjusted based on other factors, such as infrastructure investments, reporting on quality (pay-for-reporting), and/or performance on cost and quality metrics (pay-for-performance). This may also include a penalty or disincentive, i.e., a lower or withheld payment if providers do not meet quality indicators, or report events or procedures that are harmful and avoidable.

Percentage of payments: 15 percent in 2015; 28 percent in 2016.

Category 3: Alternative payment models based on FFS. Payments are based on FFS, but provide mechanisms to more effectively manage services. Providers must meet quality metrics to share in cost savings, and payments are based on cost performance against a target. Models may include:

- *Shared savings/shared risk.* Also referred to as "upside" or "downside" risk respectively, providers must meet a total-cost-of-care target for some/all services for an attributed set of patients. If actual costs are below projections, providers may keep some savings or may also be at risk for higher-than expected costs.

- *Bundled or episode-based payments.*[27] A single payment to providers for all services needed to treat a given condition (e.g., maternity care) or to provide a given treatment (e.g., hip replacement). Providers receive an inclusive payment for a specific scope of services to treat an "episode of care" with a defined start and endpoint.

In 2017, the LAN added a Category 3 sub-type, 3N, to identify risk-based payments not linked to quality. Since accountability for quality as an essential component of APMs, payments in Category 3N do not qualify as APMs.

Category 4: Population-based payments. Payments are structured to encourage providers to deliver coordinated, high-quality care within a defined budget. Payments may cover a wide range of preventive, medical, and health improvement services. Examples include global or capitated per-member-per-month payment, which may include both physical and behavioral health. Plans or providers bear the financial risk for the cost of treatment.

In 2017, the LAN added Category 4 sub-type, 4N, to identify capitated payments not linked to quality. Like Category 3N, payments in 4N do not qualify as APMs. Some community-based providers — especially safety net behavioral health providers like community mental health centers — have past or current experience receiving capitated payments or other risk-based payments (e.g., case rates), though these have rarely been tied to quality.

Percentage of payments: Categories 3 and 4 (excluding 3N and 4N): 23 percent in 2015; 29 percent in 2016.

Payment Reform Readiness

Multiple governmental and private sector health system transformation initiatives have developed frameworks to assess provider organizations' readiness for payment reform and identify general core competencies based on evidence from academic literature and provider experience. This section reviews three of these frameworks:

> **What is Payment Reform Readiness?**
>
> Payment reform readiness is the ability of a provider or practice to successfully participate in value-based models — whether directly or as part of a larger network, accountable care organization (ACO), or integrated delivery system (IDS) — while maintaining quality of care, organizational stability, and financial health.

- **Transforming Clinical Practice Initiative (TCPI)**[28]**: TCPI Change Package**[29] **and Practice Assessment Tool (PAT).**[30] The TCPI Change Package and PAT, developed in 2015, target primary care and specialty care practices participating in TCPI, a federal practice transformation initiative sponsored by the Center for Medicare and Medicaid Innovation (CMMI), through funded Practice Transformation Networks. TCPI identifies three primary drivers needed to support practice transformation and readiness to participate in APMs: (1) patient and family-centered care; (2) continuous, data-driven quality improvement; and (3) sustainable business operations. A version of the PAT aimed at specialty providers is being used with mental health and substance use treatment organizations participating in one Practice Transformation Network, the New York-based Care Transitions Network.

- **Accountable Care Learning Collaborative (ACLC)**[31]**: Required Competencies for Success White Paper Series (2016).**[32] The Accountable Care Learning Collaborative is a private-sector value-based learning effort focused on identifying and organizing competencies to improve the likelihood of success for provider organizations participating in value-based care, and supporting members in achieving those competencies. The ACLC competency white paper series outlines seven readiness domains for success in VBP arrangements: (1) Governance and Culture; (2) Financial Readiness; (3) Health IT; (4) Patient Risk Assessment; (5) Care Coordination; (6) Quality; and (7) Patient-Centeredness. Domains were developed based on a thorough literature review from which researchers identified themes and groupings; it was approved and refined by members of the Accountable Care Learning Collaborative Workgroup, which include representatives of large health systems, ancillary providers, safety net providers, national and state provider organizations, health information exchanges, and consultants. Since developing the white paper series in 2016, ACLC has translated these competencies into an Accountable Care Atlas[33] and Value-Based Readiness Assessment[34] to evaluate provider organizations' proficiency across competency domains, and prioritize steps to increase readiness.

- **National Association of Community Health Centers**[35]**: Payment Reform Readiness Assessment Tool (2014).**[36] This readiness assessment tool for community health centers, and a related article emphasizing critical considerations by two of the tool's authors,[37] is directed at a primary care safety net provider audience. This tool identifies four domains as critical for successful payment and delivery system reform participation: (1) organizational leadership and partnership development; (2) change management and service delivery transformation; (3) robust use of data and information; and (4) financial and operational analysis, management, and strategy.

Analysis of these three frameworks identifies five common domains, relevant to a wide variety of provider types: (1) patient-centered care and care coordination; (2) quality improvement; (3) HIT and data; (4) leadership, governance, and culture; and (5) business operations and financial readiness. Exhibit 2 summarizes these domains as well as drivers from each readiness framework.

