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Federal and State Policy to Promote the Integration of Primary Care and Community Resources

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Table of Contents

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States

- Alabama
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- Oregon
- Texas

Federal

- Agency for Healthcare Research and Quality
- Administration for Community Living
- Center for Consumer Information and Insurance Oversight
- Center for Medicare and Medicaid Services
- Health Resources and Services Administration
- Maternal and Child Health Bureau
- Office of the National Coordinator for Health Information Technology
- Substance Abuse and Mental Health Services Administration
- United States Senate Subcommittee on Primary Health and Aging

Private Sector

- National Association of Medicaid Directors
- National Governors Association

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Executive Summary

Around the country, models are emerging to link primary care providers not only to other medical service providers but also to resources and services in the community. This shift reflects a growing commitment to ensuring that patient-centered care has a whole-person orientation that can respond to patient needs beyond physical health issues, including behavioral, public health, or long-term services and supports or socio-economic supports available in their communities.

Both states and the federal government have significant policy levers available that can help facilitate the creation of linkages between primary care and community services. The federal government has important oversight and regulatory roles to play and has resources available to support the efforts of states and providers. The federal government also has significant influence over state purchasing and policy through Medicaid programs, particularly via its approval of waiver and demonstration authorities. States have a range of financing and regulatory policy levers available to help forge links between primary care practices and community supports.

In May 2013, NASHP convened and facilitated a discourse among high-level state and federal officials to 1) let state participants learn about and discuss new opportunities and promising practices for integration with their peers, 2) allow states to learn about new federal resources they can leverage to support integration, and 3) give federal participants the opportunity to learn about state approaches to improving integration and identify potential federal policy changes that can support state activities.

Key themes that emerged from the discussion include:

- Building new linkages will require federal and state partners to facilitate the development of community-based assets. Investments in primary care must be matched by investments in a community-based system to which primary care providers can connect.
- Increased use of Medicaid managed care presents challenges and opportunities to supporting integration for both levels of government. Sufficient expertise, appropriate contract language and state oversight are all essential to leveraging Medicaid managed care to promote integration.
- Sustainable integration requires governmental partners to engage commercial payers. Given providers cannot easily alter the way they treat patients or establish new linkages based on payment source, a true system of linkages requires multi-payer alignment.
- Better communication is needed to align federal policy with states' goals. Silos persist in part due to insufficient communication within and between levels of government.
- A shared agenda around measurement and data-sharing is needed to support integration. As states move to re-orient payment and delivery structures to encourage integration, both federal and state measurement requirements and strategies will need to be modified to reflect a focus on buying outcomes and not units of service.

Meeting participants agreed that greater alignment will allow both levels of government to achieve shared goals for integration as well as enable new innovations to better serve communities and individuals with complex and varied needs.

Building the Case for Integration of Primary Care and Community Resources

Around the country, models are emerging to link primary care providers not only to other medical service providers but also to resources in the community. This shift reflects a growing commitment to ensuring that patient-centered care has a whole-person orientation. Patients, particularly those with the most complex health conditions and social circumstances, can have a wide range of needs that impact their health.[1] In addition to physical health services, they may need behavioral, public health, long-term services and supports, or socio-economic supports available in their communities.

Actors throughout the health care system are pursuing or advocating models of primary care that meet this broader range of patient needs. States and the federal government are supporting new models like health homes, which seek to integrate primary, preventive, acute, behavioral health, and long-term services and supports for Medicaid beneficiaries with multiple chronic conditions. States are making investments in networks linking primary care with community resources, and the federal government is offering grant support and regulatory incentives to strengthen these connections. Evidence suggests this whole-person orientation for the health system has the potential to advance key goals described below.

Improving patient experience. Mobilizing community resources to meet the varied needs of chronically ill patients is a key component of the Chronic Care Model developed by Edward Wagner.[2] This holistic approach to care has demonstrated improvements in patient experience for those participating in the model, including fewer hospital days for patients with congestive heart failure and a greater likelihood that patients with asthma and diabetes receive appropriate therapy.

