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Assessment #8

Financing the Integration of Behavioral Health: Three Cases Studies: Texas, Oklahoma and Georgia

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**Financing the Integration of Behavioral Health:
Three Case Studies: Texas, Oklahoma, and Georgia**

By

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Executive Summary

Financing of integration, for the most part, depends on the programmatic approach each state uses. Within the context of primary care and behavioral health care, full integration exists when all care providers work together to address the primary care and behavioral health needs of individuals in the same setting. Organizations may introduce elements of primary care into their behavioral health practices or may include behavioral health services in a primary care setting.

At the highest level, an organization may elect to develop a fully integrated system where providers work in teams, the consumer's co-morbid conditions are addressed in a holistic manner, and patient records are readily accessible by all provider team members. Organizations that position themselves further along the integration continuum are able to improve the care they provide to their consumers while increasing the efficiency of care delivery and reducing healthcare expenditures.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has been an active partner in shaping the new landscape of healthcare delivery. The [SAMHSA-Health Resources and Services Administration \(HRSA\) Center for Integrated Health Solutions \(CIHS\)](#), run by the National Council for Behavioral Health, has provided training and technical assistance to help states address the clinical, operational, and administrative challenges associated with the path to integration.

One of the integration initiatives promoted by the CIHS is SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) model has been adopted by providers across the country. PBHCI coordinates and integrates primary health care with mental health services to help prevent and reduce chronic disease and promote wellness. Laura M. Galbraith, CIHS Director, summarizes the transformation to an integrated system as a process which moves the system from "case to care management." Some PBHCIs integrate services further through partnerships with other community providers such as Federally Qualified Health Centers (FQHCs)/Community Health Centers (CHCs). These partnerships occasionally manifest themselves through the co-location of staff to make the delivery system appear seamless.

Effective integration by state programs requires an effective braiding of multiple funding sources. Payers are increasingly adopting integrated care models, medical homes in particular. The medical home/health home model has been instrumental in the transformation of healthcare delivery from a siloed to a more holistic approach. The medical home is focused on the delivery of traditional medical care, whereas the health home model created and promoted by the Affordable Care Act (ACA), is a more behaviorally-focused integrated care model. While a medical home can receive payments from a wide range of payers, the health home model, created under § 1945 of the Social Security Act¹ and created for individuals with multiple chronic conditions—including mental health conditions and substance use disorders—is intended to be Medicaid-funded.

¹ 42 U.S.C. § 1396w-4, enacted under § 2013 of the ACA.

However a number of state agencies, such as the Oklahoma Health Care Authority, were implementing [patient-centered medical homes](#) for primary care delivery in their Medicaid programs prior to enactment of the ACA, using the authority to implement managed care under § 1932(a) of the Social Security Act² or the § 1115 Medicaid waiver authority³ to stimulate development and testing of integrated models of care through CMS-approved demonstrations and pilots.

In a state that has been very active in implementing integration efforts, the Texas Mental Health Authority and the Texas Medicaid agency have been successful in blending diverse funding sources to create an integrated system. The State of Texas funds behavioral health services through a variety of state general revenue, local, and federal funding sources. The majority of the funds available to pay for behavioral health services in Texas are authorized through the Texas Department of State Health Services (DSHS) budget. Federal funding is accessed through a variety of avenues, including the Mental Health and Substance Abuse Block Grants, Federal Medicaid matching funds (FMAP), and Medicare. A variety of other grants, contracts, and receipts make up the balance of the funding.

In their coordinated efforts to integrate services, the Texas agencies have learned that agency management styles and assessment systems often need to be better aligned to facilitate true integration. Ongoing communication and data sharing between data collection functions are essential to facilitating integration efforts. Texas has even used grant funds to physically locate a state staffer at the Federal level; HHS was involved in the personnel selection process and helped to establish the parameters and responsibilities of the staff person.

