

# Financing Integrated Care for Adults with Serious Mental Illness in Community Mental Health Centers

## An Overview of Program Components, Funding Environments, and Financing Barriers

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## Preface

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Adults with serious mental illness (SMI) experience higher rates of physical illness and early mortality compared to the general population, and also account for disproportionately high costs of care. Integrating physical health care into mental health treatment settings is a promising approach for addressing these disparities; however, such programs are often grant-funded and may face considerable barriers to financial sustainability once grant funding has ended.

This working paper provides an overview of issues related to the financing of integrated care for adults with SMI in community mental health centers (CMHC). In particular, I focus on programs funded by the Substance Abuse and Mental Health Services Administration's Primary and Behavioral Health Care Integration (PBHCI) grants, which provide four years of (non-renewable) funding to CMHCs to support integrated care for adults with SMI.

Topics covered in this paper include background information about health outcomes for adults with SMI, the promise of integrated care for addressing these problems, and components of CMHC-based integrated care programs. I describe sources of funding (e.g., grants, Medicaid/Medicare reimbursement), and a range of payment models (existing and under development) that may support integrated care. The potential influence of recent policy changes (e.g., the Affordable Care Act, and mental health parity legislation) on integrated care financing is also discussed. I then detail specific barriers to financial sustainability that CMHC-based integrated care programs may face including general limitations in CMHC funding, licensing/credentialing requirements, insufficient reimbursement, lack of coordination among payers and regulatory agencies, and CMHC difficulty developing cost-efficient workflow models.

This paper may be of interest to national and state policymakers, CMHCs, other health care organizations, patient advocacy organizations, health researchers, and others involved in improving access to physical health care for adults with SMI. This paper provides a high-level overview of integrated care financing issues; the specific funding environments, challenges, and opportunities faced by integrated care programs will vary depending on state and local factors (e.g., state-specific Medicaid policies, the distribution of health insurance status among program consumers).

Contents of this paper are based on a review of existing literature, as well as the synthesis of anecdotal reports collected through conversation with CMHC-based integrated care program informants as part of two completed RAND projects: (1) evaluation of the PBHCI program, sponsored by SAMHSA and the Assistant Secretary for Planning and Evaluation (ASPE) (Scharf, Eberhart, et al., 2014); and (2) examination of mental health based integrated care in New York State, sponsored by the New York State Health Foundation (Scharf, Breslau, et al., 2014).

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## Abstract

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Adults with serious mental illness (SMI) experience higher rates of physical illness and early mortality compared to the general population. Co-morbid SMI and physical illness are also associated with high costs of care, particularly to public payers. To address these disparities, a number of initiatives have promoted the integration of physical health care into mental health treatment settings: for example, the Substance Abuse and Mental Health Services Administration (SAMHSA) Primary and Behavioral Health Care Integration (PBHCI) grants, which provide four years of funding to community mental health centers (CMHCs) to support integrated care for adults with SMI. Despite some early successes, such programs may face considerable barriers to the sustainability of their programs, particularly given grant funding is non-renewable. This paper provides an overview of financing considerations for CMHC-based integrated care programs for adults with SMI, drawing on existing literature as well as anecdotal reports provided by program informants. Variation in program components (e.g., specific services provided, information-sharing capabilities), sources of funding (e.g., grants, reimbursement), and payment models (e.g., fee for service, shared risk/savings) may affect the sustainability of CMHC-based programs. Ongoing implementation of recent policy changes (e.g., Affordable Care Act, and mental health parity legislation) is also likely to affect program sustainability. Current barriers to financing include general limitations in CMHC funding, licensing/credentialing requirements, insufficient reimbursement, lack of coordination among payers and regulatory agencies, and difficulty developing cost-efficient workflow models. Policy changes by multiple stakeholders, including payers, regulatory agencies, and provider organizations, are likely needed to improve physical health care for adults with SMI through integrated care.

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## Summary

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Adults with serious mental illness (SMI) experience higher rates of physical illness and early mortality compared to the general population (e.g., Jones et al., 2004; Parks et al., 2006; SAMHSA, 2012). Co-morbid SMI and physical illness are also associated with high costs of care, particularly to public payers (e.g., Kasper, Watts, & Lyons, 2010; Melek, Norris, and Paulus, 2014). To address these disparities, a number of initiatives have promoted the integration of physical health care into behavioral health treatment settings: for example, the Substance Abuse and Mental Health Services Administration (SAMHSA) Primary and Behavioral Health Care Integration (PBHCI) grants, which provide four years of funding to community mental health centers (CMHCs) to support integrated care for adults with SMI. Emerging evidence suggests that CMHC-based integration can improve access to physical health care for adults with SMI, and also improve some physical health outcomes (Scharf, Eberhart, et al., 2014). Despite these promising results, however, programs may face considerable barriers to the financial sustainability of their integrated care services, particularly beyond the lifespan of the (non-renewable) PBHCI grants (Scharf, Breslau, et al., 2014; Scharf, Eberhart, et al., 2014).

This paper provides an overview of financing considerations for CMHC-based integrated care programs for adults with SMI, drawing on existing literature as well as anecdotal reports provided by program informants involved in two previous RAND studies: (1) evaluation of the PBHCI program, sponsored by SAMHSA and the Assistant Secretary for Planning and Evaluation (ASPE) (Scharf, Eberhart, et al., 2014); and (2) examination of mental health based integrated care in New York State, sponsored by the New York State Health Foundation (Scharf, Breslau, et al., 2014).

Variation in program components (e.g., specific services provided, information-sharing capabilities), sources of funding (e.g., grants, reimbursement), and payment models (e.g., fee for service, shared risk/savings) may affect the sustainability of CMHC-based programs. Ongoing implementation of recent policy changes (e.g., Affordable Care Act, and mental health parity legislation) is also likely to affect program sustainability. Current barriers to financing include general limitations in CMHC funding, licensing/credentialing requirements, insufficient reimbursement, lack of coordination among payers and regulatory agencies, and difficulty developing cost-efficient workflow models. Policy changes by multiple stakeholders, including payers, regulatory agencies, and provider organizations, are likely needed to improve physical health care for adults with SMI through integrated care.

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## Abbreviations

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ACA	(Patient Protection and) Affordable Care Act
ACO	accountable care organization
ASPE	Assistant Secretary for Planning and Evaluation
CBO	Congressional Budget Office
CCBHC	Certified Community Behavioral Health Clinics
CIHS	Center for Integrated Health Solutions
CMHB	Community Mental Health Block (grant)
CMHC	community mental health center
CMS	Centers for Medicare and Medicaid Services
EHR	electronic health record
FFS	fee for service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
MCO	managed care organization
MHPAEA	Mental Health Parity and Addiction Equity Act
NSDUH	National Survey on Drug Use and Health
PBHCI	Primary and Behavioral Health Care Integration
PCCM	primary care case management
PMPM	per-member per-month
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	serious mental illness
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
WHAM	Whole Health Action Management

# Chapter 1. Introduction

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## Background

### *Adults with SMI, and CMHCs*

In 2013, an estimated 10 million adults in the U.S. (4.2% of the country’s adult population) had experienced serious mental illness (SMI) in the past year.<sup>1</sup> The Substance Abuse and Mental Health Services Administration (SAMHSA) defines SMI—such as schizophrenia, bipolar disorder, and major depression—as “mental, behavioral, or emotional disorders that substantially interfere(s) with or limit(s) one or more major life activities”.<sup>2</sup> For the roughly 60% of adults with SMI who receive mental health treatment<sup>3</sup>, the most common treatment settings are outpatient settings,<sup>4</sup> such as community mental health centers (CMHCs). In addition to mental health treatments such as counseling and medication management, some CMHCs may also provide short-term residential services, substance abuse treatment, and support linking consumers to needed community services.

Until 2015, there had been is no standard definition for CMHCs in federal law; although the Centers for Medicare and Medicaid Services (CMS) requires a core set of services to be provided by Medicare-certified CMHCs: e.g., outpatient mental health services for any area residents discharged from inpatient mental health facilities, and 24-hour-a-day emergency care services.<sup>5</sup> As of a result of the Protecting Access to Medicare Act,<sup>6</sup> a demonstration project is currently underway to establish Certified Community Behavioral Health Clinics (CCBHC); clinics meeting specific criteria (currently under development)<sup>7</sup> will be eligible for enhanced Medicaid funding.