Promoting population health. Integration of primary care and community resources is important not only for treating individuals with chronic conditions, but also for preventing disease and illness. Understanding the roots of disease and illness requires taking a holistic view that recognizes the impact on individuals of a range of influences, from individual behavior to community networks to macro social conditions and policies. This perspective calls for integration of clinical and community-based strategies to ensure a range of services are available at different levels to meet individuals' needs.[3]

Achieving health equity. Health outcomes are influenced by a variety of social determinants including the economic and social circumstances in which people live and work.[4] The Centers for Disease Control and Prevention (CDC) has documented the roles that communities play in influencing social determinants, behavior, and ultimately health.[5] Pursuing greater health equity requires involving communities and leveraging those resources available in the community to address the social determinants of health.

Pursuing savings. Though the Institute of Medicine (IOM) estimates that $55 billion is lost annually to missed prevention opportunities, the United States dedicates only three percent of health spending to prevention activities. Similarly, the IOM estimates that $130 billion is wasted annually on inefficiently delivered health services, in part due to fragmentation across care settings.[6] [7] Better health outcomes, greater investments in preventive care and connections to needed resources will serve to help generate savings through mechanisms such as fewer inpatient hospital days. For instance, multiple studies have shown a positive return on investment when community health workers are available to help connect individuals to various health and human services.[8] Part of the cost effectiveness of employing community health workers stems from reductions in the use of urgent care as patients are encouraged to access less costly preventive and other services in the community.

Federal and State Policy Levers Promoting Integration

Both federal and state government have significant policy levers available that can help facilitate the creation of linkages between primary care and community services. The federal government has important oversight and regulatory roles to play and has resources available to support the efforts of states and providers. The Affordable Care Act of 2010 (ACA) in particular has reshaped the federal health policy agenda, emphasizing the importance of new payment and care delivery models and authorizing grant programs that can strengthen links between primary care and community-based providers. The ACA is also helping to set the policy agenda in states and is providing new tools to help states meet the needs of vulnerable populations across the care spectrum and in a range of settings.

The Federal Role

The federal government is a substantial player, directly and indirectly, in the health care system with its ability to assert financial and regulatory leverage to influence primary care delivery and reorient systems of care around the spectrum of patients' needs. The federal government also has significant influence over state purchasing and policy through Medicaid programs, particularly via its authority to approve waivers and demonstrations. Through a new Center for Medicare & Medicaid Innovation (CMMI), the Centers for Medicare and Medicaid Services (CMS) is supporting new payment and delivery system innovations, including projects that recognize the value of integration and are aimed at states. CMMI's State Innovation Models Initiative is providing grants to states to design or test new multi-payer payment models that can be leveraged to support integration.

Purchasing more integrated care. The federal government is also a major purchaser of health care services through Medicare and thus is well positioned to use its market power to influence care delivery. For example, provider organizations seeking to become accountable care organizations (ACOs) under the Medicare Shared Savings Program must describe as part of their application how they will partner with community stakeholders; involving community stakeholders on the governing boards of ACOs satisfies this requirement.[9] Beyond directly paying for health care services, the federal government can also offer grants and technical assistance to providers and states that can then be leveraged in strategies linking primary care providers to community resources.

Aligning goals and efforts across agencies. Efforts to bolster connections between primary care and a wide range of community programs including public health, behavioral health, long-term supports, and social services span a number of federal agencies. Alignment of goals within and across these federal agencies is important for sending consistent signals to states and providers alike. CMS, for example, has launched a Hospital Readmissions Reduction Program for Medicare beneficiaries. In recognition of the fact that avoiding preventable re-hospitalizations requires supports in the community, CMS also updated the Medicare physician fee schedule in 2013 to include reimbursements to primary care providers who link Medicare beneficiaries to community resources.

Clarifying existing policy. In addition to aligning policies, the federal government can also clarify existing federal laws and regulations that may influence states and providers. In particular, educating providers and states on the extent of privacy and information-sharing restrictions—for example, around behavioral health and substance abuse conditions—may help to facilitate closer connections between primary care providers and other providers in the community.

State Roles

As states pursue a whole person approach to care delivery in an effort to better serve patients with complex needs, promoting greater integration is emerging as a key strategy for containing costs and improving population health, patient experience, and health equity. States have a range of financing and regulatory policy levers available to help forge links between primary care practices and community supports.