Exhibit 2. Crosswalk: Payment Reform Readiness Frameworks

Framework and Related Assessment Tools	Target Providers	Readiness Domains					
		Patient-Centered Care and Care Coordination		Quality Improvement	Data and Health Information Technology		Leadership, Governance, and Culture	Business Operations and Financial Readiness
Transforming Clinical Practice Initiative (TCPI) TCPI Change Package and Practice Assessment Tool (2016)[38]	Primary care and specialty care practices participating in TCPI through funded Practice Transformation Networks	**Person and Family-Centered Care Design** 1.1 Patient and family engagement 1.2 Team-based relationships 1.3 Population management 1.4 Practice as a community partner 1.5 Coordinated care delivery 1.6 Organized, evidence-based care 1.7 Enhanced access		**Continuous, Data-Driven Quality Improvement** 2.1 Engaged and committed leadership 2.2 Quality improvement strategy supporting a culture of quality and safety 2.3 Transparent measurement and monitoring 2.4 Optimal use of Health Information Technology (HIT)			**Sustainable Business Operations** 3.1 Strategic use of practice revenue 3.2 Workforce vitality and joy in work 3.3 Capability to analyze and document value 3.4 Efficiency of operation
Accountable Care Learning Collaborative Required Competencies for Success White Paper Series (2016)[39]	ACLC does not identify a primary audience, but a focus on hospitals and large provider groups is inferred.	**Care Coordination** CC.1 Access CC.2 Care Management CC.3 Care Team CC.4 Care Transitions CC.5 Wellness and Prevention	**Patient Centeredness** PC.1 Ease of Use PC.2 Governance and Culture PC.3 Patient Involvement PC.4 Whole-Person Orientation	**Quality** Q.1 Culture of Improvement Q.2 Integration Strategies and Partnerships Q.3 Leadership Q.4 Measurement and Reporting Q.5 Operational Infrastructure	**Health Information Technology** HIT.1 HIT Infrastructure HIT.2 Data Acquisition HIT.3 Data Analytics HIT.4 Information Sharing HIT.5 Communication HIT.6 Behavior Change	**Patient Risk Assessment** PRA.1 Platform PRA.2 Risk Assessment Data PRA.3 Implementation and Data Processing PRA.4 Risk Monitoring and Reporting	**Governance and Culture** GC.1 Leadership GC.2 Organizational Structure GC.3 Culture of Stakeholder Engagement GC.4 Commitment to Value	**Financial Readiness** FR.1 Financial Systems FR.2 Contracting FR.3 Risk Management and Assessment FR.4 Strategy and Business Development FR. 5 Financial Data and Analytics
National Association of Community Health Centers NACHC Payment Reform Readiness Assessment Tool (2014)[40]	Community Health Centers (FQHCs and FQHC lookalikes)	**Change Management and Service Delivery Transformation** - Change Management - Service Delivery Transformation			**Robust Use of Data and Information** - Data to Inform Payment Reform Focus - Information Systems		**Organizational Leadership** - Organizational Leadership - Partnership	**Financial and Operational Analysis** - Financial and Operational Analysis and Management - Financial and Operational Strategy

Exhibit 3 translates the five common readiness domains mapped in Exhibit 2 into a list of core competencies for community-based providers who are participating in ACO or IDS arrangements or who are directly taking on financial risk. While many payment reforms assume full provider readiness from the start, others could be designed to gradually increase readiness by embedding strategies to support transformation and/or by progressively expanding financial risk and accountability.

Exhibit 3. Core Competencies by Readiness Domain

Readiness Domains				
Patient-Centered Care and Care Coordination	**Quality Improvement**	**Health Information Technology and Data**	**Leadership, Governance, and Culture**	**Business Operations and Financial Readiness**
■ Engagement of patients and families in care through collaborative care planning and shared decision-making ■ Engagement of patients and families in formal organizational governance ■ Cultural competency ■ Enhanced access – including days of the week, hours, methods of contact, and locations – to encourage patients to seek care in low-intensity settings ■ Care integration (within and across organizations) that reflects patient needs ■ Ability to smoothly refer to external services and coordinate with external provider organizations, especially with primary care as the medical home, but also with specialists, social services, and other community-based organizations ■ Development and use of evidence-based protocols and best practices, including staff training ■ Team-based care models with clear roles which allow clinicians to practice at the top of their licenses, and with clear roles and accountability within teams ■ Care coordination and management activities assigned based on risk level	■ Organizational emphasis on and culture of quality improvement, including both leadership and staff engagement ■ Leadership and staff training in quality improvement methods ■ Intra-organizational transparency regarding quality and safety performance ■ Regular measurement of clinical and business processes to assess performance, identify issues or gaps, and implement changes to improve quality and efficiency; includes measuring patient experience of care	■ Health data infrastructure to document and support patient care (including non-face-to-face visits) and support care management *(could be a full EMR, or a less complex tool tailored to organizational needs)* ■ Health data infrastructure to support population health management, support quality measurement, and allow for analysis across patient population *(could be a full EMR, or a less complex tool tailored to organizational needs)* ■ Ability to electronically communicate with other providers about patient care, including receiving and making referrals, coordinating patient care and/or sharing care plans, and receiving alerts related to ED and inpatient utilization *(may not be allowable for 42 CFR Part 2 providers)* ■ *For 42 CFR Part 2 providers*: Tools that allow for data aggregation and analysis that are Part 2-compliant ***For providers with direct risk contracts, all competencies described above and...*** ■ Ability to match clinical data with utilization data to support financial analyses ■ Tools to support risk assessment to stratify patients and assign them to interventions or levels of care	■ Active, engaged, and motivating leadership, with shared vision and goals across clinical and administrative leaders and a commitment to change management ■ Intra-organizational transparency regarding organizational operations and finances ■ Pro-change culture among staff ■ Staff engagement in transformation activities, including staff education to learn about new payment and care models and staff leadership of change projects ■ Systems to cultivate and reward high performers ***For providers participating in risk contracts through ACOs or similar, all competencies described above and...*** ■ Participation on ACO board or other governing body	■ Efficient operations (including patient care workflows and financial workflows) ■ Ability to perform workflow improvement ■ Financial analytic capabilities (e.g., ability to identify PMPMs for sub-populations and service categories), including ability to calculate ROI on services or programs ■ Data-driven decision-making ■ Ability to identify and communicate value (patient outcomes and financial value) ■ Contracting and legal competency to support negotiation with ACOs, IDSs, or other large provider networks ■ Understanding of role within local marketplace, including market penetration, additional demand, and competitors ■ Sufficient financing (self- or partner-funded) to engage in quality improvement, strategic infrastructure investments, and staffing to support high-value care and efficient operations ***For providers with direct risk contracts, all competencies described above and...*** ■ Sufficient financial reserves to responsibly carry risk ■ Ability to manage financial risks ■ Contracting competency to support negotiation with ACOs, IDSs, or other large provider networks, as well as other community-based organizations that can help achieve clinical and financial goals

Special Considerations for Community-Based Behavioral Health and Long-Term Care Providers

While the core competencies necessary to successfully participate in payment reform efforts are similar across provider types — and many of the challenges and barriers are similar for community-based providers and other provider types, such as primary care — community-based providers face additional unique challenges to successfully participating in payment reform efforts (Exhibit 4).

Exhibit 4. Barriers to Payment Reform Readiness for Community-Based Providers

Readiness Barrier	Readiness Domain(s)
Business Competencies and Financial Readiness	Business Operations and Financial Readiness
	Leadership, Governance, and Culture
Technology	Data and Health Information Technology
	Quality Improvement
Quality Measurement	
Care Siloes and Communication Barriers	Patient-Centered Care and Care Coordination

Business Competencies and Financial Readiness

Many community-based providers lack the business competencies and financial readiness necessary to successfully participate in alternative payment models. In interviews, national experts and providers alike identified business competencies as the most significant barrier for community-based providers seeking to participate in VBP. Core readiness competencies, which community-based providers will need to master, will include **financial analyses** to identify cost of care across service categories and sub-populations; **contracting and negotiation competencies**; and **efficient billing and administrative operations**. They will also need to identify **sufficient financing** to invest in transformation and infrastructure.