Results from state efforts to integrate vary, but data appears to indicate that moving to an integrated model results in state savings as well as positive health outcomes. At least one state, Oklahoma, has changed its payment system due to the success it has had in implementing its patient-centered medical home initiative. Oklahoma transitioned out of volume-based fee for services in favor of an incentive-based reimbursement system. To do this, the state leveraged federal Medicaid dollars, through an amendment to the Medicaid State Plan that was subject to approval by the Centers for Medicare and Medicaid Services (CMS). The CMS approval process was collaborative and included providers, the Oklahoma Health Care Authority, and the Medicaid agency. Outcome measurement and reporting requirements were included to ensure the most effective combination of services.

² 42 U.S.C. § 1396u-2.

³ 42 U.S.C. § 1315.

While a positive business case can be made for integration as an important factor in reducing program costs and enhancing health outcomes, each organization must choose the best model for on its own needs, population, and available resources. However, the use of peers support services can be an effective tool in a variety of integration models and works in different payment environments. In Georgia, Health-Certified Peer Specialists receive medical technical support from registered nurses and are trained to work in both behavioral health and primary care settings. The process includes [Whole Health Action Management \(WHAM\) training](#) developed by CIHS that promotes outcomes of integrated health self-management and preventive resiliency. The primary goals of this training are to teach consumers the skills they need to better self-manage chronic physical health conditions, mental illnesses, and addictions to achieve behavioral health.

Partnerships among providers, regulators, payers, and consumers are key to the success of integration efforts. Being able to braid revenues from various sources to fund integration is critical to successful efforts. State experience and strategy may differ, but one lesson is shared – change will only happen when all stakeholders work together.

This White Paper examines effective efforts at blending state and federal funds and combining stakeholder resources to achieve integration in three states—Texas, Oklahoma, and Georgia—to offer best practices that other states may wish to emulate. The examples provided in this report were gathered through interviews with behavioral health financing experts in each of the states.

Texas

Texas is a large and diverse state, with 254 counties and 39 Local Behavioral Health Authorities. At the state level, the mental health and substance abuse (MHSA) authority is part of the public health agency, which is a component of the health and human services enterprise. The Health and Human Services Commission (HHSC) is the enterprise oversight agency and also includes the single state Medicaid agency. The MHSA authority and Medicaid agency frequently collaborate.

Texas is currently financing integration of behavioral health largely through Medicaid initiatives, implemented through collaboration between the MHSA authority, state Medicaid office and /or other HHSC agencies. These initiatives include an alternative health delivery system for foster children, a § 1115 waiver that funds local delivery system reform projects throughout the state serving both Medicaid and uninsured populations. The § 1115 waiver also integrates behavioral and physical health care services into Medicaid managed care for SSI and Temporary Assistance for Needy Family (TANF) populations.

Additionally, Texas participates in national Medicaid demonstration projects which seek to provide an evidence base to more effectively integrate people with mental illness and substance use disorders, and services relevant to their needs, into the health delivery system. The MHSA authority has also implemented research and demonstration projects in collaboration with its contracted providers. At the local level, three CIHS projects have enabled some communities to test integrated models of care and helped inform their approach to other opportunities for integration

Texas Healthcare Transformation under DSRIP

State level Medicaid behavioral health integration is achieved under the Texas § 1115 Healthcare Transformation Waiver, approved by CMS in 2011. The waiver enabled Texas to expand Medicaid managed care statewide and to incentivize hospitals, local mental health authorities, and other providers, via a Delivery System Reform Incentive Payment (DSRIP) funding pool (\$11.4 billion). Texas is one of three states (in addition to New York and Massachusetts) currently implementing a DSRIP program.

The Texas DSRIP works through 20 regional health partnerships to develop projects to advance the CMS-promoted “Triple Aim” of better care, improved health, and reduced costs of care. Local governmental providers, such as local mental health authorities, provide intergovernmental transfer funds to match federal funds. Providers earn federal DSRIP funds by achieving CMS-approved metrics for their projects.

