In recent years, Colorado, Minnesota, and Rhode Island began using accountable care programs to improve delivery of behavioral health services. Already, the programs have produced improvements – Colorado reports an increase in the percentage of Medicaid enrollees receiving behavioral health services and Minnesota’s accountable care organization (ACO) providers have performed better than other clinics in screening adolescents for mental health issues. This report examines these states’ policies and experiences in using accountable care programs to improve delivery of behavioral health care.

**Background**

Medicaid is the largest payer of behavioral health care (mental health and substance use disorder) in the United States. In addition, studies show that behavioral health conditions contribute to a greater cost to treat than other medical conditions. There are great disparities in health outcomes for people with behavioral health diagnoses, individuals with behavioral health conditions are sicker and die younger than those without such conditions. As states grapple with unprecedented budget crises and increased demand for behavioral health services due to the COVID-19 pandemic, there are incentives for them to change how behavioral health care is delivered.

There is broad recognition that integrating behavioral and physical health care, and identifying and treating behavioral health conditions early can lead to improved outcomes. States also face severe behavioral health workforce shortages, especially in lower-income areas — where many of those served by the Medicaid program live.

As a result, states have for many years sought to reform their delivery systems to improve identification and treatment of behavioral health conditions, better integrate behavioral and physical health, and increase Medicaid enrollees’ access to behavioral health care. Many of these previous efforts were based in managed care or on a patient-centered medical home (PCMH) model.

A decade ago, state Medicaid agencies began to implement accountable care programs. In early 2020, the National Academy for State Health Policy identified eight states that had begun to use their accountable care programs to improve their delivery of behavioral health care: Colorado, Maine, Massachusetts, Minnesota, New Jersey, Oregon, Rhode Island, and Vermont. The ACOs participating in these programs focus on coordination and integration of care and provide an

In an accountable care program, groups of providers (called ACOs) share responsibility for the quality of care, health outcomes, and costs for a defined population. These programs emphasize primary care, care coordination and integration, and value-based payment. Payment depends on the ACO’s performance on defined metrics.
infrastructure to improve behavioral health services that, due to their focus on primary care, may prove particularly useful for advancing behavioral health integration.

The pandemic is already causing some states to delay delivery system reforms. However, over the longer term, the pandemic may cause more states to turn to accountable care to help them manage behavioral health services. In recent months, state Medicaid officials have had to focus their attention on ensuring that Medicaid enrollees receive the care they need, leaving little time to develop new reforms. Large state budget shortfalls are also projected, which are likely to lead states to implement cost containment strategies. States may turn to accountable care programs, which hold ACOs and their affiliated providers accountable for cost, quality, and health outcomes, as a way to provide quality services while containing cost. The pandemic is also likely to create increased need for behavioral health services. According to a July 2020 Kaiser Family Foundation poll, more than half of the adults reported that “stress and worry related to the pandemic has had a negative impact on their mental health.” State Medicaid agencies may, ultimately, turn to accountable care to address the combined effect of decreased state funding and increased need for behavioral health services.

This report outlines the program policies, implementation experience, and lessons learned in three states that have all used accountable care to improve behavioral health care and contain cost.

How Colorado, Minnesota, and Rhode Island Structure their Programs

The three states structured their accountable care programs in different ways.

Colorado’s Regional Accountable Entities

Colorado began its accountable care program in 2011, but the state did not emphasize behavioral health care in the program until it launched the second phase in July 2018. At that point, Colorado folded its specialized managed care program for behavioral health services into its accountable care program. Since 2018, Colorado has contracted directly with seven regional accountable entities (RAEs). Colorado assigns almost all Medicaid enrollees to a RAE (representing about 97 percent of Colorado’s 1.3 million Medicaid enrollees in July 2020). RAEs support a local network of primary care medical providers (PCMPs), deliver behavioral health services, coordinate members’ care across systems, and are accountable for the cost and quality of care delivered to Medicaid members.