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<sup>1</sup> SAMHSA, Center for Behavioral Health Statistics and Quality, 2013 National Survey on Drug Use and Health (NSDUH): <http://www.samhsa.gov/data/sites/default/files/NSDUH-SR200-RecoveryMonth-2014/NSDUH-SR200-RecoveryMonth-2014.htm#fn7>

<sup>2</sup> Ibid.

<sup>3</sup> SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2008 and 2009: <http://www.oas.samhsa.gov/NSDUH/2k9NSDUH/MH/tabs/Sect1peMHtabs.htm#Tab1.14B>

<sup>4</sup> SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2008 and 2009: <http://www.oas.samhsa.gov/NSDUH/2k9NSDUH/MH/tabs/Sect1peMHtabs.htm#Tab1.17B>

<sup>5</sup> CMS, Medicare, Certification and Compliance, Community Mental Health Centers: <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CommunityHealthCenters.html>

<sup>6</sup> Protecting Access to Medicare Act of 2014, Section 223: <https://www.congress.gov/bill/113th-congress/house-bill/4302>

<sup>7</sup> SAMHSA, Demonstration Program to Improve Community Mental Health Services (Section 223 of the Protecting Access to Medicare Act of 2014): <http://www.samhsa.gov/about-us/who-we-are/laws-regulations/section-223>

## *Poor Health Outcomes, High Costs*

Adults with SMI are at higher risk than the general population for a number of chronic physical illnesses including diabetes and cardiovascular disease (e.g., Jones et al., 2004; Parks et al., 2006; SAMHSA, 2012). Life expectancy for adults with SMI ranges from 8 to 30 years lower than that of the general population (e.g., Chang et al., 2011; Colton & Manderscheid, 2006), and much of the disparity has been attributed to unmanaged, preventable conditions, such as hypertension, and modifiable risk factors, such as obesity, poor nutrition, lack of exercise, smoking, and substance abuse (e.g., Parks, Svendsen, Singer, Foti, & Mauer, 2006). Other drivers of poor physical health among adults with SMI include side effects of psychotropic medications (Newcomer, 2006, 2007); housing instability and low socioeconomic status, which are associated with poor health behaviors, and difficulty complying with medical advice (e.g., Katon, 2003); and medical provider discomfort/inexperience treating individuals with SMI (e.g., Lawrence & Kisely, 2010). The organizational, administrative, and financial separation of mental health, substance abuse treatment, and physical health care systems also limit providers' ability to share information and coordinate care for individuals with co-morbid behavioral and physical health conditions (e.g., Druss, 2007; Horvitz-Lennon, Kilbourne, & Pincus, 2006; IOM, 2005; Pincus et al., 2007).

Co-occurring mental and physical health conditions are also costly to health care systems, particularly in terms of cost to public payers, such as Medicaid and Medicare (e.g., Jones, et al., 2004; Kasper, Watts, & Lyons, 2010; Melek et al., 2014). For example, among the highest-cost 5% of Medicaid beneficiaries, three of the top five most prevalent disease pairs include psychiatric illnesses,<sup>8</sup> such as depression and schizophrenia (Kronick, Bella, & Gilmer, 2009). High-cost beneficiaries also account for a disproportionately large share of program costs: for example, fewer than 5% of Medicaid beneficiaries account for more than 50% of overall Medicaid costs (Kronick, et al., 2009). This finding suggests that improving health outcomes and controlling costs for a narrowly targeted population of high-need individuals, such as adults with SMI and physical health conditions, has the potential to result in significant cost savings to public health payers.

## *Integrated Care as a Potential Solution*

Over the past decade, experts have been calling for the integration of physical and behavioral health care services to improve quality of care and overall health outcomes for adults with SMI (e.g., Druss, 2007; Horvitz-Lennon, et al., 2006; IOM see: Institute of Medicine, 2001, 2005; Pincus, et al., 2007; President's New Freedom Commission on Mental Health, 2003). Integrated care involves systematic collaboration between behavioral health providers and general medical providers (e.g., Butler et al., 2008).

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<sup>8</sup> The psychiatric illness category also includes anxiety disorders (e.g., phobias, panic disorders), mood disorders (e.g., depression, bipolar disorder), and eating disorders (e.g., anorexia).

Early integrated care initiatives focused on bringing behavioral health services into medical settings, such as primary care clinics. More recent initiatives that specifically target adults with SMI (e.g., SAMHSA’s PBHCI grant program) focus on bringing physical health care into community behavioral health settings, such as CMHCs. CMHC-based integration is expected to be particularly effective for adults with SMI, many of whom have established regular contact with behavioral health providers but not medical providers (Alakeson, Frank, & Katz, 2010). CMHC-based integrated care is expected to improve health outcomes for adults with SMI by increasing access to primary care and preventive medical services; and promoting collaboration and learning across behavioral health and physical health providers, thus leading to better quality, comprehensive treatment planning (Alakeson, et al., 2010).

Integrated care may also yield cost savings to health care payers, if efforts are strategically targeted toward the subgroup of adults with SMI who are frequent utilizers of high-intensity high-cost services, such as emergency department visits and hospitalizations. Cost savings could occur if integrated care successfully promotes the use of lower-intensity, lower-cost services such as outpatient primary and preventive care services, reducing the volume of higher-cost services. A substantial proportion of adults with SMI, however, are not currently high utilizers of health care services, due to lack of health insurance or other barriers to care, such as limited mobility (see Druss, 2007; Jones, et al., 2004). Efforts to promote integrated care among this subgroup are not likely to reduce overall health care costs, since those with previously unaddressed health care needs are likely to receive more services, thus incurring more costs, under this intervention.

## *PBHCI Grants*

### Program Overview

SAMHSA’s PBHCI grant program is specifically aimed at improving physical health outcomes for adults with SMI (and/or co-occurring substance use disorder) by making some primary care and preventive services available in community behavioral health settings, such as community mental health centers (CMHCs).<sup>9</sup> PBHCI grantees receive up to \$500,000 per year and are required to provide the following core program features:

1. Screening and referral for physical health conditions
2. A tracking system for physical health needs and outcomes
3. Care management/coordination
4. Prevention and wellness support service

PBHCI grants are non-renewable, and are intended to support initial infrastructure development (e.g., renovations to physical settings, upgrades to health records systems) and other administrative tasks (e.g., data reporting for continuous quality improvement, and

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<sup>9</sup> SAMHSA-HRSA (Health Resources and Services Administration) Center for Integrated Health Solutions, PBHCI program website: <http://www.integration.samhsa.gov/about-us/pbhci>

evaluation). PBHCI funds also provide time-limited support for integrated care services that are insufficiently reimbursed by health insurance payers, such as care coordination, peer support, and wellness services. Since the program's initiation in 2009, PBHCI grants have been awarded to a total of 126 programs nationwide.

## Successes and Challenges

A recent evaluation of PBHCI found the grant program has led to increased access to primary care for adults with SMI, and improvements in some physical health outcomes, such as indicators of diabetes and hypertension (Scharf, Eberhart, et al., 2014). Improvements in other health outcomes (e.g., weight, smoking) have been lacking, however, and PBHCI grantees have reported an array of barriers to their programs' success, including difficulties with staffing, information sharing, and developing collaboration among interdisciplinary care providers (Scharf et al., 2013; Scharf, Eberhart, et al., 2014).

One of the most significant and commonly reported barrier to integrated care is difficulty with program financing (e.g., Butler, et al., 2008; Kathol, Butler, McAlpine, & Kane, 2010; Kilbourne et al., 2008; Scharf, Eberhart, et al., 2014). Although PBHCI grants help defray initial program development costs (e.g., costs of preparing space, hiring and training staff, establishing a medical health record system and new clinical protocols), grantees have reported particular concern about sustaining ongoing costs (e.g., costs of providing ongoing services, engaging consumers in treatment/referral follow-through) beyond the grant lifespan (Scharf, Breslau, et al., 2014; Scharf, Eberhart, et al., 2014).