Financial analyses (i.e., cost accounting) are critical tools to manage internal and per-patient costs, enabling providers to identify improvement goals, detect patient outliers, and track progress. This requires use of claims and clinical data, as well as the analytic capacity and tools to forecast utilization and client needs and to calculate return on investment for services and programs. Additionally, historic budget constraints have required some community-based providers to artificially depress costs (e.g., salaries and overhead) to work within a fixed budget; this can prevent an accurate assessment of costs, and can set providers up to codify insufficient funding levels in new contracts with ACOs, IDSs, payers, or funders.

Contracting and negotiation skills are often limited for providers whose previous contracting experience was primarily with state Medicaid agencies. Community-based providers, especially smaller provider organizations, often lack the internal dedicated legal expertise and financial analytics to negotiate favorable contract terms with payers (including Medicaid Managed Care Organizations) or ACOs/IDSs, especially compared to larger providers such as hospitals and multi-

specialty groups. Community-based behavioral health and long-term services and supports providers may also struggle to quantify and articulate their value to contracting partners — and to assess the sufficiency of payments offered by these partners — due to populations served, service types, and historical lack of data and financial analyses.[41]

Community-based providers' billing and administrative capabilities are shaped by historical payment models, which vary significantly across provider type, payer, and service line. Mental health organizations may receive a mix of fee-for-service reimbursements, aggregate or lump-sum payments from Medicaid agencies and other public agencies to provide emergency services or serve a patient population, capitation payments from managed care plans and managed behavioral health payers, encounter or case rates, and other bundles for specific services over a period of time.[42] Long-term services and supports providers have historically received a similar web of population- and payer-specific payments depending on funding source.[43] This has resulted in mixed capacity and technology for fee-for-service billing, a key mechanism by which most medical providers document and account for services provided. This variation is a barrier to accurate cost accounting, service and financial integration, and reporting and quality measurement.[44]

Finally, low and/or stagnant payment rates, short-term grant-based funding, and a lack of insurance coverage parity by public and private insurers have resulted in a lack of reserves and tight or precarious financial situations for many community-based providers. This lack of reserves has limited community-based providers' ability to engage in alternative payment models that include financial risk directly, as well as their capacity to make investments in infrastructure (technology, business processes), quality improvement, and human resources (appropriate staff workload and compensation) that would support payment reform readiness.[45] [46] [47]

Technology

To successfully participate in payment reform, community-based providers need technology to **meet clinical needs, including care documentation and care management**; to **measure quality and support population health management**; and to **support communication with other providers across the care spectrum**.

Health information technology capabilities currently vary significantly within and across community-based behavioral health and long-term care provider organizations, hindering communication with partner organizations, quality measurement and improvement, and population health management. While the vast majority of hospitals (96 percent in 2015) and primary care providers (81 percent in 2015) nationally use electronic medical records (EMRs) to review patients' medical histories, document clinical interactions, and inform treatment, many behavioral health and long-term services and supports provider organizations lack EMRs or other tools to document care. [48,49] One key reason is the exclusion of most behavioral health and long-term care providers from Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, known as Meaningful Use.[50] Meaningful Use incentives, launched in 2011, spurred an explosion in EMR uptake for hospitals and medical practices; it also spurred an explosion in available EMR products marketed by their ability to achieve Meaningful Use requirements of care documentation, quality measurement, and population health management.[51] In contrast, behavioral health and long-term services and supports providers were left with a comparatively limited, non-Meaningful Use certified EMR market, and tasked with

self-funding technology acquisition. As a result of this exclusion, most existing EMRs are sufficient for capturing key data, but poor at integrating it for use by care teams outside of hospital and medical office settings.[52] The non-standard and proprietary clinical data formats and narrative data fields common in EMRs designed for community-based behavioral health and long-term care settings result in limited information exchange and data analysis capabilities.[53]

Note that EMRs may not be the most appropriate tools to support documentation, data analysis, and communication for all providers. Clinical registries, cloud-based care documentation tools, provider portals, telemonitoring systems, or some combination of non-EMR systems may adequately meet the needs of some community-based providers — including care documentation, care management, quality measurement, and cross-provider communication — without the financial and training investment of an EMR.

Quality Measurement

Community-based providers must be able to **regularly measure clinical and business process performance** to participate in VBP arrangements. Lack of relevant quality measures and quality measurement infrastructure present significant barriers to assessing and rewarding value for community-based providers, a critical component of all VBP arrangements.

While there are hundreds of nationally validated quality measures in the physical health realm that cover the spectrum from process to outcome to patient experience, and touch on a variety of conditions and populations, there is limited measurement consensus within behavioral health and long-term care.[54] As of March 2018, the National Quality Forum (NQF) had 588 total endorsed quality measures; of these 55 pertained to behavioral health, including just nine outcome measures (six of which focus on chronic condition-related outcomes for people with co-occurring disorders), and 53 related to home- and community-based services broadly, including 20 outcome measures (most of which focus on activities of daily living).[55] There are significant efforts underway to standardize measurement within the behavioral health and long-term care fields. For example, a 2016 NQF report documents an effort to develop a conceptual framework and prioritize measure concepts for assessing quality and outcomes in home- and community-based services, a precursor to developing a national set of consensus, validated measures.[56]

In addition to the comparative lack of consensus measures, behavioral health and long-term care providers face measurement challenges specific to the types of care they provide: care processes and outcomes are more likely to be qualitative and based on patient-defined goals than in physical health care,[57] and the lack of EMRs or other health information technology to facilitate measurement is a significant barrier.

Care Siloes and Communication Barriers

Local relationships are at the heart of integrated care. In order to successfully participate in payment reform, community-based providers must develop relationships across the care spectrum that can support **smooth referrals**, **care coordination**, and **whole-person care**.

However, for several historical reasons, siloes between physical health care and behavioral health and long-term services and supports have hindered coordination and collaboration to support

whole-person care. First, fee-for-service payment models, which failed to reimburse for cross-specialty consultation and care coordination, created a financial environment which discouraged collaboration and integration. Health plans that "carved out" behavioral health or long-term care services — contracted with specialty managed care organizations to administer benefits related to behavioral health or long-term care — reinforced this divide.[58] Second, behavioral health and long-term services and supports providers have historically lacked opportunities or reason to meaningfully network with their counterparts in physical health, creating natural professional and care silos. In some communities, imbalances (or perceived imbalances) in public funding, staff, and negotiating power color relationships between hospitals and other large physical health care providers and community-based behavioral health and long-term care organizations, which is frequently a barrier to trust, care integration, and financial integration.