RAEs are paid through a combination of per member per month (PMPM) administrative payments, capitation, and incentive payments. RAEs receive $15.50 PMPM as an administrative payment.
payment. The Medicaid agency withholds $4 of each $15.50 to fund the Key Performance Indicator (KPI) payments. The Medicaid agency assigns each of seven KPI metrics a specific PMPM amount, and if a RAE produces sufficient improvement on the measure, it receives a payment based on the PMPM amount assigned to the measure. KPI payments are calculated and distributed each quarter. Unearned incentive payments are used to fund a challenge pool that is distributed based on performance in pursuing specified state policy priorities (e.g., collaboration with institutes of mental diseases or achieving progress on other performance metrics. RAEs also receive capitation payments for behavioral health services and are eligible to receive incentives tied to performance on a set of behavioral health measures. These payments are referred to as behavioral health incentive payments.

Both PCMPs and behavioral health providers must contract with a RAE in order to serve Medicaid enrollees. PCMPs receive fee-for-service payments from the Medicaid agency and administrative and incentive payments from the RAEs. Behavioral health providers contract with the RAEs and receive all payments directly from their RAE.

Minnesota’s Integrated Health Partnerships

Minnesota began its accountable care program in 2013. The state considered behavioral health when designing the initial phase of its program, but strengthened its behavioral health focus in Phase 2 of the program (IHP 2.0), which launched in January 2018. As of June 2020, Minnesota Medicaid contracts with 26 Integrated Health Partnerships (IHPs) that, together, serve 430,000 Medicaid and MinnesotaCare (Minnesota’s basic health plan) enrollees. IHPs are provider organizations. They and their associated providers receive payment for services from either the MCOs or the Medicaid fee-for-service system.

In addition, IHPs are paid through one of two payment models.
- Track 1 is intended for small, independent provider systems, specialty health care groups that coordinate care for specific groups of individuals, or a specific major portion of services (including primary care), or other systems unable to take on financial risk.
- Track 2 is only open to IHPs that serve more than 2,000 members and that are able to take on upside and downside risk (i.e., share in both savings and losses).

All IHPs (both tracks) receive a clinical and social risk-adjusted monthly population-based payment. In exchange, all IHPs must develop and implement specific health initiatives that address certain social risk factors that their patient populations are facing and achieve satisfactory performance on a set of quality and performance measures in order to continue to participate in the program. Both the initiative itself and the measures are negotiated between the individual IHP and the Medicaid agency. IHPs that participate under Track 2 also share in both savings and losses.

Savings and losses are calculated by comparing the actual total cost of care (TCOC) of the members attributed to the IHP with the members’ projected TCOC absent the IHP. If actual TCOC is less than projected, the difference is savings; if actual is more than projected, the difference is a loss. TCOC is defined to include the cost of providing most services. (See page 54 of Minnesota’s Integrated Health Partnerships Contract for a list of included services.)
The calculation of the amount of savings to be paid to the IHP or the amount of loss to be paid to the agency is based on multiple factors. First, the IHP is only eligible to share in any amount of savings or losses that fall within a negotiated risk corridor (e.g., 6 percent). All profit or loss outside the corridor belongs solely to the agency. The exact share of the amount within the risk corridor (e.g., the available savings) each IHP receives depends on two factors — the savings split it has negotiated with the agency and its performance in three domains (care quality, health information exchange, and alerting exchange).

But the share of losses depends only on the losses split negotiated with the agency and not its performance. The standard split is 50/50, meaning that IHPs can earn up to 50 percent of available savings and will pay 50 percent of available losses. But an IHP can secure a different split by entering into an accountable partnership with a community partner (e.g., a community mental health center [CMHC]) and negotiating a different split with the Medicaid agency — typically IHPs with an accountable partnership agree to take up to 70 percent of the available savings and pay 35 percent of available losses.