As of October 2014, there were 1,490 approved DSRIP projects throughout Texas. Over 25 percent of all DSRIP projects relate to behavioral healthcare, seeking to earn approximately \$2 billion (all funds). Behavioral health DSRIP project options include some categories related to integration of behavioral health into the health delivery system. Of the approved projects, 54 seek to integrate behavioral health and primary care, 5 provide virtual

psychiatric guidance to primary care providers, 19 provide mental health peer support services, and 15 provide integrated primary care/behavioral health care management.

DSRIP projects employ a variety of strategies to integrate services. Some examples include:

- integrating primary care services into rural behavioral health centers;
- placing behavioral health providers into primary care settings;
- training and employing mental health peer specialists to provide “whole health” support to mental health consumers to prevent or manage comorbid chronic health conditions;
- developing integrated care management teams that include licensed clinical social workers and community health workers to work with primary care and address comorbid conditions (e.g., diabetes and clinical depression); and
- implementing 24/7 psychiatric and clinical guidance for primary care physicians and hospitals, in order to help physicians identify and treat behavioral health symptoms earlier.

Texas Managed Care

Over the last two decades, managed care has become the dominant model of service delivery in the state, and Texas delivers Medicaid services primarily through capitated managed care. Over time, more populations, geographic areas and behavioral health services have been included. Initially, managed care provided capitated services for the TANF population and included inpatient and outpatient behavioral health services, but not rehabilitative services or targeted case management.

In 1999 Texas implemented the NorthSTAR pilot in Dallas and surrounding counties. NorthSTAR integrates state, local, and federal behavioral health funding to provide a comprehensive behavioral health service array. The NorthSTAR managed care organization contracts with the MHSA authority to deliver managed behavioral health care to Medicaid and indigent clients in the Dallas area. In 2008, the State implemented a capitated Medicaid delivery system under § 1915(a) authority to provide physical and behavioral health services to state foster children via a single managed care delivery system. Behavioral health services in the STARhealth foster care program included inpatient, outpatient, rehabilitative and case management services.

As a result of a state legislative mandate ([Senate Bill 58, 83rd Session](#), Ch. 1143), Texas in September 2014 integrated mental health rehabilitation and targeted case management into capitated Medicaid managed care programs serving SSI adult and TANF populations. Senate Bill 58 requires that the integrated system include networks of well-qualified public and private behavioral health providers, ensure access to services, be recovery-focused, include appropriate assessment tools, performance, and quality outcomes measures and, if cost-effective and beneficial, include peer support services as a benefit. The legislation also authorizes two health home pilots for persons with serious mental illness and at least one other chronic health condition. It also establishes a Behavioral Health Integration Advisory

Committee that includes consumers, MCOs, and providers and mandates a public performance/outcomes reporting system.

Other legislation authorized the future expansion of capitated managed care to cover populations currently optional or excluded from capitated systems, such as children on SSI and individuals with intellectual and developmental disabilities receiving HCBS waiver services.

Capitated Medicaid financing mechanisms can provide advantages over traditional fee for service, such as a more flexible approach to benefits provision. For example, Texas MCOs are required to provide State Plan inpatient hospital care to members. This includes psychiatric care in general acute facilities. MCOs are allowed to contract with Institutions for Mental Disease (IMDs) to provide this care in lieu of general acute hospitals to ensure that required inpatient services are available to members of all ages who need them.

Self-Directed Care

Capitated systems also provide the opportunity to advance creative options such as self-directed care (SDC) for people with severe mental illness. In Texas, a self-directed care model was developed and tested in a randomized trial in partnership with the NorthSTAR managed care organization. In the SDC pilot, adult members managed their behavioral health services budget with the assistance of an advisor and were allowed flexibility to substitute non-traditional for traditional services or goods for services. The SDC pilot resulted in significantly improved outcomes and reduced costs for the intervention group. Participants often chose to purchase goods and services to improve their physical health and well-being, suggesting the importance of integration to recovery.