Purchasing more integrated care. Like the federal government, states wield considerable financial leverage in markets. Total spending on state Medicaid programs in FY 2010—including federal matching funds—was more than $389 billion.[10] Given the close relationship between payment structures and care delivery, states have an opportunity to leverage payment reforms to support integration. Examples of such strategies include directly paying for those activities in primary care settings that connect patients to community resources and providers, or tying specific primary care payment incentives to evidence of greater integration with the community.

Innovating through existing authorities and new partnerships. States as payers can make full use of waiver authorities and state plan options for Medicaid. These waivers include Section 1915(c) home and community-based service waivers supporting behavioral and long-term services and supports provided in the community, as well as broader Section 1115 demonstration waivers for new payment strategies and care models.[11] States also can affect change by partnering with other payers to send coherent signals to providers, and, as conveners, can form and lead multi-payer coalitions to reform payment incentives in the state.

Aligning policy across service systems. Regulatory and administrative simplifications and supports are also important mechanisms by which states can support integration. Strengthening connections between various systems in a state—including child-serving, mental health, substance abuse, and long-term service systems—can serve to ease transitions and incorporate the full spectrum of an individual's care. Developing shared standards, definitions, and protocols across systems will help to build these connections.[12]

Building capacity for integration. States can offer or secure technical assistance for primary care and community-based providers and create greater capacity in primary care offices for linking to community resources. They can build infrastructure supports to aid integration, such as creating portals to help providers track referrals or share information between providers. States can also promote an appropriate workforce for community integration, for instance by supporting community health worker workforce development and by re-examining policies that define provider licensure requirements (including maintenance of certification requirements) and credential education to include requirements for greater integration with community resources.

Leveraging managed care for integration. For many states, the primary interaction of the state may not be directly with providers but rather with Medicaid managed care organizations. Effective managed care contracting and program design thus becomes a priority and a key lever for states seeking to promote integration. Managed care can be used to provide and integrate a full range of services to provide whole-person care.[13] Medicaid managed long-term services and supports can help promote shifts toward coordinated, community-based services, particularly when programs incorporate flexibility to provide a broad benefit package and clear state expectations.[14] Appropriate oversight and monitoring of a managed care contractor, however, is crucial for ensuring that state goals to integrate primary care with community services are being met.[15]

Project Methodology

In May 2013, NASHP convened and facilitated a discussion among high-level federal and state leaders. The meeting had multiple objectives: 1) state participants had the opportunity to learn about and discuss with their peers new opportunities and promising practices for integration, 2) states were able to learn about new federal resources they can leverage to support integration, and 3) federal participants had the opportunity to learn about state approaches to improving integration and identify potential federal policy changes that can support state activities. NASHP conducted an environmental scan and synthesized background information about federal and state policy levers and initiatives to support primary care and community integration prior to the meeting, and augmented those findings with the meeting discussion to produce this report. The meeting and this report are the first in a series that will explore opportunities for improvement in federal and state policy.

Select Federal and State Initiatives

NASHP identified a number of federal and state policy approaches currently in place or in development. This list is not meant to be exhaustive but rather illustrative, highlighting key initiatives that show the range of strategies being implemented.

Federal Initiatives

A litany of ongoing federal initiatives exists with the aim of forging closer connections between primary care and community providers. Some are building out from the primary care offices, while others are oriented in the community itself and are described below. Refer to Appendix A for a table summarizing several federal approaches.

Some federal efforts are aimed at assisting state governments in developing and launching new models of payment or care delivery. Whether explicitly intended to increase primary care and community integration or not, these opportunities can be leveraged by states in support of this goal. The Health Homes for Enrollees with Chronic Conditions Medicaid State Plan Option authorized by the ACA, for example, will allow states to support practices that integrate primary care with behavioral health and long-term services and supports. [16] State Innovation Models grants awarded by CMMI in early 2013 will support states as they pursue multi-payer payment and delivery reforms that can promote integration. [17]

Other federal initiatives are aimed at directly assisting and incenting medical providers to better integrate with community providers. States can align with or complement these federal efforts to support this goal. Several examples are highlighted below.