Rhode Island’s Accountable Entities

Rhode Island Medicaid began piloting its accountable care program in 2016 and launched its full program in July 2018 when it certified six comprehensive accountable entities (AEs). The Medicaid agency does not contract directly with its certified AEs. Instead, it requires Medicaid MCOs to contract with the AEs (and AEs to contract with MCOs). Each AE and MCO negotiate their own payment models within parameters set by the state. State officials shared that they have become more prescriptive on payment model as their and other stakeholders’ experience has grown and as the number of AEs (and thus the number of contracts that must be negotiated between MCOs and AEs and overseen by the state) grows. Both MCOs and AEs agreed on the need for increased standardization. Currently, all payment models must be based in TCOC calculated according to state requirements and MCOs must share up to 50 percent of any savings with AEs. AEs may accept shared losses if the Office of the Health Insurance Commissioner, which licenses commercial health plans, has determined that the AE is qualified to accept that risk. The amount of savings awarded to an AE must depend on the AE’s performance on at least three measures selected from a common measure set. State payment model parameters also govern how people are attributed to AEs.

In 2016, the Centers for Medicare & Medicaid (CMS) authorized the creation of AEs through approval of an amendment to Rhode Island’s Section 1115 Comprehensive Demonstration waiver. This amendment also authorized the state to create the Medicaid Infrastructure Incentive Program (MIIP) as a Designated State Health Program (DSHP). This designation, which CMS stopped awarding in 2017, authorized the state to receive, over the five-year period of November 2016 to December 2020, up to $129.8 million in federal funding to match state expenditures to support AE infrastructure development. In program Year 3, MCOs may earn up to $1.60 PMPM for each member attributed to a qualified AE. AEs may earn up to $8.44 PMPM by developing and completing projects that support the state’s goals, including those related to behavioral health. Actual payment is based on the achievement of performance milestones, most of which are negotiated between each AE and MCO, subject to state approval.10

10
Why States Included Behavioral Health in Accountable Care

Colorado, Minnesota, and Rhode Island chose to include behavioral health in their accountable care programs in order to improve chronic care, increase behavioral health integration, and produce cost savings. Officials from both Colorado and Rhode Island reported that their new accountable care programs built on their previous efforts to strengthen primary care and better integrate behavioral health into primary care. Rhode Island officials explained that the primary care-centered approach worked well for individuals with moderate or low behavioral health needs, but the “needs of the other end of continuum also need to be considered.” Rhode Island believed that the structure of the accountable care program gave the CMHCs, which can better serve high need individuals, more opportunity to leverage their skills and strengths to be a resource for primary care. Eventually, this state would like to bring primary care to CMHCs in at least some of their AEs.

Both Colorado and Rhode Island emphasize that behavioral health providers are well-positioned to engage patients with complex needs. Colorado officials also believe that RAEs’ structure, which makes them responsible for both primary and behavioral health care, would increase integration between the two types of services. Officials stated that the care coordination provided by CMHCs under its managed behavioral health program was strong. But they believed that folding the behavioral health program (and CMHCs) into their accountable care program fostered whole person care coordination for those with complex needs. They believed that increased integration and more holistic care coordination would lead to less fragmentation of care, create economies of scale, and, in turn, produce cost savings.

Colorado had also hoped that the RAEs would increase access to behavioral health services. This state has seen an increase in the proportion of Medicaid enrollees who receive one or more behavioral health services, and stakeholders are reporting that access and choice are both stronger.

How States Improve Behavioral Health through Accountable Care

All three states through their ACO contracts (Colorado and Minnesota) or certification standards (Rhode Island), consider performance on behavioral health measures in ACO payments. All three states also considered behavioral health in the performance requirements they created for their ACOs regarding network adequacy, care coordination and integration, and health information technology (HIT) supports. One or more of these states also called out behavioral health in the requirements they established in many other areas of performance.
Attribution

Attribution is the process used to identify the members of the defined population for which the ACO is accountable. All attribution processes consider where the patient has obtained care in the past. All three states featured in this brief first attribute Medicaid enrollees to a primary care provider (PCP) or a subset of PCPs who have met state-established qualifications. These states then consider each ACO to be “accountable” for the enrollees attributed to the providers affiliated with the ACO. All three states attribute enrollees with behavioral health conditions to a primary care provider, but only Minnesota currently considers behavioral health in that process. The first step of Minnesota’s process is to attribute Medicaid enrollees who have received services from a behavioral health home (or health care home) to the IHP with which that provider is affiliated.