Under a SAMHSA grant administered by NASMHPD, Texas also initiated a planning process with the state Medicaid agency and other stakeholders to develop guidelines for a potential SDC pilot in the STAR+PLUS program. The potential to integrate some Medicaid physical health funding also exists, since STAR+PLUS includes both physical and behavioral health funding.

National Demonstration Projects: MFP and MIPCD

National demonstrations can also provide an opportunity for states to finance development of the evidence base for integration. Texas has participated in several projects funded by the Centers for Medicare and Medicaid Services (CMS) which has advanced the research base regarding integration. Current demonstration projects include the Money Follows the Person demonstration (MFPD) and the Medicaid Incentives for Prevention of Chronic Disease (MIPCD) study.

MFPD provides enhanced federal funding for demonstration services and full funding for administrative activities, allowing states to test new options with very modest outlay of state revenue. Texas in 2008 included a behavioral health pilot in its MFPD, which integrates evidence-based mental health and substance use treatment services into the HCBS system for adults leaving nursing facilities. It is administered by the MHS authority and provided

in close coordination with other HHSC agencies and Medicaid MCOs. The pilot operates in two service areas, serving over 300 people to date.

Approximately 70 percent of pilot participants served have remained in the community with improved functional outcomes. Examples of increased independence include getting a paid job at competitive wages, driving to work, volunteering, getting a GED, teaching art classes, leading substance use peer support groups and working toward a college degree. Providing services in the community can also save Medicaid money, since community-based care costs about 40 percent less than nursing facility care. The MHSa is currently working with the state Medicaid agency to consider how pilot interventions might be brought to greater scale in the future.

The MIPCD demonstration evaluates the effectiveness of providing incentives to Medicaid beneficiaries to adopt healthy behaviors to prevent or better manage chronic physical health conditions. Texas chose to focus its project on adult STAR+PLUS members with serious mental illnesses and members who have behavioral health conditions coupled with chronic physical health conditions.

Wellness Incentives and Navigation (WIN) under MIPCD

The Texas MIPCD project, known as Wellness Incentives and Navigation (WIN), includes over 1,250 voluntary residents of Houston and surrounding counties, between the ages of 21 and 55, randomly enrolled into intervention and control groups and a comparison group drawn from other service delivery areas.

WIN employs a complement of research-based incentives including:

- Wellness planning and navigation facilitated by trained, professional health navigators, who use Motivational Interviewing (MI) techniques to help participants define and achieve their wellness goals;
- Individual flexible wellness accounts to support specific health goals defined by the participant, with purchases authorized by the health navigator; and
- Wellness Recovery Action Planning (WRAP) to assist individuals in managing mental illnesses.

The most common wellness goals are weight loss, improved eating habits, and increased physical activity. Examples of items purchased for these goals include gym memberships, exercise equipment, blood pressure monitoring devices, and cookbooks. After one year of interventions, the intervention group has reported more significant improvements than the control group in smoking cessation, emotional health, and increased physical activity.

Oklahoma

Oklahoma's public mental health system relies primarily on state general funds to support its operating budget. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has a formal agreement with the Oklahoma Health Care Authority (OHCA) to serve as the operating entity for a range of Medicaid-covered mental health and substance use services.

Medical Home Services Funded Through Medicaid

In 2008, the Oklahoma Legislature created a Medical Home Task Force. The mandated studies by that Task Force led to the creation of the Oklahoma Health Care Authority's (OHCA's) [Sooner Care Choice](#) program under an approved § 1115 statewide demonstration waiver. Care is managed through a primary care case management system, which provides members with a medical home, coordinated by a primary care provider (PCP). The PCPs manage the basic health care needs, including after-hours care and specialty referrals. In exchange for this service, each PCP is prepaid a fixed monthly capitated payment for care coordination. Providers are also eligible for performance incentive payments when they meet specified quality improvement goals. Visit-based services are paid under the fee-for-service system. SoonerCare Choice has more than 400,000 members enrolled statewide and more than 1,000 PCPs.