- Two initiatives authorized by the ACA but not yet funded, the **Primary Care Extension Program** and a grant program to support **Community Health Teams**, would educate and support primary care providers and support teams that link primary care and community resources for patients. [18] [19]
- New requirements on non-profit hospitals under the ACA will require periodic **community health needs assessments** that take into account input from a range of stakeholders representing the interests of the community. [20]
- The **meaningful use criteria** developed by the Office of the National Coordinator for Health Information Technology will be used to qualify providers for electronic health record adoption incentive payments with the aim that transitions across care settings are accompanied by the information providers need at the point of care. [21]

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) are working together through their Center for Integrated Health Solutions to integrate primary care and community-based behavioral health services. Their Primary and Behavioral Health Care Integration Program is funding grant sites (including state mental health departments) to build infrastructure supporting the provision of primary care in community behavioral health settings and the follow-up process for securing specialized services beyond primary care settings. [22]

The CDC has awarded numerous Community Transformation Grants to state and local government agencies to connect community resources, including those focused on social and emotional well-being.[23] Grantees are engaging a range of community partners to work together to improve the health of communities.

State Initiatives

States are developing and operating initiatives to build systems around patients that better connect primary care to a plethora of resources in communities. See Appendix B for a table summarizing several state initiatives.

Strategies for promoting primary care and community integration vary across states. Some are pioneering new care models that are helping to broaden the mission of primary care and create links with resources in the community.

- In **Michigan**, a partnership between the Michigan Public Health Institute and the state Department of Community Health is building Pathways Community Hubs in three counties, which will connect individuals with chronic conditions to community health workers and others who will help to coordinate health and human services.[24]
- **Alabama's** Medicaid program is using nonprofit community networks to build linkages between community resources and primary care providers.[25]
- **Montana** Medicaid is using care managers in Federally Qualified Health Centers to help connect patients receiving primary care in the clinics to other resources in the community.[26]

Other states are focusing on population and public health-focused efforts. The Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP) is spurring local action, leveraging the efforts of 18 Local Health Improvement Coalitions that are supporting the SHIP's goal of improving on 39 distinct public health objectives. The SHIP is part of Maryland's vision of transforming its health system to integrate patient-centered primary care with community health initiatives through community-integrated medical homes.[27]

Several other states are addressing long-term service needs: Vermont's Support and Services at Home (SASH) program, part of the state's Blueprint for Health operated out of the Department of Vermont Health Access, extends the reach of the multi-disciplinary Community Health Teams it uses to connect patient-centered medical home patients with other services they need in the community. [28] The SASH program links primary care with the long-term service system, improving access to non-medical services needed for vulnerable Medicare beneficiaries living at home.

Some states are re-thinking Medicaid payment structures on a broad scale to better coordinate services.

- **Colorado's** Medicaid program has launched an Accountable Care Collaborative program to better integrate services for fee-for-service Medicaid beneficiaries. Under this approach, Regional Care Collaborative Organizations take on the responsibility of working with primary care providers and easing care transitions for beneficiaries. [29]
- The **Oregon** Health Authority has created Coordinated Care Organizations (CCOs), capitated risk-bearing entities that are responsible for integrating physical and behavioral health services for Medicaid enrollees. [30]

States are also building infrastructure to better track patients after they are referred to services outside the primary care setting. Oklahoma, through a partnership between the Oklahoma Health Care Authority and the University of Oklahoma, has built a web-based portal to allow pediatric and community providers to track referrals across systems for children.[31] In Colorado, a Statewide Data and Analytics Contractor is supporting primary care providers under the Accountable Care Program by providing access to clinically actionable data that will eventually include data on member care coordination (including non-medical services data).

Opportunities for Policy Improvement

Despite the range of models being implemented to promote integration, substantial room exists for improvement in current policies. Representatives of states and the federal government implementing many of the initiatives featured above gathered to discuss barriers to integration that remain, as well as potential paths forward at the intersection of federal and state policy. The conversation was wide-ranging with several themes emerging from the discussion. Together they offer direction for future federal and state alignment.

Building new linkages will require federal and state partners to facilitate the development of community-based assets.

In recent years, states have made significant investments in primary care infrastructure. Meeting participants agreed that the majority of patient needs should, to the extent that they can, be met in primary care settings to avoid the dangers inherent in hand-offs. However, taking the next step to forge closer connections between primary care and resources in the community for those patients who need services beyond primary care requires an available robust system of community-based services. Participants suggested that there must be a "platform" of available resources to help primary care providers identify and connect their patients with needed services.