## About this Paper

### *Contents*

Contents of this paper are based on existing literature (academic and grey), as well as anecdotal reports provided in conversation with CMHC-based integrated care program informants participating in two previous RAND studies: (1) evaluation of the PBHCI program, sponsored by SAMHSA and the Assistant Secretary for Planning and Evaluation (ASPE) (Scharf, Eberhart, et al., 2014); and (2) examination of mental health based integrated care in New York State, sponsored by the New York State Health Foundation (Scharf, Breslau, et al., 2014).

Chapter 1 introduces the topics of poor health outcomes and high costs of care for adults with SMI, the promise of integrated care in CMHC settings for addressing these problems, and an overview of the PBHCI grants program. Chapter 2 identifies specific components of CMHC-based integrated care programs (e.g., services provided, organizational partnerships) whose financing is discussed in subsequent sections. Chapter 3 describes sources of funding that may be available to CMHCs (e.g., grants, Medicaid/Medicare reimbursement), and a range of payment models (existing and under development) that may support integrated care (e.g., fee for service,

partial capitation, shared risk/savings). The potential influence of recent policy changes (e.g., through the Affordable Care Act, and mental health parity legislation) on integrated care financing is also discussed. Chapter 4 presents specific barriers to financial sustainability that CMHC-based integrated care programs may face, depending on program-specific approaches and funding/policy environment. Specific barriers include general limitations in CMHC funding, licensing/credentialing requirements, insufficient reimbursement, lack of coordination among payers and regulatory agencies, and CMHC difficulty developing cost-efficient workflow models. Chapter 5 includes conclusions and recommendations for future research.

### *Limitations in Scope*

Adults with SMI often have additional service needs beyond medical and behavioral health care, such as with housing, employment, and social support. These needs have direct impacts on individuals' overall health, and more comprehensive integrated care programs should address them; however, consideration of these additional services is beyond the scope of this project.

This paper is focused on promoting the financial sustainability of CMHC-based integrated care, assuming such programs have positive health effects for the consumers they serve. While emerging evidence on program effectiveness has indeed shown some improvements in physical health outcomes and wellbeing (e.g., Scharf, Eberhart, et al., 2014), more research is needed to identify specific components of integrated care programs that are most effective. As this research continues to emerge, financial sustainability efforts must be tailored to focus on supporting these most effective approaches.

## Chapter 2. Integrated Care Program Components

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### Services and Providers

To integrate physical health care into their behavioral health treatment programs, CMHCs must add a variety of services to their existing programs (see Table 1). Some newly added services may be provided by existing behavioral health staff (e.g., psychiatric nurse practitioners, case managers), with appropriate training as necessary. Other service providers may be added to the program either by being hired directly by the CMHC, or through a contractual relationship between the CMHC and another health care organization (e.g., provider group, health clinic).

**Table 1. Services and individual providers that may be added to a CMHC behavioral health treatment program to develop integrated care**

<b>Integrated Care Service Type</b>	<b>Example Services</b>	<b>Potential Individual Service Providers</b>
Primary care services	<ul style="list-style-type: none"> <li>• Treatment for chronic conditions (e.g., diabetes, hypertension, asthma)</li> <li>• Treatment for acute conditions (e.g., sore throat, back pain)</li> <li>• Referrals to medical specialists</li> </ul>	<ul style="list-style-type: none"> <li>• Physician, nurse practitioner (psychiatric or non-psychiatric), or physician assistant</li> </ul>
Preventive care services	<ul style="list-style-type: none"> <li>• Screening and assessments for physical health conditions</li> <li>• Immunizations</li> </ul>	<ul style="list-style-type: none"> <li>• Physician, nurse practitioner (psychiatric or non-psychiatric), or physician assistant</li> <li>• Some screening/assessments (e.g., blood pressure) may be provided by support nurse, medical assistant, social worker, or (non-licensed) health paraprofessional</li> </ul>
Wellness activities	<ul style="list-style-type: none"> <li>• Nutrition education</li> <li>• Disease management (e.g., diabetes education)</li> <li>• Tobacco cessation services</li> <li>• Exercise groups</li> <li>• Social support groups</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse or other licensed health care professional</li> <li>• Non-licensed health paraprofessional</li> <li>• Behavioral health case manager, counselor, or social worker with additional training</li> <li>• Peer support/counselors</li> </ul>
Coordination of care among providers	<ul style="list-style-type: none"> <li>• Communication among providers (e.g., medical, mental health, or other specialists) within and across organizations/settings to support coordinated and collaborative consumer treatment</li> <li>• Support staff to facilitate communication among providers</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral health, primary care, and medical specialty providers</li> <li>• Communication among providers may be supported by nurse or non-nurse care coordinator</li> </ul>
Care management/navigation support for consumers	<ul style="list-style-type: none"> <li>• Monitoring consumer participation in and response to behavioral health and medical treatments (with care management service intensity proportional to consumer complexity)</li> <li>• Linking consumers to needed services (e.g., medical specialists)</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse care manager (psychiatric or non-psychiatric)</li> <li>• Non-nurse care manager</li> <li>• Behavioral health case managers (licensed or non-licensed), possibly with additional training</li> </ul>

Additional consumer support services	<ul style="list-style-type: none"> <li>• Transportation assistance for consumers to access health care services</li> <li>• Peer support (e.g., to encourage consumer participation in treatment)</li> </ul>	<ul style="list-style-type: none"> <li>• Peer counselors</li> <li>• Other non-professional support staff</li> </ul>
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PBHCI integrated care programs vary widely in terms of the range of services made available at the CMHC location (e.g., full service primary care vs. basic screening and coordination only), types of staff involved, and other service provision details (Scharf et al., 2014). The costs of providing integrated care that PBHCI grantees incur is directly related to each of these factors.

## Additional Capabilities

To further support the services described above, CMHCs may also develop the following capabilities or infrastructure:

- Shared electronic health records (EHRs) (e.g., across physical and behavioral outpatient providers, emergency departments, hospitals)
- Auxiliary services available onsite (at the CMHC location), including blood drawing, laboratory testing, and pharmacy
- Tele-health care services
- Measurement-based care (i.e., clinical decision-making based on consumer health data)
- Continuous (program-level) quality improvement through analysis of access, care process, and outcome data; monitoring fidelity to evidence-based practices
- Outreach to high-risk consumers, and community members

The development of some of these capabilities, such as shared EHRs, may only involve start-up costs; however, other capabilities, such as continuous data monitoring and outreach to high-risk consumers, require ongoing resources.

## Organizational Partnerships

CMHCs may partner with other organizations, such as Federally Qualified Health Centers<sup>10</sup> (FQHCs), to provide physical health care services for their integrated care consumers. Among the first three cohorts of PBHCI grantees, most (n=45, 82%) had partnered with other health care and community organizations (e.g., hospitals, community health clinics, FQHCs) (Scharf et al., 2013). FQHCs and FQHC look-alikes<sup>11</sup> are becoming increasingly involved in integrated care

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<sup>10</sup> Federally Qualified Health Centers (FQHCs) are public and non-profit health clinics that receive federal support to serve the uninsured by fulfilling the following requirements: serve a high need area or population; provide comprehensive primary care and supportive services (e.g., education, translation, transportation) that promote access to health care; provide services to all, with fees adjusted based on ability to pay; and meet performance, accountability, and governance requirements. Health care organizations that do not meet FQHC requirements may still be certified by CMS as a “Health Center”, or FQHC look-alike, and may also compete for federal funds. For more information, see HRSA website at: <http://bphc.hrsa.gov/about/>

<sup>11</sup> Ibid.

efforts, sometimes through partnerships with CMHCs (e.g., Brolin et al., 2012; Scharf, et al., 2013).

CMHCs' options for organizational partnerships depend in large part on their own organizational structure (e.g., whether freestanding or already affiliated with a larger health care system), availability of providers in their geographic area, number of consumers served, and financing options (e.g., Alexander & Druss, 2012). Agreements between organizational partners may be informal or contractual—if contractual, agreements are likely to include details about financing arrangements (e.g., which organization bills which payers for which service). These arrangements clearly impact the overall financial sustainability of integrated care programs, and represent yet another organizational policy lever that CMHCs can consider when developing their sustainability plans.