In addition, clinical training among medical care, behavioral health, and long-term care providers varies widely; providers rarely receive interprofessional education that emphasizes collaboration between these fields, which can present challenges for collaborative communication. [59,60] Finally, 42 CFR Part 2 hampers communication when substance use disorder treatment providers are involved.[61]

Confidentiality of Substance Use Disorder Patient Records under 42 CFR Part 2

Federal regulations provide extra privacy protections for substance use disorder (SUD) treatment information under 42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records, which governs all records tied to federally regulated or assisted programs that would identify an individual as having or receiving treatment for an SUD.[62] These protections, first enacted in 1975 and revised in 1987 and 2017, require a higher confidentiality standard for SUD information than the Health Insurance Portability and Accountability Act (HIPAA). Until 2017, 42 CFR Part 2 required SUD treatment providers (both SUD-only providers and organizations that provide SUD treatment among other services) to keep any information identifying a patient as receiving or seeking SUD treatment confidential, unless the patient provides specific written consent for each disclosure. While the 2017 revision streamlined some confidentiality provisions, 42 CFR Part 2 remains a major barrier to SUD integration with medical providers.[63]

Strategies for Increasing Payment Reform Readiness for Community-Based Behavioral Health and Long-Term Care Providers

Despite the special considerations described above, there are significant opportunities for states, the federal government, foundations, payers, and ACOs/IDSs to work with community-based providers to overcome barriers to successful payment reform participation.

The following strategies draw on early successes in increasing payment reform readiness for community-based providers, as well as similar efforts to build capacity for physical health providers. While some strategies are well suited to address particular readiness barriers, many cut across competency areas. They can be implemented independently as targeted efforts to improve a

particular readiness competency, or in concert as part of a comprehensive effort to increase overall payment reform readiness. Finally, while many payment reforms assume readiness from the start, others could be designed to gradually increase readiness by gradually increasing provider accountability, or by embedding strategies to increase readiness (e.g., shared infrastructure, technical assistance) within the program model.

1. Provide Funding to Jump-Start Transformation

For many provider organizations, practice transformation requires long-term commitment to change, technical assistance, and funding. The latter is an asset that can be in particularly short supply for community-based providers. Funding to jump-start transformation can help these providers support investment in infrastructure, staff, and quality improvement. Funding can come in the form of lump-sum grants or contracts, fee increases, per-member per-month payments, or other arrangements, and can be provided either by state and federal governments, payers, ACOs/IDSs, or by private grantors.

- **Massachusetts** is providing funds to community-based providers participating in its Community Partner Program,[64] funded via a Delivery System Reform Incentive Payment program as part of the $52.4 billion MassHealth 1115 waiver renewal authorized in November 2016.[65] The Community Partner Program seeks to increase integration of behavioral health and long-term care services for Massachusetts Medicaid enrollees by requiring the state's Medicaid ACOs to partner with networks of community-based organizations (Community Partners). Behavioral health providers and long-term care providers who receive community partner designation are eligible for funding for capacity building and infrastructure development in four areas: 1) technology; 2) workforce development; 3) business startup costs; and 4) operational infrastructure.[66]

Similar models have been used to support practice transformation for physical health providers, particularly in the context of efforts to improve patient-centered medical home competencies in primary care settings:

- The **Connecticut** Department of Social Services' Person-Centered Medical Home program, which aims to support primary care practices in achieving advanced primary care competencies, provides participating practices who are in the process of seeking medical home recognition with a 14 percent fee differential for primary care codes.[67]

2. Subsidize Shared Infrastructure

Shared infrastructure can increase provider access to key supports while leveraging economies of scale and avoiding duplication of effort. This is particularly true for expensive health information technology tools like EMRs, disease registries, alert systems, communication tools, or analytic systems; shared infrastructure both saves money and supports interoperability across practices or provider organizations.

States and provider organizations have taken the lead in providing shared infrastructure to support payment reform readiness.

- In **Vermont**, funds from the state's State Innovation Models (SIM) grant were combined with federal Health Resources and Services Administration dollars to build a data repository that serves 16 mental health, SUD, and developmental disabilities services providers via their statewide network (see below).

Vermont Care Network and the State of Vermont: A Shared Data Repository for Community-Based Behavioral Health Providers

The State of Vermont, federal Health Resources and Services Administration, and Vermont Care Network, a statewide provider network, partnered to build a data repository for Vermont's Designated Mental Health Agencies and Specialized Service Agencies. Designated and Specialized Service Agencies are regional non-profit community organizations contracted by the state to serve Vermonters with mental health, SUD, and developmental disabilities services needs.[68] The data repository stores clinical information and provides analytics tools necessary for organization-specific and system-wide continuous quality improvement and business case development. A **recent case study** describes key factors considered in developing the Vermont Care Network data repository that can inform similar efforts across the country.

While states have thus far been leaders in providing or subsidizing shared infrastructure, there is significant opportunity for payers, larger health care organizations, and ACOs/IDSs to step to the forefront. This could mean providing community-based providers with access to existing infrastructure or resources, including technology like communication tools, portals, or alerts, or it could mean building upon current structures to accommodate the needs of community-based provider partners.

- **OCHIN** (formerly Oregon Community Health Information Network) was launched in 2001 by a consortium of federally qualified health centers, with the goal of acting as an information hub for local health care providers and facilitating joint purchasing of health information technology systems and technical support.[69] Since that time, it has expanded to include over 10,000 clinicians across the country, including safety net primary care providers, ACOs, public health departments, and community-based behavioral health providers.[70] In addition to centrally-purchased and -hosted EMRs and practice management systems, OCHIN supports data warehousing, analytics, telehealth, public health measurement, and tools to enable behavioral health-physical health integration — all tailored to the needs of its network and the safety net population it serves. [71]

- Detroit's **Henry Ford Health System** and the **Ruth Ellis Center** (REC), a social services agency serving lesbian, gay, bisexual, transgender, and questioning youth, have partnered to provide **co**-located primary care, social services, and behavioral health to their clients. This included connecting the REC with the health system's EMR, enabled by HIPAA training for REC staff and a memorandum of understanding (MOU) between the two organizations. This allows for cross-organizational discussion of patients' clinical, behavioral, and social services needs electronically, facilitates care conferencing, and supports billing.[72]

3. Share Data and Reports

Shared data and reports are common features of state-driven ACO programs and patient-centered medical home models. Many states with ACO programs provide participants with raw data, data extracts, and/or reports and analyses to allow the ACO and its network to better understand their patient populations, track their own performance on quality and cost goals, and identify improvement priorities, sometimes in lieu of building new analytics infrastructure at the ACO level. State-governed data — including Medicaid claims and encounter data, multi-payer claims from all-payer claims databases, clinical registry information, or public health registries and databases — form the core of these products.