Participants identified a need for greater investments to promote community-based assets. They suggested that availability of federal start-up Medicaid funds to support the launch of state integration initiatives would be valuable. Federal participants indicated that they are looking for ways to incorporate more flexibility into the way Medicaid reimburses for services to be more supportive of system transformation at the state level. The federal Balancing Incentive Program, in which a federal Medicaid match can be used to help offset upfront investments needed to support a shift from institutional long-term services and supports to community-based long-term services and supports, was held up as a potential model for future activity. However, the federal government will need to allow flexibility and opportunities for states to explore innovative strategies for promoting integration. For instance, Oregon's CCOs have latitude under the program—and the waiver authority under which it operates—to be flexible in the types of services offered under their global budgets.

Participants also suggested the need for cooperation across government agencies, communities, providers, and philanthropies to identify ways to address social determinants of health that typically fall outside the jurisdictional control of health agencies. Government agencies referenced included, for example, transportation, education, and environmental agencies, whose primary missions do not focus on health but whose policies and programs have significant population health impacts. One attendee stressed the importance of building community infrastructure from the ground up, emphasizing the connection between community empowerment, social justice, and improved health equity. Federal and state agencies, along with health providers and community partners alike, will also need to dedicate themselves to strengthening the training and utilization of community health workers as part of an increased focus on prevention. Participants suggested the need for investment in a national infrastructure for assessing core competencies of community health workers and supporting community health worker training.

At a broader level, participants suggested community organizations must come together as a single community system because, as one attendee put it, "payers don't want to deal with a bunch of one-offs."

One approach that both levels of government might adopt is to offer resources for the development of community-based assets but also charge the community with investing a component of those resources directly into primary care. Models, like Health Homes for Enrollees with Chronic Conditions, that link primary care providers with community-based interventions to address home-based environmental risks, such as pediatric asthma, were offered as an example of this approach. States can also use regulatory levers to require that commercial insurers' quality improvement plans involve investing in the community as a key strategy for improving health. Massachusetts currently uses regulatory levers to spur similar investments on the provider side, leveraging a Determination of Need process to ensure that health care institutions seeking to expand must dedicate a percentage of their project budgets to community health initiatives.

At the federal level, medical loss ratio requirements can encourage commercial insurers to make investments as part of strategy for fostering shared community-based resources, while closer collaboration between HRSA and CMS can help to better target federal investments. Each level of government can also move to leverage and build upon the community health needs assessment requirements for non-profit hospitals contained in the ACA.

Increased use of Medicaid managed care presents challenges and opportunities to supporting integration for both levels of government.

As more states have turned to contracting with managed care organizations to manage the Medicaid benefit, the state role in facilitating integration has begun to shift. This has not diminished the importance of the policy levers identified above, but it has added emphasis to managed care contracting as a key vehicle for promoting integration. If the approaches and policies are consistent among them, managed care organizations have the potential to both send a strong message about the need for integration of community resources and begin shifting the culture among providers. For instance, Texas is pursuing changes to its managed care system that will support integration, building service coordination requirements into managed care contracts.

A theme that resurfaced throughout the day centered on the observation that Medicaid managed care is not necessarily "managed," in the sense of guiding beneficiaries between systems and ensuring critical linkages between resources exist. If states wish to use managed care organizations (MCOs) as vehicles for integration, they will need to contractually obligate integration. Discussants suggested that lack of expertise in contracting with MCOs in the past has led to reluctance in including necessary requirements in contracts and hesitancy around incorporating and using penalties.

However, participants also pointed out that appropriate contract language alone is not sufficient to get results; state oversight and meaningful culture change among service providers are also necessary to ensure integration is supported. Participants suggested that the federal government can take a more active role at the state level in supporting or investing in contract training as well as in providing instruction on navigating the Medicaid State Plan Amendment and waiver approval process. States would need to couple such opportunities with a new willingness to engage MCOs and demand integration.

Officials noted the federal government's understanding of what is happening in state Medicaid programs is diminishing as states increasingly rely on managed care. The quality of the data tracking service delivery for beneficiaries enrolled in managed care plans varies from state to state and is not always readily available to the federal government. Ensuring that future goals of integration are being met will require states to closely monitor MCOs and will require the federal government to insist on better reporting on managed care from states.