## Chapter 2. Funding Environments for CMHC-Based Integrated Care

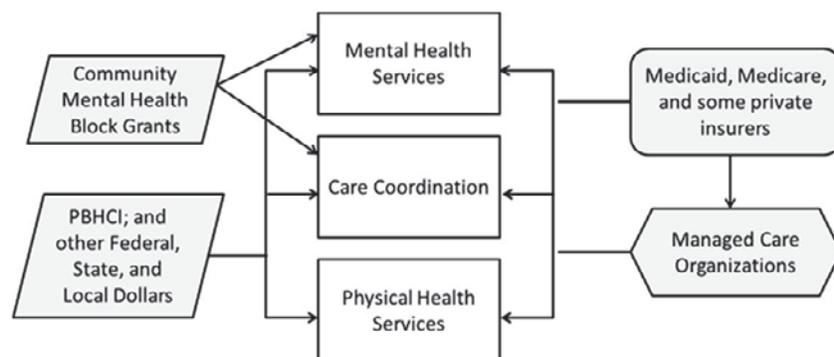
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### Sources of Funding

#### Overview

CMHCs finance their integrated care programs through a complex network of federal, state, and local funding streams (see Figure 1), the details of which have not been well documented. Funding streams include grants that are dispersed annually (e.g., federal Community Mental Health Block (CMHB) grants), time-limited grants (e.g., PBHCI), and payments from health care insurers (e.g., Medicaid, Medicare). Funding from insurers may be paid directly to CMHCs, or may be mediated by managed care organizations, whose aims include cost control. The specific rules that govern each funding stream (e.g., what types of services/providers are reimbursable, at what amount) differ widely across payers. While CMHCs are accustomed to navigating behavioral health payment streams, integrated care requires CMHCs to develop new pathways for funding care coordination and physical health services.

**Figure 1. Sources of funding for services provided by CMHC-based integrated care programs**



Adapted from Smith et al., 2005

Traditionally, reimbursement from insurers has been more generous for physical health care services than for mental health or substance abuse treatment programs (e.g., Frank & Glied, 2006); however, this is changing due, in part, to health care reform mandates requiring behavioral health services coverage. This is discussed in more detail in the section on other influences on CMHC funding environments, later in this chapter.

CMHCs vary in terms of the proportion of funding they receive from grants (e.g., CMHB grants, state-specific funding) vs. health care insurers (e.g., Medicaid, Medicare, private

insurance). For CMHCs that receive a significant proportion of their funding through reimbursement from health care insurers, their funding environment depends in large part on the distribution of insurance status among their consumer populations. The majority of adults with SMI have historically been either uninsured, or covered by public health insurance programs (i.e., Medicaid and/or Medicare) (Pratt, Dey, & Cohen, 2007). Data from the first three cohorts of PBHCI grantees show wide variability in the distribution of insurance status among integrated care target consumer populations (see Table 2), with a majority of consumers expected to be beneficiaries of Medicaid and/or Medicare. (Changes in insurance coverage related to health care reform are discussed in more detail below.)

**Table 2. Distribution of health insurance coverage among PBHCI programs' target populations of adult consumers with SMI**

Health Insurance Coverage <sup>a</sup>	Percent of PBHCI program target population Median (Range)
Medicaid	<b>66 (3-99)</b>
Medicare	<b>21 (3-95)</b>
Uninsured	<b>22 (4-64)</b>

NOTE: From Scharf et al., 2013, data based on grant proposals submitted by first three cohorts of PBHCI grantees (N=56)

<sup>a</sup> Medicaid and Medicare were not mutually exclusive categories

Efforts to develop financial-sustainability for integrated care programs for adults with SMI focus primarily on reimbursement from public health insurers (Medicaid and Medicare) because they cover a significant proportion of the target population, and provide a regular source of funding. This remainder of this section provides a general overview of Medicaid and Medicare. The following section provides an overview of health care payment approaches, with specific examples of models used in financing integrated care services.

### *Medicaid*

Medicaid is a state-run health insurance program (with federal funding contributions) for individuals and families with limited income and resources. While there are some federally mandated requirements, there is tremendous variation across state Medicaid plans in eligibility requirements, what services are covered, how care is delivered, and how providers are reimbursed (KFF, 2013). Medicaid eligibility, coverage, and payment rules have changed (or are currently in the process of changing) as a result of the ACA, and these changes are discussed in more detail below.

Prior to the ACA, adults with SMI could qualify for Medicaid through the following pathways:

1. Inclusion in a federally mandated eligibility group: e.g., low-income pregnant women, parents;
2. Qualifying for Supplemental Security Income (SSI), a federal cash assistance program for low-income individuals who are old or disabled, including disability due to mental illness or substance abuse;<sup>12</sup> or
3. Inclusion in state-specific low-income groups beyond those federally mandated.

As of 2011, only eight states (including DC<sup>13</sup>, Hawaii, Arizona, Minnesota, New York, Vermont, Connecticut, and Delaware) provided Medicaid or Medicaid-equivalent coverage to low-income adults who had not qualified for SSI (KFF, 2011), leaving many low-income adults with SMI across the nation without health insurance.

The Medicaid expansion component of the ACA was intended to address such gaps in coverage by expanding federally mandated coverage to all individuals with incomes under 133% of the federal poverty level. In participating states, Medicaid expansion will lead to more adult with SMI having Medicaid coverage, and, consequently, more Medicaid funds potentially available to support CMHC programs. In non-participating states, integrated care programs are likely to serve a higher proportion of uninsured consumers, and will rely more heavily on federal and state grant funding, such as CMHB grants. Approximately 3.4 million adults with SMI are expected to gain insurance coverage as a result of the ACA.<sup>14</sup>

## *Medicare*

Medicare is a federally funded and administered health insurance program that covers individuals ages 65 and older, younger adults with permanent disabilities, and people with end-stage renal disease. Adults with SMI under the age of 65 qualify for Medicare after receiving Social Security Disability Income (SSDI) payments for 24 months. Qualification for SSDI requires an individual to (a) meet a threshold of prior work experience based on age at time of disability onset (in contrast to SSI, which does not have prior work requirements), and (b) have a

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<sup>12</sup> A minority of states have more restrictive criteria for providing Medicaid benefits for SSI recipients

<sup>13</sup> For ease of discussion, Washington DC is referred to as a “state” in this paper

<sup>14</sup> Obtaining the estimate of 3.4 million adults with SMI: A 2011 study estimated that 3.7 million adults with severe mental disorders would gain health insurance coverage once the ACA was fully implemented in 2019 (Garfield, Zuvekas, Lave, & Donohue, 2011).; however, these estimates were made prior to the Supreme Court decision to effectively allow states to opt out of Medicaid expansion. As a result of the Supreme Court decision, the Congressional Budget Office (CBO) revised its projections for changes in health insurance coverage noting that the expected reduction in number of uninsured individuals by 2022 had fallen from 33 million to 30 million (CBO and staff of the Joint Committee on Taxation, July 2012, available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>). Some individuals with incomes between 100% and 133% of the FPL who would have been covered under Medicaid expansion will receive subsidized coverage through Health Insurance Exchanges; however, some of these individuals will choose to remain uninsured due to the remaining non-subsidized costs of coverage. Individuals with incomes under 100% of the FPL who are not covered by their state Medicaid programs will not be eligible for Exchange plan subsidies, and are expected to remain uninsured. This all suggests that the 2011 estimate of 3.7 million adults with severe mental disorders gaining coverage through the ACA is an overestimate. Applying the CBO’s correction of its projection to this 3.7 million estimate, the revised estimate is approximately 3.4 million.

medically determined mental or physical impairment that precludes the individual from returning to gainful employment (KFF, 2010). Approximately 30% of individuals qualifying for SSDI do so based on a mental disorder (Garfield, 2011).

## Payment Models

Payment models refer to the different approaches used by health care payers to pay for the health care provided to insured consumers. Optimally, payment models should support high value care, incentivizing providers to provide high quality care while also controlling total costs of care. This section provides background information to support better understanding of the different payment models currently being used (or proposed) within CMHC-based integrated care programs; I then provide specific examples of these models.