Rhode Island had implemented a similar policy at program launch but now considers only primary care in attribution. Officials reported that they made this change because they determined that including attribution to an Integrated Health Home as the first step was difficult and time consuming. This, along with member churn impacted the state’s ability to confidently collect performance data. Additionally, Rhode Island found that many of the people served by integrated health homes were engaged in primary care with a separate provider.

Payment

As previously described, Colorado, Minnesota, and Rhode Island have each created a unique payment model for their ACOs. All three states, however, consider behavioral health performance in ACO payments and have established policies that foster consideration of behavioral health performance in payments to individual providers.

ACO Payment: Payment is considered to be the driving force to ensure ACO accountability for performance. All three states have tied ACO payment to behavioral health performance. Colorado’s RAEs may earn two types of incentive payments for performance. A RAE may earn incentives of up to $4 PMPM in key performance indicator (KPI) payments, which are primarily tied to the performance of the PCMP network. The RAE may also earn up to 5 percent of its behavioral health capitation rate (about $30 million) in behavioral health incentive (BHI) payments, which are primarily tied to the performance of the behavioral health network.

In both Minnesota and Rhode Island, ACOs may earn a share of the savings they produce — and are sometimes required to also share in any losses. Both of these states calculate savings and losses using a TCOC methodology. Both also include behavioral health services in the TCOC calculation, and Minnesota considers behavioral health services when calculating the monthly population-based payment that each of its IHPs also receives.

Regardless of their specific ACO payment model, all three states tie ACO payment to performance on a set of metrics that includes behavioral health measures, along with measures of other types of performance. In Colorado, performance on the metrics governs the amount of the incentives the RAEs earn. In Minnesota, performance on the metrics governs whether Track 1 IHPs may continue to participate in the program and whether Track 2 IHPs earn the full portion.
of their contracted share of any savings they produce. In Rhode Island, performance on the metrics governs what portion of savings are paid to the AE and how much the MCO may retain (and for those AEs that have been approved to accept downside risk, what portion of the losses they are required to pay to the MCO).

There is little commonality between the behavioral health measures these states chose to factor into payment (Table 1). Only one measure is used by all three states – follow-up appointments within X days after an inpatient hospital discharge for a mental health condition, although even on this measure, states have made different choices as to when to specify seven-day follow-up and when to specify 30-day follow-up. Although there was little commonality between the specific measures used, there was some commonality regarding the domains to be measured. All three states included measures of engagement and follow-up.

When asked why they chose their specific measures, state interviewees uniformly reported that the choices were based on their goals for the program and stakeholder input. They also reported that the choices were informed by previous efforts.

- Rhode Island, for example, drew its measures from a common measure set created as part of the state’s State Innovation Model (SIM) initiative.

- Colorado emphasized that it considered areas that it knew had “room for improvement” and used measurement to create incentives for the RAESs to change that part of the system. For example, the state tied payment to “follow-up after a positive depression screen” in order to incent behavioral health and primary care integration. Further, Colorado sought to align its behavioral health (BHI) and primary care (KPI) payments to incentivize the same behavior across the program. As one official explained, “behavioral health is not in a silo, and requires the engagement of physical health as well.”

- Finally, this measure set is not static, Minnesota, for example, is currently phasing out its medication measures.

“Measures [in Rhode Island] were shaped by high-level goals of the organization and we wanted to make sure that there are mechanisms for balanced, useful data.”
### Table 1: Behavioral Health Measures that Factor into ACO Payments