Under current waiver terms and conditions, SoonerCare members choose their medical homes and can change PCPs with no delay in enrollment effective date. The number of visits to the medical home PCP is unlimited. PCPs are paid monthly care coordination fees for each member on their panels, in amounts that vary depending on the level of medical home services provided and the mix of adults and children the provider accepts. Providers are also eligible for performance incentive payments when they meet quality improvement goals defined by the state.

The [SoonerCare Health Management Program \(HMP\)](#), also specifically authorized under the § 1115 waiver, assists SoonerCare Choice members who have, or are at risk, for developing a chronic disease to improve their health. Available HMP services include behavioral health screenings and health coaching conducted by registered nurses in PCP offices, and well as assistance in locating community resources—all services not otherwise covered under Medicaid.⁴

Client Assessment Records

OHCA has developed and implemented the [Client Assessment Record \(CAR\)](#), a tool to evaluate the health and wellness functioning level of its fee-for-service and SoonerCare Choice members. Use of the CAR—a standardized assessment tool that measures consumer

⁴ SoonerCare" Medicaid § 1115 demonstration waiver (No. 11-W-00048/6) extension and amendments, as approved by CMS August 13, 2014, last accessed at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/ok-soonercare-ca.pdf>.

functioning in nine domains—has resulted over the past four years in increased levels of provider awareness of the co-morbid chronic conditions prevalent in the SMI and SUD populations. As an incentive to help members better manage their healthcare needs, providers may be eligible for pay-for-performance bonuses on demonstration of improvement of a consumer’s CAR score. All other services provided in the medical home by specialists, hospitals, or other providers are reimbursed on a fee-for-service basis with upper limits negotiated contractually.

Publicly (HHS) Funded CMHCs and FQHCs

A network of 15 CMHCs—five state-operated and 10 contracted nonprofits, serving all 77 of Oklahoma’s counties—serves as the point of entry for behavioral healthcare services, including crisis services, outpatient therapy, case management, Program of Assertive Community Treatment, and other community-based services. CMHCs provide a mental health safety-net for uninsured adults and children and Medicaid enrollees, working with Federally Qualified Health Centers (FQHCs)—entities publicly funded by grants from the Health Resources and Services Administration to serve federally-defined Medically Underserved Areas—by co-locating staff at either the FQHC or the CMHC.

FQHCs offer supportive services (transportation, education, translation, etc.) in addition to traditional healthcare. The availability of an FQHC ensures that services are available to all, with consumer fees adjusted based on ability to pay. FQHCs are generally reimbursed under a federal prospective payment system (PPS) developed exclusively for them. States have the flexibility to create new payment mechanisms for FQHCs, and Oklahoma has done so through its Enhanced Tier Payment System, discussed [below](#).

Integration with FQHCs through SAMHSA PBHCI Grants

SAMHSA’S PBHCI grantees have partnered with FQHCs to help CMHCs/CHCs increase the availability of primary healthcare services for individuals with SMI or co-occurring SMI and SUD, using the “health home” model. PBHCI grantees, through an agreement with OHCA, coordinate and integrate primary health care with mental health services.

Through the PBHCI program, SAMHSA provides support to communities to coordinate and integrate primary care services into publicly funded, community-based behavioral health settings, in order to:

- improve access to primary care services;
- improve prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease;
- increase availability of integrated, holistic care for physical and behavioral disorders; and
- improve the overall health status of consumers.

Training and technical assistance is provided directly by CIHS to CMHCs that receive PBHCI grants, as well as to other primary care and behavioral health organizations.