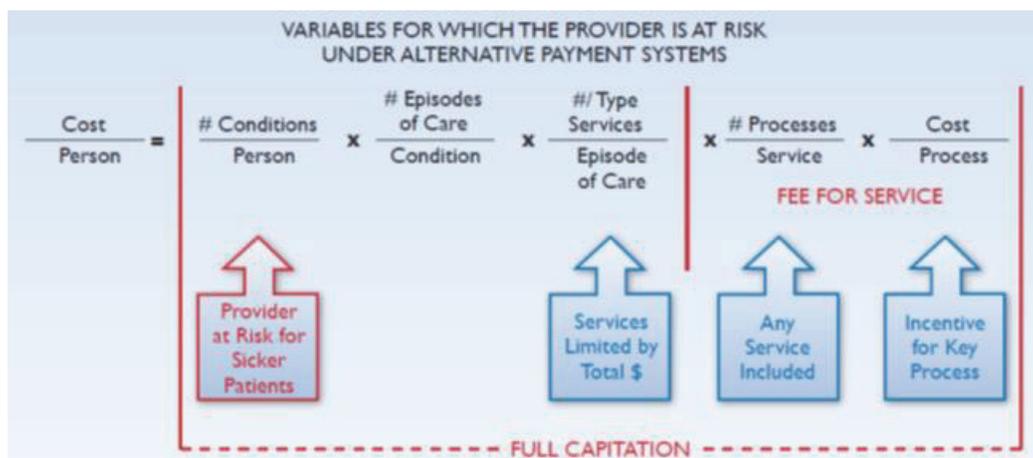
### *Conceptual Background*

Fundamentally, costs of care are determined by two factors: (1) quantity of services provided (or utilization) and (2) price/cost of services; however, to better understand differences in payment models, it is useful to examine contributing components of these factors in more detail, as shown in the equation below (Figure 2).

For adults with SMI and comorbid physical health conditions, examples for each of these components of total cost of care per person are as follows:

- *# Conditions per Person*: e.g., schizophrenia, diabetes, heart disease
- *# Episodes of Care per Condition*: e.g., number of psychotic episodes, number of heart attacks.[For chronic conditions, episodes can be defined as periods of time (e.g., year with depression). In practice, how to define an episode of care for chronic diseases is complex, and discussed in more detail elsewhere (e.g., Hussey, Sorbero, Mehrotra, Liu, & Damberg, 2009)]
- *# and Types of Services per Episode*: e.g., number of visits to CMHC providers, emergency departments
- *# Processes per Service*: e.g., for visits to CMHC providers: time spent with psychiatrists, counselors, case managers; medications provided; lab tests; time spent by providers for care coordination
- *Cost per Process*: e.g., cost of staff time, medications, supportive infrastructure

**Figure 2. Variables that contribute to costs of care per consumer, and comparison of provider risk under fee for service vs. full capitation**



Source: Network for Regional Healthcare Improvement (NRHI), 2009<sup>15</sup>

Payment models (e.g., fee-for-service (FFS), capitation) differ in terms of balancing payer vs. provider financial risk for each of these components/variables. In FFS models, providers are reimbursed a fixed fee for each (reimbursable) discrete service they provide (e.g., 15-minute visit with psychiatrist, medication prescribed). As such, providers are only at risk for the number and costs of processes within each reimbursable service, and not for other components in the cost equation shown in Figure 2. FFS has been criticized as a driver of high costs and comparatively low quality of health care provided in the U.S., because providers are financially rewarded for providing a high volume of services (i.e., more visits, and more services per visit), regardless of whether these services are cost-efficient or in the best interests of the consumer (SAMHSA, 2013).

In contrast to FFS, full capitation models put providers at risk for all care costs (i.e., the entire cost equation shown in Figure 2) by giving providers a fixed payment per time period per consumer to cover all services provided during the time period. If the actual cost of care for an individual is larger than the fee dispensed, the provider is fully responsible for covering those costs. Without oversight, providers in a capitated system would be financially rewarded for providing the fewest possible services to consumers. To counterbalance this incentive, capitated payment arrangements require providers to meet certain quality standards.

Successful capitated payment approaches depend critically on the way in which capitated rates are calculated, which may be especially difficult when establishing payment rates for adults with SMI. Capitation rate calculation typically involves consideration of the case-mix of a population (i.e., demographic and medical characteristics), local costs associated with service

<sup>15</sup> Robert Wood Johnson Foundation and Network for Regional Healthcare Improvement, “Better ways to pay for health care”, available at: <http://www.rwjf.org/content/dam/web-assets/2009/01/better-ways-to-pay-for-health-care>

provision, and average utilization. The use of average utilization (e.g., as observed within FFS systems) may be inappropriate for adults with SMI because utilization under FFS may vastly underestimate needed services for the subgroup of adults with SMI who have historically had considerable unmet health care needs in FFS systems (e.g., Jones, et al., 2004; KFF, 2012). Furthermore, if capitated payments are made to a clinic based on the service utilization of their own consumers over the previous year, the same perverse incentives exist as in fee-for-service arrangements wherein providers benefit from providing a larger quantity of services, regardless of quality or cost-control concerns.

### *Payment Models in CMHC-Based Integrated Care*

This section describes various models of reimbursement that CMHCs face when funding their integrated care programs. The following section describes financing challenges that PBHCI grantee programs face, many of which are directly related to the payment models described here.

#### **Fee-for-Service (FFS)**

CMHCs have traditionally received the majority of Medicare payments through a FFS approach (KFF, 2010). In January 2015, however, the Department of Health and Human Services (HHS) announced explicit goals to move away from traditional FFS payments: e.g., by the end of 2016, 30% of traditional FFS payments are to be tied to quality or value through alternative payment models.<sup>16</sup>

CMHCs may also be reimbursed for services provided to Medicaid beneficiaries using a FFS approach.<sup>17</sup> Even in states that use capitated approaches in Medicaid plans, the capitated fee may be paid to a third-party managed care organization (MCO), which then dispenses payments to CMHCs (and other providers) using a FFS approach.

Medicare and Medicaid reimburse providers for physical health services, and some mental health services. States with more generous Medicaid FFS plans reimburse for care coordination/management services, and other support services that integrated care programs may include, such as non-emergency transportation to health services. Historically, Medicare has not reimbursed for care management, non-emergency transportation, or peer support services (Garfield, Lave, & Donohue, 2010); however, as of January 2015, Medicare will cover non-face-to-face care management services for beneficiaries with two or more chronic conditions.<sup>18</sup>

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<sup>16</sup> HHS press release, January 26, 2015, “Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value”, available at: <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>

<sup>17</sup> Data are lacking to indicate the likelihood CMHCs receive FFS as opposed to capitated payments for Medicaid beneficiaries

<sup>18</sup> See Federal Register, Vol. 79, No. 219, November 13, 2014; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Final Rule: available at

Proposals for Medicaid CCBHCs (currently under development, as described in Chapter 1) include reimbursement for care coordination services.<sup>19</sup>

### Capitated Payments for Coordination Services

Some CMHCs (or integrated care partner organizations) receive a capitated payment (often administered per-member per-month (PMPM)) to cover a set of care coordination services, often including services that are not reimbursed in FFS models. Outside of the scope of these coordination services, payment for other services may use a FFS or capitated approach.

Primary Care Case Management (PCCM) is an option provided by some state Medicaid plans, in which a primary care provider receives a per member per month (PMPM) payment to support care management. PCCM can be used to cover integrated care services like communication among providers and telephone consults with consumer, but are more likely to be paid to CMHC primary care partners, rather than directly to a CMHC. As of 2010, 31 states reimbursed for PCCM (Gifford et al., 2011). Enhanced PCCM models involve higher-intensity coordination and quality assurances, and are specifically aimed at caring for beneficiaries with chronic conditions such as SMI. As for 2010, 9 states reported having enhanced PCCM programs (Gifford et al., 2011).

Medicaid Health Homes is an optional Medicaid benefit created by the ACA to promote care coordination for beneficiaries with chronic diseases, such as SMI and comorbid physical health conditions. As of May 2012, four states had proposed PMPM approaches to fund care coordination provided by their behavioral Health Homes, with considerable variation in payment rate and approach:<sup>20</sup>

- *Flat payments:* Missouri pays a flat rate of \$78.74 PMPM for enrollees in behavioral Health Homes. Rhode Island pays a flat rate of \$442.21 PMPM. Both states require that enrollees receive services on at least a monthly basis.
- *Adjusted for case-mix and/or geography:* New York adjusts PMPM which range from approximately \$75 to \$390 PMPM based on geography and consumer case-mix (e.g., diagnosis, illness severity). Health Home enrollees must receive services on at least a monthly basis.
- *Adjusted for provider tier:* Oregon adjusts PMPM payments (\$10, \$15, or \$24) based on the level of a Health Home provider's functions using state-developed criteria. Health Home services must be documented at least quarterly for providers to receive reimbursement.