<table>
<thead>
<tr>
<th></th>
<th>Colorado</th>
<th>Minnesota</th>
<th>Rhode Island</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening and Assessment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening for depression and follow-up plan</td>
<td>Some IHPs*</td>
<td>Optional</td>
<td></td>
</tr>
<tr>
<td>Behavioral health screening or assessment for children in the foster care system</td>
<td>BHI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental screening in first three years of life</td>
<td>Optional</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Engagement and Follow-up</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiation and engagement of alcohol and other drug abuse or dependence (AOD) treatment</td>
<td>Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement in outpatient substance use disorder (SUD) treatment</td>
<td>BHI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral health engagement: Percentage of members who received a behavioral health service delivered either in primary care settings or under the capitated behavioral health benefit within a 12-month evaluation period</td>
<td>KPI</td>
<td></td>
<td>Track 1: 7- or 30-day Track 2: 30-day Required, opt for 7- or 30-day</td>
</tr>
<tr>
<td>Follow-up appointment within 7 or 30 days After an inpatient hospital discharge for a mental health condition</td>
<td>BHI; 7-day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up appointment within 7 days after an emergency department (ED) visit for a substance use disorder</td>
<td>BHI</td>
<td></td>
<td>Some IHPs*</td>
</tr>
<tr>
<td>Follow-up after a positive depression screen</td>
<td>BHI</td>
<td></td>
<td>Required</td>
</tr>
<tr>
<td><strong>Medication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressant medication management: acute and continuous</td>
<td>Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adherence to antipsychotics for individuals with schizophrenia</td>
<td>Required</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Acronyms: BHI=behavioral health incentive payment; KPI=key performance indicator payment; IHP=Integrated Health Partnership.

*The measure is used if it is appropriate to the topic of the health intervention that the IHP and Minnesota Medicaid jointly select.

To date, only Colorado has published a summary of ACO performance on the measures that factor into incentive payments. This state has seen some positive results. On the primary care side, payment is tied to behavioral health engagement. During the first year of program operation, the RAEs produced almost a two-percentage point increase in this metric. On the behavioral health side, Colorado established incentives for performance on five measures.

Colorado’s RAEs have increased the percent of Medicaid enrollees who receive behavioral health care.
During the program’s first year of operation:

- All seven RAEs met performance improvement goals for engagement in outpatient SUD treatment and follow-up after a positive depression screening;
- Five met the goal for behavioral health assessment for children in the foster care system; and
- Four met the goals for follow-up from mental health inpatient stays and SUD emergency room visits.11

Although not yet complete, Rhode Island is conducting an evaluation of its program which, when complete, will shed more light on its program’s impact on behavioral health care.

Minnesota officials report that IHPs perform above average when compared to clinics and/or systems that are not IHPs, on many quality measures, including those related to diabetes, asthma, and vascular care. In terms of behavioral health metrics, IHPs perform better than non-IHPs on ensuring adolescents are screened for mental health issues. Additionally, those IHPs with health interventions with a behavioral health focus have seen some positive results, including high levels of relative improvement across years.

**Payment to Individual Providers**

Colorado and Rhode Island both sought to ensure that the individual providers, including behavioral health providers, affiliated with their ACOs would benefit from performance payments earned by the ACO. Colorado explicitly requires its RAEs to share any incentive payments the RAE receives with the providers who form the RAE’s health neighborhood, which consists of the providers (including behavioral health providers) and facilities that work with an individual’s PCMP to meet all of the person’s health needs. RAEs are also required to report all payment arrangements, including those with behavioral health providers to the Medicaid agency. Rhode Island does not require its AEs to share savings, but it does require the AEs to have documented relationships with behavioral health provider partners to meet their patients’ needs, and Rhode Island Medicaid envisions that some of those relationships will include shared savings. It also requires the AEs to share 10 percent of any incentive payments they receive with a partner organization, which may be a behavioral health provider.

Minnesota encourages its IHPs to implement accountable care partnerships by potentially rewarding the IHP with more favorable financial arrangements. For example, instead of receiving 50 percent of any savings, the IHP might receive 70 percent. An IHP can use this mechanism to also reduce the share of any losses that it must pay, and Medicaid officials report that it is this attribute that is often most attractive to the IHP. The financial arrangements are negotiated with each IHP. Minnesota offered an example of a potential partnership between an IHP and a CMHC. The CMHC agrees to provide behavioral health services to a targeted set of patients who screen positive for a behavioral health need. IHP-affiliated providers will screen patients, refer those who screen positive to the CMHC, and the CMHC will provide any needed services and ‘close the loop’ by providing information back to the referring provider. Minnesota Medicaid also negotiates the specific measures that will be used to judge the success of the partnership. In this case, that might include the number of patients who were screened for behavioral health needs divided by the total number of patients, or it could also include the total patients who received services divided by the total patients referred. Although there is no
requirement that partners be paid, eligibility for a more favorable risk arrangement depends on several factors that encourage payment, including how well the partners are working together.