In some states, this support is currently limited to ACOs and/or ACO-participating physical health providers, but others have expanded these resources to include broader partners, including community-based providers. There are rich opportunities for others states to do the same.

- Phase Two of Colorado Medicaid's Accountable Care Collaborative initiative, launching in July 2018, seeks to integrate behavioral health and primary care for Medicaid members through Regional Accountable Entities (RAEs) in the state. The state's seven RAEs will have access to dashboards and customized reports via a Business Intelligence and Data Management system that combines Medicaid claims with specialized datasets for enrollment, long-term services and supports, and pharmacy benefit.[73]

- Massachusetts' MassHealth ACO Program provides participating ACOs with both reports and data to assess performance and support decision-making. Quarterly summary reports describe ACO performance on quality and cost, details member utilization (including utilization stratified by top five percent and top 15 percent of cost), and identifies conditions associated with high-cost members; a quarterly roster report includes information on the ACOs' attributed lives. ACOs also receive monthly Medicaid claims extracts, which include both paid Medicaid claims and behavioral health encounter data, and are intended to support ACOs in identifying high-cost members, stratifying members for care management interventions based on utilization and cost, and identification of cost drivers.[74]

4. Invest in Learning Activities

Peer learning collaboratives and tailored, one-on-one technical assistance can both give community-based providers access to much-needed expertise and advice. These strategies can be implemented individually, or be combined to create a package of learning activities to support improved readiness.

Peer Learning

Peer learning activities can connect community-based providers with similar organizations and experts to support quality improvement, workflow transformation, or improve business competencies. Peer learning models allow community-based providers to glean lessons from exemplar organizations, work through implementation challenges, and develop a community of like-minded peers which can last long beyond the term of the learning collaborative.

■ Starting in 2013, the federal **Administration for Community Living** partnered with private foundations to convene two learning collaboratives to improve business competencies among networks of community-based aging and disability organizations (see below).

Administration for Community Living: Improving Business Acumen for Community-Based Aging and Disability Organizations through Learning Collaboratives

The federal Administration for Community Living (ACL),[75] a division of the U.S. Department of Health and Human Services established in 2012, works with community-based aging and disability organizations across the country to support people with disabilities and older Americans in their ability to live and thrive in community settings. Most providers within ACL's scope have been historically grant funded, and lack experience working with insurers, contracting, and communicating the business case for services in the context of integrated care models. In 2012, ACL launched a Business Acumen Initiative[76] with the goal of developing strong local and regional networks of community-based organizations (CBOs) that can thrive under new payment and delivery system models.[77] This has included two Business Acumen Learning Collaboratives, convened from 2013 to 2016, combining targeted training and technical assistance with remote and in-person peer learning to discuss common challenges, share approaches and successes, and identify emerging best practices. Participation has propelled CBOs to develop innovative business models that enable them to market their services, compete in a changing marketplace, ensure funding for services, and help payers achieve quality goals and cost savings. A hallmark of ACL's Business Acumen Initiative is the collaboration it has catalyzed across government, private foundations, provider associations, and leading-edge CBOs, both through conscious planning and by chance. These partnerships have been synergistic, and have led to co-design of technical assistance activities, exchange of guides and toolkits, and supplemental funding. Learn more in a **recent case study**.

Tailored Technical Assistance

Expert, one-on-one consultation, guidance, and facilitation can help providers identify and implement necessary changes to increase payment reform readiness. Technical assistance can support organizations with limited internal expertise in specific areas like change management, quality improvement, business development, or contracting; it can be particularly valuable for improving readiness competencies related to business operations and financial readiness.

States implementing payment and delivery system initiatives are common technical assistance sponsors.

■ **Care Transitions Network for People with Serious Mental Illness**, is a technical assistance center funded through CMMI's Transforming Clinical Practice Initiative (TCPI) and operated by the National Council for Behavioral Health in partnership with the New York State Office of Mental Health and two health systems. The state has encouraged participation in the Care Transitions Network as a vehicle for supporting behavioral health organizations' VBP readiness through the network's targeted coaching, on-site trainings, and clinical webinars.[78]

■ **Minnesota**'s SIM grant[79] funded technical assistance to 23 primary care, behavioral health, and social services providers through its Practice Facilitation program, part of the SIM project's overall practice transformation effort. Following a needs assessment process, participating

organizations received technical assistance, advice, troubleshooting, and training on readiness competencies like quality improvement methods, change management, leadership and organizational culture, and business competencies.[80,81]

5. Convene Partners to Build Relationships

Bringing local or statewide partners — including community-based providers, primary care, public health, policymakers, advocates, and others — together with a neutral convener can help to develop integrated care processes, build trust, establish common goals and understanding of services available across the care spectrum, and encourage quality improvement partnerships — all central to breaking down long-standing siloes and improving coordination across the care spectrum. These relationships, once formed, can be cemented through development and documentation of workflows that reflect integrated care, and efforts to implement MOUs between physical health organizations and community-based providers. Coupled with other strategies — particularly shared infrastructure like community-wide electronic communication systems to support care management, or local learning collaboratives — local convenings can have a major impact on how whole-person care is delivered within a medical neighborhood.

- **Vermont**'s SIM effort included an explicit focus on building stakeholder relationships as a facilitator to payment and delivery system reform.[82] In addition to convening leaders from across sectors at the statewide level, the Vermont SIM program partnered with Vermont's statewide patient-centered medical home initiative, the Blueprint for Health, to expand regional Community Collaboratives across the state. Community Collaboratives combine local PCMH and ACO governance and quality improvement efforts, and include representatives from ACOs, hospitals, primary care, designated mental health providers, home health agencies and visiting nurse associations, social services, and in many regions, public health — ensuring that local priority-setting includes broad perspectives and building new relationships among local partners.[83]

Looking Ahead

Payers and health care providers must grapple with how to effectively partner with community-based providers — both to support integrated, whole-person care, and to support cost containment goals. This is especially true for Medicaid-based reforms, which have much to gain from addressing costs from beneficiaries with behavioral health and long-term care needs.

So far, the charge to increase community-based providers' readiness for payment reform has been led by states, the federal government, and national provider organizations. However, with federal and state funding for payment and delivery system reform development and implementation — in particular the SIM program — waning, there is an opening for foundations with an interest in community-based providers or the people they serve to expand their work in this area. Initiatives that bring foundations together with government or payers, like the Administration for Community Living Business Acumen Initiative (described on page 14), have particular potential to support community-based providers in driving toward a common readiness goal.