Oklahoma has several PBHCI Programs: Central Oklahoma Community Mental Health Center, NorthCare, Grand Lake Mental Health, Family and Children Services and Carl Albert Community Health Center. The Oklahoma PBHCI programs:

- facilitate screening/referral for primary care;
- track the provision of health care services and outcomes;
- provide wellness support services; and
- establish referral services and ongoing evaluation for primary healthcare services provided beyond the primary healthcare setting.

These behaviorally-focused medical homes provide a combination of comprehensive care management, care coordination using health information technology, health promotion, comprehensive transitional care from inpatient to other settings of service, engagement of individuals in self-management and recovery, family support services, and referral to community and social support services. One Oklahoma PBHCI, NorthCare, has worked with a FQHC to co-locate staff.

All providers are currently participating in a five-year granted program funded through settlements with the tobacco industry. The program requires an overall health assessment, and outcome measurement and reporting requirements are in place to ensure that the proper combination of services is developed. PBHI grantees are required to collect data regarding treatment outcomes in twice-yearly reassessments and at discharge. Data collected pertains to overall health, tobacco use, and illegal substance use. Grantees also assess an individual's "social connectedness," the degree to which an individual feels supported by family, friends, and peers.

Oklahoma Enhanced Tier Payment System

Recognizing the effectiveness of the payment system used in the medical home initiative, ODMHSAS began efforts to transition out of its volume-based service system in favor of an incentive-based reimbursement system, the [Enhanced Tier Payment System \(ETPS\)](#). Making this type of change to the provider payment methodology required Oklahoma to amend its Medicaid State Plan, a collaborative drafting effort that included CMHC providers, OHCA, and the state Medicaid agency. ODMHSAS and the OHCA worked closely with the CMS central and regional offices throughout the SPA approval process.

ODMHSAS's ETPS leverages federal matching dollars to invest in an incentive-based system. As part of the State Plan Amendment (SPA) drafting process, ODMHSAS analyzed the gap between the prior payment system and state UPL payments to ensure that proposed payments under the ETPS would not exceed the UPL payments.

One concern raised by CMS during the SPA approval negotiation process was that the OHCA would be making payments to ODMHSAS rather than directly to providers. ODMHSAS demonstrated that it would function as a conduit for the money and not use any of the moneys for its own administrative expenses—that the providers would receive disbursements based on their performance, and that all of the money would end up with

providers. Additionally, as is traditionally required in an SPA, ODMHSAS and OHCA had to detail specific separate rate methodologies that would be applied for each of the specific provider types defined in the state plan.

The ETPS, implemented in July 2008, has resulted in increased integration. Providers must meet the benchmarks established by the state in order to receive payment. The dollars are distributed to providers based on the volume of consumers served. For example, providers that serve 10 percent of the total number of consumers receive 10 percent of the dollars in the pool. If a provider exceeds a benchmark by one standard deviation, the provider is eligible for a bonus payment. Similarly, if a provider fails to meet the benchmark, a portion of payment is withheld. The bonus payment dollars come from any money in the pool that is not distributed when providers do not meet benchmark requirements. In this way, providers are incentivized not only to meet benchmarks, but also to exceed them.

Additionally, the state has adopted a “safety valve” methodology which allows providers who are within one standard deviation below the benchmark to receive a 50 percent partial payment for partially meeting benchmarks. However, if a provider performs more than one standard deviation below the benchmark, that provider does not receive payment for that measure.

In FY 2009, this initiative resulted in \$6 million in payment to providers, increasing to \$19.7 million in FY 2010, and an estimated \$28.6 million in FY 2011. As illustrated in the next section, the performance measures are consistent with approaches to improving integration of primary and behavioral health services.