Finally, when it launched its accountable care program, Colorado Medicaid began directly paying PCMPs (i.e., primary care providers) for short-term behavioral health treatment (up to six visits) on a fee-for-service basis. Other behavioral health services are paid for by the RAEs. Colorado Medicaid had anticipated that this change would foster behavioral health integration and support then-existing partnerships between some federally qualified health centers (FQHCs) and CMHCs. As expected, this policy did improve access for patients with more mild behavioral health conditions. However, some FQHCs chose to withdraw from the partnerships and hire staff to provide the short-term services. Colorado Medicaid also found the policy more difficult to implement than anticipated, as the agency had to adjust the payments it made to the RAEs for behavioral health services to reflect that payment for some short-term services that would now be made by the agency.

**ACO Performance Requirements**

Colorado, Minnesota, and Rhode Island all complemented their payment reforms with performance requirements to help ensure that their ACOs were prepared to deliver accountable care and that savings would be produced by improving care rather than curtailing access. These three states all chose to address behavioral health in their ACO performance requirements governing provider network composition and access to services, care coordination, and health information technology.

**Table 2: Performance Area Requirements**

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Colorado</th>
<th>Minnesota</th>
<th>Rhode Island</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network and access to services</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Care coordination</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Health information technology</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Provider support</td>
<td>√</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Quality</td>
<td>√</td>
<td></td>
<td>√</td>
</tr>
</tbody>
</table>

**Network Composition and Access to Behavioral Health Services**

All three states required their ACOs to include at least some behavioral health providers among their affiliated providers, although only two required contracts. Colorado required its RAEs to create a statewide behavioral health network and offer contracts to CMHCs and substance use disorder (SUD) clinics. Similarly, Minnesota’s IHPs must contract with CMHCs “to the extent possible,” and each AE in Rhode Island must demonstrate that they have sufficient partnerships with behavioral health providers to provide the population that the AE plans to serve with access to a range of treatment options that represent a continuum of care. Rhode Island officials reported that in the early years of their program, they required the AEs to partner with CMHCs. Now that many of the AE/CMHC partnerships are well-established, this performance standard
has been broadened to count partnerships with all types of behavioral health providers, not just CMHCs. Rhode Island has broadened the requirement to include all behavioral health providers. These three states also established other performance expectations. For example, Rhode Island requires each AE to include a representative of a community-based behavioral health provider within its governance structure.

Colorado officials reported that access to behavioral health services increased because those providers who had been delivering care through the specialty managed care program continued to deliver care as part of the RAES’ networks, but the RAES had expanded their independent provider network as well. Officials viewed this to be an overall positive outcome because both traditional providers (e.g., CMHCs) and independent providers who had not previously treated Medicaid enrollees were needed to meet the current Medicaid population’s full range of needs. However, some RAES, especially those that hadn’t established some utilization review requirements, found that utilization of expensive services, such as inpatient services, increased. These RAES are now working to ensure that the right utilization management is in place, and one aspect of that work is to assess whom the independent provider networks are serving and consider if that is the best place for those enrollees to receive care.

Care Coordination and Population Health Management

One of the hallmarks of accountable care is ensuring that patients’ needs are systematically identified and addressed, and that care is coordinated across systems and providers. All three states established policies for care coordination that addressed behavioral health issues.

- Minnesota used its IHP selection process to establish the expectation that IHPs should screen patients for behavioral health and chemical dependency conditions and that care coordination should feature “integration of medical/behavioral-chemical/social service community care coordination and planning.”
- Colorado’s contract with its RAES defines care coordination to include coordination of behavioral health needs and then includes numerous requirements for care coordination. Because this state has also tasked its RAES with delivering behavioral health care, it has created requirements for that system, including requiring RAES to fund intensive case management from savings.
- Rhode Island’s certification standards require AE’s to have policies and procedures in place that support integration of physical, behavioral, and social supports.