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<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html?DLPage=1&DLSort=2&DLSortDir=descending>

<sup>19</sup> SAMHSA, Demonstration Program to Improve Community Mental Health Services (Section 223 of the Protecting Access to Medicare Act of 2014): <http://www.samhsa.gov/about-us/who-we-are/laws-regulations/section-223>

<sup>20</sup> A July 2012 review of key issues in States' implementation of Health Homes by the National Academy for State Health Policy is available at [http://www.nashp.org/sites/default/files/health.home\\_\\_state\\_\\_option.strategies.section.2703.pdf](http://www.nashp.org/sites/default/files/health.home__state__option.strategies.section.2703.pdf)

## Capitation and Risk-Based Managed Care Organizations (MCOs)

In risk-based MCO arrangements, states pay MCOs a capitated rate per Medicaid beneficiary to cover a full range of services (e.g., all physical and/or behavioral health care). Most states adjust capitation rates based on beneficiary demographic characteristics, eligibility category, and health status. As of 2010, 36 states (including DC) contracted with risk-based MCOs (Gifford et al., 2011). Among them, 21 MCO arrangement had behavioral health carve-outs, meaning that behavioral health services were not covered under the same fixed fee, or administrative oversight, as for medical services. Given the growing emphasis on integrated care, and high rates of behavioral and physical health comorbidities among Medicaid enrollees, some states are revisiting or reversing the use of MCO behavioral health carve-outs (Frank & Garfield, 2007; Gifford, Smith, Snipes, & Paradise, 2011). Alternatively, payers may require MCOs to contractually commit to coordination and information-sharing with behavioral health providers and organizations (Gifford et al., 2011). Although MCOs receive capitated payments from payers, such as Medicaid, the payment approach they use in reimbursing CMHCs may be either FFS or capitated.

## Shared Risk/Savings

In contrast to full capitation models, in which providers bear all financial risk for the costs of care, shared risk models involve financial risk-sharing between payers and providers. In these models, a target is predetermined to cover all spending on a consumer during a set time period, then compared to actual spending during that time. If actual spending is lower than the target, this difference (i.e., savings) is shared between the payer and provider. A shared risk agreement is asymmetric if the provider can only share in savings, but is not liable for losses if spending is higher than the target. Shared risk is symmetric if the provider may share both losses and savings.

Accountable care organizations (ACOs) are groups of providers (e.g., individual primary care physicians and specialists, physician groups, and hospitals) that are jointly accountable for the quality and cost of care for a defined set of patients (Shortell & Casalino, 2008). In Medicare ACO programs, Medicare uses a shared risk approach for reimbursing providers. Despite the lack of explicit emphasis on behavioral health care in current Medicare ACO regulations, experts expect ACOs to include behavioral health providers, given the high costs of care associated with comorbid behavioral and medical conditions (e.g., Bao et al., 2013; O'Donnell et al., 2013). A 2013 publication about the extent to which behavioral health has been integrated across ACOs found that 36% of ACOs had no formal relationship with behavioral health providers, whereas 43% included behavioral health providers within the ACO, and the remaining 21% contracted with external behavioral health providers.<sup>21</sup>

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<sup>21</sup> Organizational and Financial Integration of Behavioral Health into Accountable Care Organizations by Van Citters et al., 2013, available at <http://academyhealth.org/files/2013/sunday/vancitters.pdf>

Although ACOs typically begin with asymmetric shared risk arrangements (i.e., providers may share in savings accrued, but are not liable for losses), some payment plans involve progression toward symmetric shared risk (e.g., see Maine and Minnesota)<sup>22</sup>, although losses may be capped by a predetermined amount.

## Other Influences on CMHC Funding Environments

### *Expanded Coverage for Behavioral Health*

As of 2014, the ACA mandates that all Medicaid programs will be required to cover mental health and substance abuse treatment services, and anti-smoking medications; these benefits will also be subject to federal parity regulations (discussed below). States will have flexibility in determining the specific set of services to be covered within federal guidelines, so considerable variability in services covered across states is likely to persist. The expansion of behavioral insurance coverage is expected to support the financing of integrated care in CMHCs by providing a general increase in the availability of funds for these clinics.

### *Parity Legislation for Behavioral Health*

The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) is a federal law that mandates that health insurance requirements of consumers (e.g., co-pays, deductibles) and treatment limitations (e.g., visit limits) applicable to behavioral health benefits be no more restrictive than those applied to medical benefits.<sup>23</sup> The purpose of parity legislation is to correct a long-standing disparity in which coverage for behavioral health services has typically been more restricted than coverage for general medical health services. The disparity has been manifest in higher cost-sharing for behavioral health compared to medical or surgical treatments: for example, prior to the MHPAEA, co-insurance (i.e., the percentage of costs paid by consumer) for behavioral health services was typically 50% compared to 20% for outpatient medical services (Barry et al., 2003).

The MHPAEA broadly takes effect in 2014, and its effects on CMHCs are still unknown. To comply with mental health and substance abuse parity regulations, health insurers may move away from the common administrative and financial separation of behavioral health and medical payment streams. For example, full capitation plans covering both behavioral health and medical services may become more prevalent. If capitation rates are set appropriately to cover necessary

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<sup>22</sup> National Academy for State Health Policy, Accountable Care Organization payment: <http://nashp.org/aco/payment>

<sup>23</sup> The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Public Law 110-343, Sections 511 and 512 is available at: <http://www.gpo.gov/fdsys/pkg/PLAW-110publ343/html/PLAW-110publ343.htm>

expenditures, the shift toward combined financing for behavioral health and medical services has the potential to support integrated care efforts.

## Chapter 3. Barriers to Financial Sustainability of CMHC-Based Integrated Care

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### Overview

This chapter describes barriers to financial sustainability that may affect CMHC-based integrated care programs. The literature on these barriers is limited, in part because most integration efforts have focused on bringing behavioral health care into medical settings and not the reverse model studied here (i.e., physical health care in mental health settings). Barriers for medical-setting-based programs described in the literature are included here when they are also relevant to CMHC-based integrated care; however, the barriers described in this section are primarily based on anecdotal reports by PBHCI grantees across several states,<sup>24</sup> as well information gained from a recent study of integrated care initiatives in New York state (Scharf, Breslau, et al., 2014).

The implementation of integrated care within a CMHC involves both transition costs (i.e., start-up costs) as well as the ongoing costs of providing physical health care, care coordination, and wellness services. Transition costs are related to training staff, developing new protocols and clinical workflows, establishing physical health record systems, and preparing physical space, which may include building renovations as well as the purchase of medical equipment. Ongoing costs are related to the services that are added to a behavioral health treatment program to create an integrated care program (Table 3). Under traditional fee-for-service environments, some components of integrated care have been more easily reimbursable than others. Information is lacking about reimbursement for services covered under bundled or otherwise capitated payment models, which are expected to become increasingly common given health care reforms (as discussed in the previous chapter).

The particular set of financial barriers faced by an individual integrated care program depends on state-specific funding and regulatory environments, the distribution of health insurance status among program consumers, the organization structure of the program (e.g., whether organizational partners are involved), and other program characteristics. For example, programs that serve mostly Medicaid beneficiaries are largely affected by their particular state's Medicaid regulations. Programs that serve mostly uninsured consumers rely on discretionary state funds and corresponding regulations. For programs that involve partnership organizations, financing procedures must be negotiated between the organizations. Programs with partner

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<sup>24</sup> Anecdotal reports were primarily obtained during site visits I attended in California, Florida, Ohio, Virginia, and Washington as part of the RAND evaluation of PBHCI (Scharf, Eberhart, et al., 2014), and in New York State as part of RAND's examination of integrated care in New York State (Scharf, Breslau, et al., 2014)

organizations may also leverage funding opportunities available to non-CMHC providers (e.g., prospective payments for FQHCs).