Measuring Effectiveness of Integration Efforts through Outcome Measures

ODMHSAS Deputy Commissioner Carrie Slatton-Hodges says “outcome measures have transformed the system.” ODMHSAS first implemented its outcome measures initiative with six measures and expanded six months later to the 12 measures currently in use. ODMHSAS has focused on improving access to care and selected outcome indicators accordingly. The second group of measures included access and engagement measures similar to those in the first grouping, but also included clinical outcome measures. Three domain areas were selected for inclusion in the second group of measures: interpersonal, medical/physical, and self-care. Three of the second group of indicators measured consumer improvement on the CAR. ODMHSAS identified ensuring consumer engagement in treatment as a priority and, accordingly, included as additional measures two self-reported measures of consumer drug use.

ODMHSAS has convened monthly meetings to give CMHC directors an opportunity to share changes they have made to their operations, staffing, and culture that resulted in improved performance. ODMHSAS’ Integrated Consumer Information System (ICIS) has also played an important role. By enabling providers to view their organization’s performance and consumer-specific data on key indicators in “real time,” ICIS facilitates continuous quality improvement, ultimately furthering integration efforts.

ICIS data has indicated that ODMHSAS increased by 22 percent the number of people served in various settings from January 2009 through June 2010. Given that service volume determines how large the provider's share of the payment will be, the use of provider financial incentives makes this finding somewhat unsurprising. A more surprising related finding is that the infusion of incentive money has stabilized the workforce by increasing staffs' tenure in their organizations. Agencies have used their bonus payments to increase training, and support their staff in understanding the "business" side of the work.

A third finding is that the state initiative has also promoted community integration and recovery-oriented approaches, including the use of peer support services. Implementation of important community approaches not funded by Medicaid, such as parenting classes, has also increased.

Next Steps

- Oklahoma is scheduled to submit a State Plan Amendment on or about September 1, 2014 that it hopes to implement on January 1, 2015 for both adult and children's services. The state hopes to expand the requirements for robust data sets around evidence-based screening and health indicators. Third party contractors will collect and maintain the data pertaining to the programs.
- As instructed by the state legislature, the state convened a task force to study the health home model authorized under the ACA. OHCA worked with ODMHSAS to prepare a State Plan Amendment for submission to CMS to create a health home to coordinate care for individuals with a SMI and provide long-term services and supports. The proposed effective date in January 1, 2015.

Georgia

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) understands that promoting individuals' self-determination skills is a fundamental element of an effective healthcare delivery system. GDBHDD therefore focuses on implementing programs that promote self-determination and choice, while providing the supports essential to positive outcomes. The state promotes the role of peers in the delivery system, and its work toward integration is guided by the belief that peers are the most significant factor in determining success.

Whole Health and Wellness Peer Support

The use of peer support specialists was originally approved by CMS for Georgia in 1999 as the first specific "peer-delivered" Medicaid approved service in the country. Peer support services have subsequently been approved for reimbursement in 32 states and the District of Columbia, as of September 1, 2014.⁵ CPSs receive medical technical support from registered nurses and are trained to work in both behavioral health and primary care settings. Support from behavioral health nurses is also available, as necessary.

CMS approved Georgia as the first state to have Medicaid-reimbursed Whole Health and Wellness Services provided by certified whole health and wellness peer specialists (CPSs) in June 2012 and that program was implemented in January 2013. The State Medicaid agency submitted a formal request to change the CPS service definition in the Georgia Medicaid plan. Approximately 1000 CPSs are currently health-certified in Georgia. The certification process includes a two-day, 10-session, in-person WHAM training.

CPSs assist the individual in setting a whole health goal based on personal motivation and person-centered planning. Once the goal is set, the CPS helps create and log a weekly action plan. The individual also learns how to effectively cope with stress and establish self-management skills.

Whole Health Support services also include a substance use component. This allows Georgia to expand its behavioral health workforce by using certified addiction recovery empowerment specialists (CARES) as CPSs. The service meets all CMS requirements for peer support.⁶ This new workforce will bill Medicaid for peer support, with the addition of a substance abuse modifier. Program services have their own Healthcare Common Procedure Coding System billing code.