There is also ample space for health care providers participating in alternative payment models — especially ACOs and IDSs — to support payment reform readiness for community-based providers. By actively and strategically engaging community-based providers and supplying them with tools to enable success, like health information technology or administrative infrastructure, ACOs and IDSs stand to benefit from community-based providers' unique expertise with individuals in need of behavioral health and long-term care services.

While community-based providers face unique barriers to successful participation in payment reform, these barriers are surmountable with support. Partnerships with government, payers, and provider organizations will be critical in promoting success.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit **www.chcs.org**.

ENDNOTES

[1] Berwick D, Nolan T, Whittington J. The Triple Aim: Care, health, and cost. *Health Affairs*. 2008; 72(3):759-769.

[2] Health Care Payment Learning and Action Network. APM Measurement: Progress of Alternative Payment Models. 2017. Available at: http://hcp-lan.org/workproducts/measurement_discussion%20article_2017.pdf. Accessed April 7, 2018.

[3] Davis K, Buttorff C, Leff B, et al. Innovative Care Models for High-Cost Medicare Beneficiaries: Delivery System and Payment Reform to Accelerate Adoption. *Am J Manag Care*. 2015 May 1; 21(5): e349-56. Available at: http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/innovative-care-models-for-high-cost-medicare-beneficiaries-delivery-system. Accessed August 9, 2017.

[4] National Council for Community Behavioral Health. Creeping and Leaping from Payment for Volume to Payment for Value: An Update on Behavioral Healthcare Payment Reform. 2014. Available at: https://www.thenationalcouncil.org/wp-content/uploads/2014/09/14_Creeping-and-leaping.pdf. Accessed October 19, 2017.

[5] de Lisle K, Merrill T, Muhlestein D. Defining high-value behavioral health providers for ACO partnerships. Leavitt Partners. 2016. Available at: http://leavittpartners.com/wp-content/uploads/2016/10/LP_RWJF_Behavioral_Health_brief_final.pdf. Accessed August 20, 2017.

[6] American Hospital Association. Bringing behavioral health into the care continuum: Opportunities to improve quality, costs and outcomes. January 2012. Trendwatch. Available at: http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf. Accessed October 19, 2017.

[7] Gilbody S, Bower P, Fletcher J, Richards D, Sutton A. Collaborative care for depression. *Arch Intern Med.* 2006; 166: 2313-2321.

[8] Thoda A, Sipe TA, Byard G, et al. Collaborative care to improve management of depressive disorders: A community guide, systematic review, and meta-analysis. *Am J Prev Med.* 2012; 42(5):525-538.

[9] Unützer J, Harbin H, Schoenbaum M, Druss B. The Collaborative Care Model: An approach for integrating physical and mental health care in Medicaid Health Homes. May 2013. Center for Health Care Strategies for the Centers for Medicare & Medicaid Services (CMS) Health Home Information Resource Center. Available at: https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf. Accessed October 19, 2017.

[10] Davis K, Buttorff C, Leff B, et al. Innovative care models for high-cost Medicare beneficiaries: Delivery system and payment reform to accelerate adoption. 2015.

[11] Center for Behavioral Health Statistics and Quality. 2016 National Survey on Drug Use and Health: Detailed Tables. 2017.

[12] Center for Behavioral Health Statistics and Quality. 2016 National Survey on Drug Use and Health: Detailed Tables. 2017.

[13] Note: Some individuals included in this study had both mental health conditions and substance use disorders. Figures are not cumulative. Government Accountability Office. A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures (GAO Publication No. 15-460). 2015.

[14] Melek S, Norris D, Paulus J. Economic Impact of Integrated Medical-Behavioral Healthcare Implications for Psychiatry. Milliman, Inc. for the American Psychiatric Association. April 2014. Available at: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Milliman-Report-Economic-Impact-Integrated-Implications-Psychiatry.pdf. Accessed August 20, 2017.

[15] Harris-Kojetin L, Sengupta M, Park-Lee E, Valverde R. Long-Term Care Services in the United States: 2013 Overview. National Center for Health Statistics. *Vital Health Stat.* 2013; 3(37). Available at: https://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf. Accessed August 20, 2017.

[16] O'Shaughnessy C. National Spending for Long-Term Services And Supports (LTSS), 2012. National Health Policy Forum. March 2014. Available at: http://www.nhpf.org/library/the-basics/Basics_LTSS_03-27-14.pdf. Accessed October 19, 2017.

[17] O'Shaughnessy C. National Spending for Long-Term Services And Supports (LTSS), 2012. 2014.

[18] Soper MH, Matulis R, Menschner C. Moving Toward Value-Based Payment for Medicaid Behavioral Health Services. Center for Health Care Strategies. June 2017. Available at: https://www.chcs.org/media/VBP-BH-Brief-061917.pdf.

[19] Taylor E, Dyer MB, Bailit M. State Strategies: Value-Based Payment for Medicaid Populations with Complex Care Needs. April 2017. Bailit Health Purchasing. Available at: https://www.shvs.org/wp-content/uploads/2017/04/Value-Based-Payment-Models_4.10.pdf. Accessed May 2, 2018.

[20] Center for Behavioral Health Statistics and Quality. 2016 National Survey on Drug Use and Health: Detailed Tables. Rockville, MD: Substance Abuse and Mental Health Services Administration; September 2017. Available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf. Accessed October 21, 2017.

[21] Government Accountability Office. A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures (GAO Publication No. 15-460). Washington, D.C.: U.S. Government Printing Office; May 2015. Available at: http://www.gao.gov/assets/680/670112.pdf. Accessed October 19, 2017. Analysis excludes those dually eligible for Medicaid and Medicare.

[22] O'Shaughnessy C. National Spending for Long-Term Services And Supports (LTSS), 2012. National Health Policy Forum. March 2014. Available at: http://www.nhpf.org/library/the-basics/Basics_LTSS_03-27-14.pdf. Accessed October 19, 2017.

[23] Health Care Payment Learning and Action Network. Alternative Payment Models (APM) Framework Refresh. July 2017. Available at: https://hcp-lan.org/groups/apm-refresh-white-paper/.

[24] Payments include data from 78 health plans, 3 managed fee-for-service Medicaid states, and Medicare fee-for-service. Data includes 84% of insured individuals in the U.S. Health Care Payment Learning and Action Network. APM Measurement: Progress of Alternative Payment Models. 2017. Available at: http://hcp-lan.org/workproducts/measurement_discussion%20article_2017.pdf. Accessed April 11, 2018.

[25] Health Care Payment Learning and Action Network. Alternative Payment Models (APM) Framework Refresh. July 2017.

