Treating the Whole Person by Integrating Care
By Laura Tobler and Chris Edmonds

For many patients, including those enrolled in Medicaid, behavioral health problems—such as stress, anxiety, bipolar disorder, post-traumatic stress disorder, or alcohol and substance abuse—exacerbate their physical ailments. Research shows that total health care costs for treating patients with co-occurring physical and behavioral health issues are exponentially higher than treating them for physical conditions alone. Even when behavioral health disorders are diagnosed and treated, a patient’s primary and behavioral health care services are often conducted separately, and the two or more providers treating the patient may not communicate about that patient’s conditions, diagnosis and treatments.

To improve both the effectiveness and efficiency of Medicaid, state lawmakers are considering and adopting policies to integrate behavioral health and primary care. These initiatives—such as “health homes” (see box)—treat the “whole person” by organizing doctors and other caregivers around patients (sometimes called patient-centered care) so that a team of providers can coordinate primary care, acute care, behavioral health, case management, long-term services and supports, and more.

Modeled after existing state programs, the Affordable Care Act’s (ACA) Medicaid Health Home State Plan Option allows states to design and implement health homes to provide comprehensive, coordinated care to Medicaid beneficiaries with chronic conditions. Participating states receive enhanced federal financing—a 90 percent federal share for the first two years of a state’s approved program—for the costs associated with coordinating care.

The models for integrating care vary. One model requires the primary care practice to screen, support and refer patients to behavioral health specialists (called SBIRT). Another enhances the coordination between behavioral health providers and primary care providers. Some successfully integrated models feature co-location of behavioral health providers and primary care providers.

The Center for Health Care Strategies points to five key steps to integrate care successfully:
- Offer incentives to reward providers for integrating care.
- Support sharing patients’ health care records among various types of providers.
- Establish team-based care, such as medical or health homes.
• Create methods for evaluating the quality of care, so that best practices can be identified and replicated.
• Maintain networks of available providers.

**State Action**
Most state Medicaid programs have implemented models that feature patient-centered care coordination. At least 12 states have received approval from the Centers for Medicare and Medicaid Services (CMS) to establish health homes for Medicaid patients following the new ACA guidance.

**Missouri.** Missouri’s Medicaid health home plan, the first to be approved by CMS, went into effect on Jan. 1, 2012. Under the program, Community Mental Health Centers (CMHCs)—25 behavioral health providers responsible for all patients in their service area—are required to integrate and coordinate care for their most complicated, and therefore most expensive, patients. The CMHC became the patient’s mental health home, which included a team of primary care physicians, behavioral health specialists and case managers located and working together to serve the patient. Evaluation results show improved quality and reduced costs. Since the program began, pharmaceutical costs declined by 23.4 percent, mostly by eliminating unnecessary or contradictory prescriptions; general hospital costs decreased by 6.9 percent; and overall costs went down by 16 percent.

**New York.** The first phase of New York’s Health Homes program also became operational on Jan. 1, 2012. It started in 10 counties and has since expanded statewide. The program targets Medicaid patients who have two or more chronic conditions, or one behavioral health condition, or HIV/AIDS and are at risk of developing another chronic condition. The state estimates that 18 percent of current Medicaid beneficiaries qualify. The providers selected to be health homes receive a fixed payment for each person in the program, which is adjusted for the region and the characteristics of the pool of patients. The health homes are responsible for treating and coordinating care for their patients in an integrated and efficient manner. This initiative currently is being evaluated.

**Federal Action**
In addition to the Affordable Care Act’s Medicaid Health Home State Plan Option, several other federal initiatives aim to coordinate care. The CMS helps states develop integrated care models through the Integrated Care Resource Center. The program is for Medicaid beneficiaries who are also enrolled in Medicare and who have expensive, chronic needs. The federal State Innovation Models (SIM) Initiative provides grants to states to develop health care delivery system transformation models designed to improve health system performance. In addition, federally qualified community health centers, which receive financial support from the federal government, provide coordinated services, including primary care, mental health care, and substance abuse counseling and treatment. Some also offer oral health care and/or 24-hour crisis intervention services.

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**Additional Resources**
The State Health Care Spending Project of the Pew Charitable Trusts and the MacArthur Foundation will release data on the costs of Medicaid, mental health and substance abuse services over the next few months.

Medicaid Health Homes, Centers for Medicare and Medicaid Services.