⁵ National Association of State Mental Health Program Directors (NASMHPD), *State Survey on Peer Support Services*, 2014.

⁶ As outlined by CMS in State Medicaid Director Letter (SMDL) #07-011 (April 15, 2007).

SAMHSA PBHCI Grants: Cobb-Douglas Community Services Board Implementation of Whole Health and Wellness Peer Support

[Cobb-Douglas Community Services Board](#), Georgia's largest PBHCI, awarded a SAMHSA PBHCI grant in 2010, offers a wide array of services, including psychosocial rehabilitative services using an evidence-based recovery model. Consumer-driven goals guide the individual treatment plans. The Whole Health and Wellness Peer Support Program is an essential component of Cobb Douglas' model. Peers are involved in a number of ways, from providing breakfasts for consumers to performing community outreach. Consumers are engaged with a variety of services and, last year, peers achieved 100 percent success in getting required physical health screenings performed.

FQHC-CHC Implementation of Whole Health and Wellness Peer Support

HRSA-funded FQHCs have also successfully implemented the Whole Health and Wellness Peer Support Program. Georgia's FQHCs are "safety net" providers which include community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and homeless individuals. Georgia FQHCs provide comprehensive services and ensure the availability and accessibility of not only essential primary and preventive health services, but also mental health and substance use treatment services.

Georgia's Primary Care Office, within the State Office of Rural Health, partners with the Georgia Association for Primary Healthcare in providing technical assistance to communities in the development and expansion of existing and new FQHCs and CHCs in Georgia's rural and underserved areas.

Four Corners Project: A Collaborative Effort between a FQHC and a Community Services Board

An Atlanta-based FQHC, West End Medical Center, Inc., has partnered with the Cobb County Community Services Board to create the [Four Corners Project](#). The project is funded through a SAMHSA-HRSA grant. Four Corners is designed using the health home model and treats the whole person within a behavioral healthcare setting. The program targets individuals with SMI and a co-occurring medical disorder, focusing on whole health, wellness, treatment, and prevention. It encourages consumer-directed healthcare action steps, based on integrated treatment plans and reflecting an array of supportive wraparound services. The program goals include increasing access to PHHCI services, improving processes and service delivery, removing barriers to parity, and enhancing consumer education and awareness.

Initial results reported in August 2014, based on data collected between June 2011 and March 2012, have been promising. Four Corners has exceeded its first-year goals for the number of consumers seen by 73 percent. Four Corners reported over 1200 primary care encounters and 800 behavioral encounters during the reporting period. More than 1000 consumers had been screened through a self-reporting questionnaire; 90 percent self-reported having had no previous primary care provider or having used a local hospital emergency department to meet primary care needs.

Four Corners has taken several steps to further advance its integration efforts. The program has initiated a system which includes an integrated treatment team and doctor-psychiatrist meetings. They are also working to increase the connection with the wraparound services provided by the PBHCI. The program is seeking to increase peer engagement through improved consumer outreach /retention efforts. Two strategies being used toward achieving this goal are the use of onsite health educators and consumer outreach marketing via social media. Four Corners plans to utilize new Medicaid billing codes for nursing and CPS wellness services.

Georgia Balancing Incentive Program

Georgia was awarded a CMS [Balancing Incentive Program \(BIP\)](#) grant in October 2012. Once the grant was awarded, the state began work on the development of statewide training through a no-wrong-door point of entry approach, with a focal point of entry through the state's Aging and Disability Resource Centers. Georgia's BIP expands the use of community-based long-term services and supports through various strategies, including the following:

- funding through State Plan dollars three new community-based services for Medicaid recipients with serious and persistent behavioral health needs;
- expanding intensive community-based services to youth with serious emotional disturbances and their families; and
- providing web-based training on community-based long term services and supports available to targeted referral sources.

The budget for BIP is \$19,086,355 per year, or a total of \$57,259,065 over a three-year period.

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