[26] Exhibit 2 adapted from Soper MH, Matulis R, Menschner C. Moving Toward Value-Based Payment for Medicaid Behavioral Health Services. Center for Health Care Strategies. June 2017. Available at: https://www.chcs.org/media/VBP-BH-Brief-061917.pdf.

[27] While some organizations use the terms bundled payments and episode-based payments interchangeably, the Urban Institute Catalyst for Payment Reform distinguishes between them. "Bundled payment" refers to payments that cover care for a defined clinical condition *across* various providers (e.g., inpatient and outpatient) whereas "episode-based payment" refers to the duration of service the payment covers, whether or not provided by a single provider or providers working together. See http://www.urban.org/research/publication/payment-methods-how-they-work.

[28] Center for Medicare and Medicaid Innovation. Transforming Clinical Practice Initiative [website]. https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/. Last updated July 31, 2017. Accessed August 20, 2017.

[29] Transforming Clinical Practice Initiative. TCPI Change Package: Transforming Clinical Practice (Version 2.0). March 16, 2016.

[30] Transforming Clinical Practice Initiative. Specialty Practice Assessment Tool 2.0.

[31] The Accountable Care Learning Collaborative is a membership organization that seeks to accelerate adoption of alternative payment models. Members include ACOs, provider organizations, insurers, associations, academics, and others. For more information: https://www.accountablecarelc.org/.

[32] Accountable Care Learning Collaborative. White Paper Series: Required Competencies for Success. 2016. All white papers are available at: https://www.accountablecarelc.org/aclc-competencies. Accessed November 3, 2016.

[33] Accountable Care Learning Collaborative. Accountable Care Atlas. 2017. https://www.accountablecarelc.org/atlas. Accessed May 2, 2018.

[34] Accountable Care Learning Collaborative. Value-Based Readiness Assessment. 2017. https://www.accountablecarelc.org/value-based-readiness-assessment. Accessed May 2, 2018.

[35] The National Association of Community Health Centers (NACHC) is the national provider organization for federally qualified health centers (FQHCs), FQHC lookalikes, and some other primary care safety net providers. For more information: http://www.nachc.org/.

[36] National Association of Community Health Centers. Payment Reform Readiness Assessment Tool. 2014. Available at: http://nachc.org/wp-content/uploads/2015/11/NACHC_PR_ReadinessAssessmentTool_Final_CORRECTED_8.5.2014-2.pdf. Accessed October 31, 2016.

[37] Lausch KB and Moody S. Are You Ready for Payment Reform? [blog post]. Northwest Regional Primary Care Association. May 20, 2016. Available at: http://www.nwrpca.org/news/290450/Are-You-Ready-for-Payment-Reform.htm. Accessed October 31, 2016.

[38] The Transforming Clinical Practice Initiative outlines primary drivers, secondary drivers, change concepts, and change tactics to support practice transformation and readiness to participate in APMs. The Specialty Practice Assessment Tool is being used with mental health providers and community-based organizations working with people with serious and persistent mental illness in one Practice Transformation Network, New York-based Care Transitions Network.

[39] Within each domain, the ACLC framework identifies categories and competencies for successful participation in APMs.

[40] The NACHC identifies four domains for successful service delivery redesign and payment reform participation.

[41] Davis R, Romm I. Using a Cost and Utilization Lens to Evaluate Programs Serving Complex Populations: Benefits and Limitations. Center for Health Care Strategies. March 2017. Available at: https://www.chcs.org/media/CCIL-cost-and-utilization-paper_032317.pdf.

[42] Hackbarth NS. Financing Integrated Care for Adults with Serious Mental Illness in Community Mental Health Centers: An Overview of Program Components, Funding Environments, and Financing Barriers [working paper]. RAND Health. June 2015. Available at: https://www.rand.org/content/dam/rand/pubs/working_papers/WR1000/WR1084/RAND_WR1084.pdf. Accessed March 4, 2018.

[43] Smith GK, et al. Creating Comprehensive Cost-Effective Systems: System Design Issues. In *Understanding Medicaid Home and Community-Based Services: A Primer*. Washington, DC: Office of the Assistant Secretary of Planning and Evaluation. October 2010.

Available at: https://aspe.hhs.gov/basic-report/understanding-medicaid-home-and-community-services-primer#Chap9. Accessed March 4, 2018.

[44] Soper MH, Matulis R, Menschner C. Moving Toward Value-Based Payment for Medicaid Behavioral Health Services. Center for Health Care Strategies. June 2017.

[45] Hackbarth NS. Financing Integrated Care for Adults with Serious Mental Illness in Community Mental Health Centers: An Overview of Program Components, Funding Environments, and Financing Barriers [working paper]. 2015.

[46] Appelbaum PS. The 'Quiet' Crisis in Mental Health Services. *Health Affairs*. 2003;22(5):110-116.

[47] Kathol, RG, et al. Barriers to Physical and Mental Condition Integrated Service Delivery. *Psychosomatic Medicine*. 2010;72(6):511-518.

[48] Ranallo PA, Kilbourne AM, Whatley AS, Pincus HA. Behavioral Health Information Technology: From Chaos to Clarity. *Health Affairs*. 2016;35(6):1106-1113.

[49] Office of the National Coordinator for Health Information Technology. 2015 Update to Congress on the Adoption of Health Information Technology: Full Report. February 2016. Available at: https://dashboard.healthit.gov/report-to-congress/2015-update-adoption-health-information-technology-full-text.php.

[50] The Meaningful Use program provides incentives to eligible hospitals and non-hospital-based professionals. In the first iteration of the program, Medicare MU-eligible professionals included MDs, DOs, dentists, podiatrists, optometrists, and chiropractors. The Medicaid EHR Incentive program added physician assistants who work primarily in safety net practices, nurse practitioners, and nurse midwives. Centers for Medicare & Medicaid Services. EHR Incentive Program: Eligibility [website]. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligibility.html. Published May 17, 2012. Accessed March 3, 2018.

[51] Office of the National Coordinator for Health Information Technology. Health IT Dashboard: Quick Stats. https://dashboard.healthit.gov/quickstats/quickstats.php. Accessed March 3, 2018.

[52] Ranallo PA, Kilbourne AM, Whatley AS, Pincus HA. Behavioral Health Information Technology: From Chaos to Clarity. 2016.

[53] Ranallo PA, Kilbourne AM, Whatley AS, Pincus HA. Behavioral Health Information Technology: From Chaos to Clarity. 2016.

[54] Soper MH, Matulis R, Menschner C. Moving Toward Value-Based Payment for Medicaid Behavioral Health Services. 2017.