**Table 3. Level of CMHC financing difficulty across types of services that may be added to CMHC behavioral health treatment programs to develop integrated care**

<b>Integrated Care Service Type</b>	<b>Example Services</b>	<b>Relative Level of Financing Difficulty:<sup>a</sup> Description</b>
Primary care services	<ul style="list-style-type: none"> <li>• Treatment for chronic conditions (e.g., diabetes, hypertension, asthma)</li> <li>• Treatment for acute conditions (e.g., sore throat, back pain)</li> <li>• Referrals to medical specialists</li> </ul>	<i>Med:</i> services are generally reimbursable given appropriate licensing and staff, although not necessarily at an adequate rate to account for extra time required to serve SMI consumers
Preventive care services	<ul style="list-style-type: none"> <li>• Screening and assessments for physical health conditions</li> <li>• Immunizations</li> </ul>	<i>Low:</i> services are generally reimbursable given appropriate licensing and staff
Wellness activities	<ul style="list-style-type: none"> <li>• Nutrition education</li> <li>• Disease management (e.g., diabetes education)</li> <li>• Tobacco cessation services</li> <li>• Exercise groups</li> <li>• Social support groups</li> </ul>	<i>Med:</i> services reimbursable by some payers but not others, reimbursement rates may be inadequate given time and resources required to manage care for complex consumers
Coordination of care among providers	<ul style="list-style-type: none"> <li>• Communication among providers (e.g., medical, mental health, or other specialists) within and across organizations/settings to support coordinated and collaborative consumer treatment</li> <li>• Support staff to facilitate communication among providers</li> </ul>	<i>High:</i> services often not reimbursable, or not reimbursed at an adequate rate to sustain employment of qualified wellness educator staff
Care management/navigation support for consumers	<ul style="list-style-type: none"> <li>• Monitoring consumer participation in and response to behavioral health and medical treatments (with care management service intensity proportional to consumer complexity)</li> <li>• Linking consumers to needed services (e.g., medical specialists)</li> </ul>	<i>High:</i> coordination activities among providers are generally not reimbursable
Additional consumer support services	<ul style="list-style-type: none"> <li>• Transportation assistance for consumers to access health care services</li> <li>• Peer support (e.g., to encourage consumer participation in treatment)</li> </ul>	<i>High:</i> peer support and transportation services are reimbursed by some payers but not others; non-health-care funding sources may be necessary to support social service support

<sup>a</sup>Levels of financing difficulty are described from the perspective of CMHCs, and reflect traditional fee-for-service reimbursement environments.

Barriers described below include general limitations in behavioral health funding, licensing requirements, billing restrictions, lack of coordination among payers and regulatory agencies, and difficulty developing cost-efficient workflow models.

## Barriers

### *General Limitations in CMHC Funding*

Funding for CMHCs is limited and generally in decline (Honberg, Diehl, Kimball, Gruttadaro, & Fitzpatrick, 2011). Some clinics serve a significant proportion of consumers who are uninsured, which means these clinics cannot rely on regular reimbursement from health care payers for services provided, and must instead seek uncertain discretionary funding sources and otherwise subsume costs of care. Reimbursement rates for behavioral health services have also been criticized as being inadequate to cover the costs of providing care (Appelbaum, 2003; Kathol, et al., 2010).

Given such scarce resources, it may be difficult for CMHCs to spend the time and resources necessary to implement a new care delivery system like integrated care. In addition to the costs of providing physical health and wellness services to their consumers, CMHCs often face considerable initial transition costs related to training staff, developing new protocols and clinical workflows, establishing physical health record systems, and preparing physical space.

Limited funding is especially problematic for CMHCs that are freestanding, or unaffiliated with hospitals or other health care organizations. Integrated care approaches are expected to generate cost-savings within the larger system of health care due to, for example, associated reductions in hospitalizations or emergency department visits. However, CMHCs themselves will not typically experience such savings. A health care organization that encompasses a behavioral health clinic may be willing to take on the additional costs associated with integrated care incurred by the behavioral health clinic if there are savings to be achieved in other organization areas (e.g., hospitals). Freestanding behavioral health clinics have less flexibility to absorb these additional costs. One way this can be remedied is if the behavioral health clinic receives compensation from payers for reducing costs to other health care organizations, for example through reductions in emergency department visits. (This type of shared savings occurs in ACOs, as described in the section above.)

### *Licensing and Credentialing*

#### **Agency-Level Requirements**

CMHCs that hire primary care providers directly into their agency (i.e., by following the In-House model of integrated care) must ensure that their agency has the appropriate licensing to be able to bill payers for providing physical health services, and to meet state-specific regulations. This process typically involves a number of licensing-specific requirements, including specific parameters about the preparation of space for physical health care services that may be burdensome and costly for the behavioral health clinic.

In models where CMHCs partner with physical health organizations (e.g., FQHCs) that provide medical personnel, the physical health organization may also be required to apply for

additional licensing. For example, FQHCs that have not previously provided behavioral health care must apply to HRSA for a “change of scope” approval to allow their employees to provide services at a behavioral health site (Brolin, et al., 2012). These health clinics may also be required to apply for licensing from state mental health authorities (e.g., in New York, the Office of Mental Health). The specific requirements of agency licensing may be time-consuming and, in some cases, may involve costly changes to building or information system infrastructure. Approval processes are also often prolonged over extended periods of time, during which clinics are unable to begin providing their integrated care services and gaining reimbursement.

### Provider-Level Rules and Requirements

Health care payers require service providers to have specific licensing or credentialing to be eligible for reimbursement when providing services. These requirements often differ across payers (e.g., Medicaid, Medicare, private insurance) and settings (e.g., behavioral health clinic, primary care clinic, hospital).

These inconsistencies can be complex and costly for integrated care programs to navigate. For example, some payers may reimburse nurses providing wellness education services in a behavioral health setting at a lower rate than social workers providing the same services. These payers may also reimburse nurses at a higher rate for providing the same services in a physical health care setting instead of a behavioral health setting. Programs must devote considerable administrative staff time and resources to determine which providers can provide services under various settings for consumers covered by different health care plans. Multiple staff providing the same services may be required simply to meet licensing or credentialing requirements of different payers.

Some licensing requirements may also be unnecessarily stringent for services that are important components of integrated care. For example, peer specialists (i.e., behavioral health service consumers who are trained to provide support to their fellow peers) may be particularly effective for supporting integrated care through case management or wellness support, but their services are often not reimbursable by existing plans. Overly stringent licensing or credentialing requirements of providers threaten programs’ financial sustainability because programs must generally pay higher salaries or pay rates to support providers with additional licenses or credentials. In 2012, Georgia became the first state to have Medicaid-reimbursable whole health and wellness support provided by certified peer specialists.<sup>25</sup> Regulations mandate that these peer specialists be certified in Whole Health Action Management (WHAM), a training program that promotes physical and mental health self-management and preventive resiliency.

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<sup>25</sup> Center for Integrated Health Solutions (CIHS) summary available at: [http://www.integration.samhsa.gov/workforce/NASMHPD-CIHS\\_GA\\_Peer\\_Whole\\_Health\\_Coaches.pdf](http://www.integration.samhsa.gov/workforce/NASMHPD-CIHS_GA_Peer_Whole_Health_Coaches.pdf)

### *Same-Day Billing Restrictions*

A number of payers do not reimburse providers for two or more services provided to a given consumer on the same day when these services are billed using the same (agency-level) provider number. As of 2007, Medicaid programs in 14 states did not cover such same-day visits (see Brolin, et al., 2012). Consequently, if a Medicaid beneficiary in one of these states received care from an integrated program in a behavioral health clinic and saw both a physician and a psychologist in the same day, the clinic would only be able to bill Medicaid for one of these services. This is a significant problem given that a key benefit of integrated care is the consumers' ability to visit multiple interdisciplinary services providers during a single day at a single location—a convenience that is expected to increase the likelihood that consumers follow-through with recommended treatment plans.