Sustainable integration requires governmental partners to engage commercial payers. Greater integration of primary care and community resources will require designing payment policies that facilitate the formation of those linkages. Participants, however, observed that payer-specific strategies or standards alone would not be successful, as providers cannot easily alter the way they treat patients or establish new linkages based on payment source. Instead, building a true system of linkages will require multi-payer collaboration aligning the signals payers send to the provider community. One participant noted the delivery system has to be built for the entire population and not just the publicly insured, suggesting that "primary care needs one approach [to care delivery and integration] or it will collapse."

The necessary steps to increasing integration identified at the meeting included multi-payer alignment around comprehensive primary care redesign, measure alignment, and infrastructure support. Also identified as a critical catalyst for forging new collaboration was the need for state and federal partners to work together to define the value proposition for commercial payers and providers. For instance, Oregon successfully brought health plans and providers together in person to discuss care coordination and determine how to best leverage existing plan-level and provider-level case managers to avoid duplication.

Several potential barriers to this work will need to be addressed. One participant suggested new Federal Trade Commission guidance to clarify when and how private payers and providers can collaborate on shared goals to promote the integration of primary care and community resources. Another suggestion was the creation of new channels and opportunities for federal-state collaboration. Historically states have developed an idea or proposal for a new approach to payment or delivery and they have approached the federal government to seek approval through the Medicaid waiver process; some participants were interested in a new approach in which Medicare can approach states with innovative multi-payer ideas.

Better communication is needed to align federal policy with states' goals. Despite widespread agreement among state and federal participants of the meeting on the broad goal of integration and the contours of a strategy to achieve it, participants felt strongly that closer collaboration and more coherence in strategies is needed across levels of government.

The federal government needs guidance from the states on what does and does not work when flexibility is provided in the grant-making process (e.g., federal grants for workforce development or chronic disease prevention). In some cases, states differed on their desire for greater flexibility; for instance, some participants felt a lessening of federal restrictions on the types of providers Medicaid can reimburse might enhance the ability to provide needed services typically considered community services; others thought it would create problems with fraud and abuse for state programs. One attendee commented, "I don't care so much what happens in the black box" as long as desirable cost and quality outcomes are achieved. Better communication channels will help the federal government understand the nuance in these different state perspectives. More channels for feedback are particularly essential as CMS explores new ways to increase the definition of what Medicaid can buy.

Participants also noted conceptual and practical language barriers between meeting participants (e.g., different understandings of the term "acute care"), suggesting silos between systems and services persist even among meeting participants. Reducing or eliminating these silos will require building a shared vocabulary and understanding between potential partners; meeting participants suggested federal grants could contain additional collaboration requirements aimed at building new partnerships within state governments. Better communication—as well as data sharing—between Medicare and the states is also a priority for eliminating siloed approaches to care delivery.

Some participants also noted current federal funding to states can reinforce existing silos; finding new ways to combine or bundle federal streams may be necessary for aligning non-Medicaid funding to support the goals of integration and for aligning measurement and grant reporting requirements. In addition, more conversation is needed around the impact federal definitions and designations have on state goals and initiatives; for instance Maryland has established health enterprise zones to target disparities reductions efforts but the zones do not entirely overlap with HRSA's medically underserved area designation, depriving some zones of potential federal funding.

A shared agenda around measurement and data-sharing is needed to support integration. In line with a common theme throughout the day of breaking down existing silos, the sharing of data and information across care settings was identified as a key infrastructure support needed to enable integration. Practitioners in community and primary care settings need timely and reliable data to serve patients. At the same time, state and federal officials assessing the success and extent of integration need reliable measurement systems. As infrastructure for measurement and data-sharing is developed at the state and federal level, alignment around a shared agenda and goals is needed to avoid duplication of effort and confusion at the provider and community level.

Both state and federal officials agreed on the need to streamline the "asks" of service providers and work together to identify a set of measures to gauge the quality of services and the strength of linkages. CMS has a shared vision of moving toward a parsimonious core measure set that can be drawn from electronic health records across all of its programs. The Agency for Healthcare Research and Quality (AHRQ) is developing new care coordination and community linkages measures in particular. Participants agreed it should be a federal priority to ensure the measures selected can also meet state needs. As states move to reorient payment and delivery structures to encourage integration, federal and state measurement requirements and strategies will need to be modified to reflect a focus on buying outcomes and not units of service. Electronic health records that are built to measure clinical outcomes relevant to both children and adults will need to be a key component of these new measurement strategies.