[55] National Quality Forum. Quality Positioning System [website]. http://www.qualityforum.org/QPS/QPSTool.aspx. Accessed March 6, 2018.

[56] National Quality Forum. Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement. September 2016.

[57] Soper MH, Matulis R, Menschner C. Moving Toward Value-Based Payment for Medicaid Behavioral Health Services. 2017.

[58] Butler M, et al. Integration of Mental Health/Substance Abuse and Primary Care. Rockville, MD: Agency for Health Care Research and Quality. October 2008. Available at: https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf.

[59] Kathol RG, et al. Barriers to Physical and Mental Condition Integrated Service Delivery. 2010.

[60] Kane RL. The Interface of LTC and Other Components of the Health and Social Services Systems in North America. In *Key Policy Issues in Long-Term Care* [chapter]. Geneva: World Health Organization. 2003. Available at: http://www.who.int/chp/knowledge/publications/policy_issues_ltc.pdf.

[61] Soper MH, Matulis R, Menschner C. Moving Toward Value-Based Payment for Medicaid Behavioral Health Services. 2017.

[62] Full text available at: https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2. An FAQ from the Substance Abuse and Mental Health Services Administration (SAMHSA) provides additional detail on the application of 42 CFR Part 2: https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs.

[63] McCaman L, Purington K. April 18, 2017. The New Substance Use Disorder Confidentiality Rules: A Work in Progress [blog post]. State Health Policy Blog. National Academy for State Health Policy. Available at: https://nashp.org/the-new-substance-use-disorder-confidentiality-rules-a-work-in-progress/. Accessed March 3, 2018.

[64] Massachusetts Executive Office of Health and Human Services. MassHealth Delivery System Restructuring [presentation]. April 14, 2016. Slides available at: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/mass-health-restructuring-overview-document.pdf.

[65] Massachusetts Executive Office of Health and Human Services. Baker-Polito Administration, Centers for Medicare and Medicaid Services Announce Five Year, $52.4 Billion Deal for MassHealth Restructuring [press release]. November 4, 2016. Available at: http://www.mass.gov/eohhs/gov/newsroom/press-releases/eohhs/52-4-billion-deal-for-masshealth-restructuring.html. Accessed January 22, 2018.

[66] Centers for Medicare & Medicaid Services. MassHealth Medicaid Section 1115 Demonstration, Special Terms and Conditions, Attachment M, # 11-W-00030/1. November 4, 2016. Attachment M available at: https://www.mass.gov/files/documents/2017/05/zm/dsrip-protocol.pdf. Full waiver approval available at: http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/1115-waiver-extension-approval-11-04-16.pdf.

[67] Connecticut Department of Social Services. Person-Centered Medical Home: Glide Path [website]. http://www.huskyhealthct.org/providers/PCMH/pcmh-glide-path.html. Accessed January 22, 2018. For more information on this program, see: http://www.huskyhealthct.org/providers/pcmh.html.

[68] Vermont Department of Mental Health. Designated Agencies [website]. http://mentalhealth.vermont.gov/providers/designated-agencies. Accessed October 8, 2017. For a map of Vermont's Designated Mental Health Agencies, visit: http://mentalhealth.vermont.gov/individuals/designated-agencies.

[69] DeVoe JE and Sears A. The OCHIN Community Information Network: Bringing Together Community Health Centers, Information Technology, and Data to Support a Patient-Centered Medical Village. *J Am Board Fam Med* May-June 2013; 26(3): 271-278.

[70] OCHIN. 2016 Annual Report. Available at: https://ochin.org/media/OCHIN-2016-Annual-Report-170328.pdf. Published March 28, 2017. Accessed April 11, 2018.

[71] DeVoe JE and Sears A. The OCHIN Community Information Network: Bringing Together Community Health Centers, Information Technology, and Data to Support a Patient-Centered Medical Village. 2013.

[72] Chazin, S. Meeting the Health and Social Service Needs of High-Risk LGBTQ Youth in Detroit: The Ruth Ellis Health & Wellness Center. October 2017. Nonprofit Finance Fund, Center for Health Care Strategies, Alliance for Strong Families and Communities. Available at: http://www.chcs.org/media/REC-HFHS-Case-Study_101217.pdf. Accessed April 19, 2018.

[73] Colorado Health Institute. The Route to the RAEs: Analyzing the Next Phase of Medicaid's Accountable Care Collaborative in Colorado. July 12, 2017. Available at: https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/ACC%20Phase%20Two_0.pdf. Accessed April 19, 2018.

[74] Massachusetts Executive Office of Health and Human Services. MassHealth ACO Program Development: Provider Reports User Guide, Round 1. Spring 2016. Available at: https://www.mass.gov/files/documents/2017/11/03/provider-reporting-user-guide.pdf. Accessed April 19, 2018.

[75] The Administration for Community Living sits within the federal Department of Health and Human Services (HHS). It was established in 2012, and combined the former Administration on Aging, Office of Disability, and Administration on Developmental Disabilities. For more information on ACL's history and activities, visit: https://www.acl.gov/.

[76] Administration for Community Living. Business Acumen Initiative [fact sheet]. July 2017. Available at: https://www.acl.gov/sites/default/files/programs/2017-07/AcumenFactSheet.pdf. Accessed August 8, 2017.

[77] Administration for Community Living. Business Acumen Initiative [fact sheet]. 2017.

[78] Care Transitions Network for People with Serious Mental Illness. Technical Assistance [website]. https://www.thenationalcouncil.org/care-transitions-network-people-serious-mental-illness/technical-assistance/. Accessed March 11, 2018.

[79] Minnesota Department of Human Services. Minnesota Accountable Health Model – State Innovation Model Grant [website]. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_home. Last Updated: March 13, 2018. Accessed April 13, 2018.

[80] Minnesota Department of Human Services. Minnesota Accountable Health Model – Practice Facilitation [website].http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_PFTOPIC. Last Updated: January 11, 2016. Accessed April 13, 2018.

[81] State Health Access Data Assistance Center (SHADAC). Evaluation of the Minnesota Accountable Health Model: Final Report. September 2017. Available at: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary& allowInterrupt=1&dDocName=DHS-297901. Accessed April 13, 2018.

[82] State of Vermont. Vermont State Innovation Model Sustainability Plan. June 2017. Available at: http://healthcareinnovation.vermont.gov/sites/vhcip/ files/documents/Final Vermont SIM Sustainability Plan 6.30.17.pdf. Accessed March 6, 2018.

[83] John Snow Inc. Vermont Health Care Innovation Project State-Led Evaluation. June 2017. Available at: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/VHCIP_Final_State-led_Evaluation_Report_0.pdf. Accessed March 6, 2018.