Colorado and Rhode Island also created requirements to ensure that behavioral health was addressed at the population level by requiring their ACOs to prepare population health plans that address behavioral health issues. Rhode Island also includes requirements designed to ensure that...
the plan guides each AE’s population health management activities, including behavioral health integration that considers risk factors for poor behavioral (as well as physical) health outcomes.

Health Information Technology (HIT)

Data is key to systematically identifying and managing a population’s health needs, identifying gaps in care, and measuring health outcomes. Colorado, Minnesota, and Rhode Island took slightly different approaches to ensuring that providers had, and could use, data to improve delivery of behavioral health services.

- Minnesota provides clinical data, including behavioral health claims data, to IHPs on a monthly basis and requires IHPs to use the data to improve performance.
- Colorado also provides claims data to the RAes and, in addition, emphasizes the use of electronic care coordination and other analytic tools. This state required each RA to have a care coordination tool to help PCMPs and other providers, including behavioral health providers, coordinate care — and also required that the tool had to support “HIPAA and 42 CFR Part 2 compliant data sharing.” RAes were additionally required to have other data analytic tools and to support providers use of the tools.
- Rhode Island established requirements for using analytic tools (decision-support tools) and is developing a dashboard for AEs that provides information about their performance on quality measures. In addition, this state requires AEs to include behavioral health provider contacts in patient registries.

Provider Support

Shifting to a new delivery and payment model can be difficult, even when providers voluntarily shift. Changing providers’ approaches to delivering care, including behavioral health care, to enable them to thrive under a new system can be particularly difficult. Colorado and Rhode Island both addressed these concerns in their accountable care programs but took very different approaches.

Colorado required its RAes to provide the support. Each RA was required to prepare and implement a provider support plan that addressed the RAe’s plan to help providers work toward behavioral health integration. Under these plans, RAes offer providers access to care coordinators, practice transformation coaches, and ongoing training. They also offer in-person coaching and online support, including access to tools and resources for provider use. Rhode Island’s MIIP, which is funded as a Designated State Health Program under the state’s 1115 waiver, paid for projects that support the providers associated with the AEs. Each AE develops projects to help build its capacity in specific areas, including some related to behavioral health, such as implementation of evidence-based behavioral health integration and consultation services.

Through this work, officials found that behavioral health providers, even more so than primary care providers, needed a better understanding of alternative payment methodologies (APMs) and how to manage their practices to thrive under these arrangements. Those that had not previously...
served Medicaid enrollees (e.g., independent behavioral health providers) had even greater technical assistance needs because they often also had to learn Medicaid policies and create new infrastructure. One state official noted the program would have benefited from a comprehensive assessment of providers’, including behavioral health providers, technical assistance needs well before program launch to identify and address critical gaps in provider understanding before they affected the program’s success.

**Quality**

One of the aims of accountable care programs is to hold providers accountable for the quality of care they deliver. Colorado and Rhode Island chose not only to hold their ACOs accountable by measuring the outcomes they produce on quality metrics, but also the process each ACO used to achieve quality. Rhode Island requires each AE to establish a quality committee to oversee the AE’s quality assurance and improvement program. This state requires that the committee membership include at least one licensed behavioral health clinician who is an AE participant.

Colorado’s requirements are based in Medicaid managed care requirements. Each RAE must conduct two performance improvement projects each year. One of these projects must address behavioral health, and RAEs may choose to dedicate both to improving integration of physical and behavioral health care. RAEs must also prepare quality plans that address behavioral health.

**Lessons Learned**

Officials from the three states advised those seeking to use ACOs to improve behavioral health services to seek and use stakeholder input, leverage infrastructure and relationships built during previous initiatives as well as the knowledge and experience of the providers currently serving Medicaid enrollees, and expect growing pains. In addition, an examination of these states’ experience finds three overarching takeaways.