Same-day billing restrictions can be circumvented by integrated care programs that involve a partnership between physical and behavioral health care organizations. In these cases, behavioral health services can be billed under the provider number of the behavioral health organization, and primary care services can be billed under the primary care organization provider number. The national Center for Integrated Health Solutions (CIHS) offers state-by-state assistance on navigating state-specific billing requirements, including same-day restrictions.<sup>26</sup> It is notable that same-day billing restrictions are not federally mandated and, in fact, Medicare does allow a physical health and mental health visit on the same day by the same provider.<sup>27</sup>

### *Insufficient Reimbursement*

#### *Integrated Care Services*

In traditional fee-for-service environments, most payers do not reimburse providers for a number of services associated with integrated care, such as wellness activities and other services that promote consumer self-management (e.g., exercise groups, illness management education and support groups). Typically, there is also no mechanism for providers to claim reimbursement for time spent communicating or collaborating with other providers about a particular consumer, which is another important aspect of integrated care. Furthermore, there are typically no reimbursement mechanisms in place to finance consumer engagement. Encouraging individuals with SMI to take part in integrated care programs, to follow-through with their treatment plans, and to follow-up with primary care and specialist providers is a vital aspect of integrated care and can be resource-intensive, requiring relationship- and trust-building, frequent reminders of upcoming appointments, and assistance with logistics such as transportation.

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<sup>26</sup> CIHS billing tools available at: <http://www.integration.samhsa.gov/financing/billing-tools>

<sup>27</sup> According to Code of Federal Regulations Title 42 Volume 2, Part 405. Section 405.2463

As mentioned in earlier sections of this paper, little is known about the details of capitated payment models that cover CMHC-based integrated care. This is a planned area of inquiry in the dissertation research project for which the current paper's contents were originally developed.

### Physical Health Care Services for Adults with SMI

Unlike for the wellness, care coordination, and consumer engagement services described above, primary and preventive care services are generally reimbursed by all health care payers once the clinic and individual providers have secured appropriate licensing. However, the rates at which these services are reimbursed are often inadequate given the complexity of the population being served. Adults with SMI often have multiple physical and mental health comorbidities in addition to cognitive or communication limitations which lengthen the time required by a practitioner to assess and serve their health needs. As a result, physical health practitioners serving adults with SMI are unable to see consumers at a rate equivalent to that for practitioners serving the general population. Some providers report that visits with SMI consumers take on average three times longer than visits with the general population. Total payments collected may be insufficient to sustain the salary of physical health providers.

### *Lack of Coordination Across Payers, Plans, and Regulators*

The various health care services provided to a given consumer are often reimbursable by different organizational entities. For example, care for dual eligible consumers is funded by both Medicaid and Medicare, which are separately administered. Most managed care arrangements involve carve-outs in which separate health plans are responsible for managing care and reimbursing providers for different sets of services. The organizational separation that results from carve-outs inhibits referrals, communication, and coordination of care between behavioral health and medical providers (Frank & Garfield, 2007).

To receive reimbursement for these various sources, provider clinics must follow requirements and protocols that are typically not coordinated across organizational entities. These requirements involve licensing, credentialing, and reimbursement restrictions as described above, as well as varied data reporting and claim submission protocols. Navigating these varied requirements and protocols involves administrative complexity that is costly to programs in terms of the staff time and resources.

In addition to the various payer organizations involved in an integrated care program, provider clinics must also interact with a number of regulatory agencies, such as the state mental health authority, substance abuse authority, and department of health, whose policies are typically also uncoordinated. The administrative complexity of meeting the uncoordinated requirements of these agencies may also be costly to programs.<sup>28</sup>

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<sup>28</sup> The non-profit Healthcare Association of New York State published examples of regulatory inefficiencies in 2012 available at [http://www.hanys.org/legislation/reform/docs/2012-04-30\\_still\\_tangled\\_up\\_in\\_rules.pdf](http://www.hanys.org/legislation/reform/docs/2012-04-30_still_tangled_up_in_rules.pdf)

## *Workflow Difficulties*

The implementation of integrated care within behavioral health settings requires programs to add a new set of clinical services and processes to their existing workflow models. As described in Table 3, these services may include screening for physical health conditions, as well as monitoring and treatment of such conditions. New processes may include care management to address consumer physical health needs and communication protocols for behavioral and primary care providers to coordinate care and jointly develop treatment plans. Given scarce resources, programs must design their workflows efficiently to create a financially sustainable integrated care model of care. This involves minimizing time required by staff to complete tasks; for example, some physical health screening questionnaires may be completed by consumers in waiting rooms.<sup>29</sup> Efficiency also requires that programs ensure that staff take on appropriate roles for their qualifications (i.e., work at the “top of their licenses”). The use of over-qualified staff contributes to unnecessarily costly care since staff compensation is generally directly related to their level of qualification. For example, as opposed to nurses or physicians, paraprofessional staff can be sufficiently trained to complete many physical health screenings.

The development of cost-efficient workflow models requires that clinics monitor their existing workflows, assess the strengths and weaknesses of the current approach, identify potentially beneficial workflow changes, and adjust workflows accordingly. This cycle of continuous quality improvement requires systematic data collection, and many behavioral health clinics have limited experience and resources necessary for such efforts. Compared to other health service areas, behavioral health organizations have lagged in terms of incorporating data collection and performance measurement into their organizational models (e.g., Kilbourne, Keyser, & Pincus, 2010). Front-line providers may also be resistant to engaging in cost-control efforts, and may find these concerns to be in opposition to their priorities regarding quality patient care (even though unsustainable costs ultimately means that care will not be provided to consumers).

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<sup>29</sup> “The Business Case for Behavioral Health Care” published in 2013 by CSI Solutions for CIHS provides examples of workflow redesign in the context of integrating behavioral health care into primary care settings [http://www.integration.samhsa.gov/financing/The\\_Business\\_Case\\_for\\_Behavioral\\_Health\\_Care\\_Monograph.pdf](http://www.integration.samhsa.gov/financing/The_Business_Case_for_Behavioral_Health_Care_Monograph.pdf)

## Chapter 4. Conclusion

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Poor physical health among adults with SMI is a significant public health problem (e.g., Parks, et al., 2006) and also contributes to disproportionately high costs of care (e.g., Jones, et al., 2004; Kasper, et al., 2010; Kronick, et al., 2009; Melek, Norris, and Paulus, 2014). Integrated care based in behavioral health settings provides a promising means of improving health for adults with SMI (Alakeson, et al., 2010; Scharf, Eberhart, et al., 2014) and, if strategically targeted toward high utilizers of health care services, may also lead to cost reductions.

CMHC-based integrated care programs, such as PBHCI grantees, have commonly reported financing difficulties as a major barrier to program sustainability (e.g., Butler, et al., 2008; Kathol, et al., 2010; Kilbourne, et al., 2008; Scharf, Eberhart, et al., 2014); however, to date, there exists minimal literature systematically describing the extent and nature of these challenges. The current paper provides a comprehensive (though high-level) overview of issues related to CMHC-based integrated care financing, including (1) variation in CMHC-based integrated care program components to be funded (i.e., range of services and providers that may be included, partnership approaches), (2) complexity in funding environments (e.g., diverse funding sources and payment models; recent and anticipated changes related to health care reform), and (3) specific types of financing barriers CMHCs may face. Barriers identified include general limitations in behavioral health funding, licensing/credentialing rules and requirements, billing restrictions, lack of coordination among payers and regulatory agencies, and difficulty developing cost-efficient workflow models

Funding to support physical health, mental health, and substance abuse treatment in integrated care programs involves a diverse set of payers, reimbursement approaches, and regulations. Several components of the ACA (e.g., the expansion of access to health insurance, the development of new models of care delivery and reimburse such as Health Homes and ACOs) also have the potential to influence the funding environments of integrated care programs (Mechanic, 2012). Many of these components are currently under development, and their effects on the financial sustainability of integrated care programs have yet to be documented.

A more thorough understanding of the funding challenges faced by a CMHC-based integrated care program requires detailed examination of the program's specific funding environment, as well as its program components and organizational structure. Systematic assessment of these funding challenges is essential to inform policymaking on the part of payers, regulators, and health care organizations that supports financially sustainable integrated care for adults with SMI. Further research is also needed to determine what program components and organizational models of integrated care are associated with most favorable health outcomes, to further support the development of financially sustainable, cost-effective care.

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