**States worked to strengthen the primary care system and integrate primary care and behavioral health before introducing accountability for behavioral health services.** State officials in all three states used an iterative process to incorporate behavioral health services into their ACOs. Both Colorado and Minnesota waited to incorporate behavioral health until they had several years of experience operating their programs. Colorado officials stated that even when they were planning the first phase of their program, they knew that they ultimately wanted to include behavioral health. They did not do so at that time because they wanted to first focus on ensuring that the primary care aspects of their program were working well. They also knew that the shift to the new delivery system was going to require the reworking of a long-standing behavioral health services delivery structure and believed that making major simultaneous changes to both primary and behavioral health care would cause too much disruption. Rhode Island included behavioral health in its accountable care program from the beginning, but had a very strong, widespread patient centered medical home (PCMH) program in place prior to launching the accountable care program.

All three states had also previously worked to increase behavioral health integration. Rhode Island, for example, had funded an Integrated Behavioral Health Pilot (IBH) that supported
primary care practices in incorporating co-located behavioral health clinicians into their operations. Minnesota had established a behavioral health home program to promote whole-person care. Colorado established learning collaboratives to help primary care and behavioral health providers develop the skills needed to support integration, such as creating a multidisciplinary team.

**States adjusted program policies as their own and other stakeholders’ experience grew.** Both Colorado and Rhode Island reported that they considered their programs to be iterative after launch. Rhode Island officials shared that, during the third year of the program, they began requiring MCOs to calculate shared savings in a specific way and allowed the AEs to earn up to 50 percent of the savings based on their performance. The Medicaid agency made this change due to feedback from both AE and MCOs about the difficulty of managing a growing number of contracts, each with potentially different financial arrangements. Increased standardization also eased the state’s oversight and monitoring. Rhode Island had anticipated that it would need to adjust its policies as its experience grew because the Medicaid agency was, as one official described, “Designing, building, and flying [the airplane] at the same time.”
A Colorado official similarly reported that, “Our program is iterative, and we continue to tweak and learn from it.” Recently, Colorado is encountering challenges related to COVID-19, including questions about how to integrate specialty providers and behavioral health.

**States found that ACO leadership, like their associated providers, benefit from support.** Officials recognized and planned for provider support, although some wished that they had offered more support. The states also knew that ACOs would need support in order to achieve success. They found that many ACO technical assistance needs were similar to those of providers. Some ACOs, like providers, needed a better understanding of the type of alternative payment models that could work for behavioral health providers. Rhode Island engaged a contractor to provide individual and group technical assistance to both MCOs and AEs — one focus of which was to support both as they entered into shared-risk contracts.

Colorado reported that some newer RAES had moved back to fee-for-service reimbursement for behavioral health providers but were now working with CMHCs to develop more value-based payment arrangements. Also similar to providers, ACOs that had not previously served Medicaid enrollees had greater technical assistance needs. In Colorado, new RAES were less familiar with Colorado Medicaid and its emphasis on community-based services. One official wished that the state had allowed sufficient time during implementation to support peer learning for new RAES, perhaps through shadowing existing contractors, underscoring that education and collaboration were critical. Although Colorado found that new RAES needed to improve their understanding of Medicaid policies, experienced RAES needed to be “shaken up” to encourage continued engagement and innovation. Officials in this state worked to engage both newer and more experienced RAES in peer learning. As one official stated, “When they [RAES] first started, it was a competition. Now they meet and learn from each other.”

**Conclusion**

In recent years, states have begun to use Medicaid accountable care programs to better integrate behavioral and physical health, improve identification and treatment of behavioral health
conditions, and increase Medicaid enrollees’ access to behavioral health care. Examining the strategies and outcomes of three of these states offers others valuable information that they can apply to their own programs. All three states’ Medicaid agencies took different approaches to selecting and paying their ACOs, but all three based ACO payment in performance and established ACO performance standards — and considered behavioral health in both of these aspects of their programs. All interviewees reported that their programs were improving care but, to date, only Colorado has published a summary of ACO performance on the measures that factor into payment. This state has seen some positive results, including a modest increase by all RAEs in the percent of Medicaid enrollees receiving behavioral health services and follow-ups after a positive depression screening.

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Notes

10 Rhode Island EOHHS. Attachment K – Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities. http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Access%20of%20Care%20Collaborative%20Program%20Improvement%20Attachment%20K.pdf