While the second stage of the federal meaningful use requirements for electronic health records will have a higher bar for interoperability, the federal government is beginning to look at how to extend beyond the federal incentive program and engage and assist non-medical providers. Beyond developing a data infrastructure, states and the federal government need to support the development of human capital and staff resources to operate that infrastructure. Such support is especially critical in those community settings lacking the resources to create such an infrastructure. For instance, North Carolina is using grant money to allow safety net providers like Federally Qualified Health Centers and school-based health centers to connect to the state's health information exchange.

Meeting participants also noted the importance of recognizing the perception among stakeholders of barriers to information sharing is as important as any actual barriers. Clarifying what federal privacy laws—such as the Health Insurance Portability and Accountability Act (HIPAA) and the Federal Educational Rights and Privacy Act (FERPA)—do and do not allow is necessary to facilitate greater integration. The need for clarification is particularly important for providers in the community who may have limited experience in interacting with these laws.

Pulling it together: compiling next steps for the federal government and states

The themes and lessons described above offer concrete steps for federal and state partners. As mentioned in the discussion above, experts at the meeting suggested a need for:

- Federal start-up Medicaid funding to support the launch of state integration initiatives;
- Investments at the state and federal level in community health worker training and utilization;
- Additional federal and state investments in training in managed care contracting at the state level;
- New channels of communication between state and federal partners;
- The use of medical loss ratio and community health needs assessment requirements to foster the development of shared community-based resources;
- New Federal Trade Commission guidance to promote multi-payer collaboration;
- Development of human capital and staff resources to operate a new health information technology infrastructure; and
- Clarification of federal privacy laws to offer clearer guidance to providers.

These priorities provide a starting point for federal and state efforts to facilitate greater integration of health and community-based providers.

Conclusion

Breaking down silos of care and forging new links between primary care settings and community-based resources must be a key component of any strategy to generate savings while improving patient experience, population health, and health equity. Both states and the federal government have a slate of policy levers available to them to begin moving systems in the direction of greater integration. In recent years, these levers have been used to launch a number of new initiatives in states and at the federal level. These initiatives are facilitating the creation of new linkages across care settings, including stronger ties to community resources.

Despite these advances, greater alignment of federal and state policies is needed to address a number of remaining barriers to integration. Officials from both levels of government were convened to discuss these issues. They pointed to the importance of developing existing or additional community-based assets and investing in primary care transformation. They suggested a need for closer coordination between states and the federal government around Medicaid managed care contracting strategies and multi-payer payment approaches. Participants also stressed the need for a shared data agenda and more robust communication channels between levels of government to facilitate policy alignment. Throughout the discussion, meeting participants emphasized the importance of federal and state partners maintaining a focus on and commitment to health equity as they pursue greater integration. Each of the themes and action steps identified by the participants must be viewed through a health equity lens.

Together these findings sketch out a path to creating a more aligned policy environment mutually reinforcing federal and state approaches. Such an environment will allow states and the federal government to build on their existing successes and spread promising models of integration to benefit more communities. Greater alignment will allow both levels of government to achieve shared goals for integration as well as enable new innovations to better serve communities and individuals with complex and varied needs.

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APPENDICES

Appendix A: Select Federal Initiatives Supporting Primary Care and Community Integration

Initiative	Description	Status	Responsible Agency
Primary and Behavioral Health Care Integration Program[32]	The SAMHSA-HRSA Center for Integrated Health Solutions is supporting community-based behavioral health agencies' efforts to build the partnerships and infrastructure needed to initiate or expand the provision of primary healthcare services for people in treatment for serious mental illnesses (SMI) and co-occurring SMI and substance use disorders. A total of 93 grants were awarded; each grantee received up to $500,000 per year for up to 4 years. [33]	First grants awarded in late 2009	SAMHSA
Community Transformation Grants[34]	Grants for implementation, evaluation, and dissemination of evidence-based community preventive health activities. Goal is to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. In 2011, 66 grants totaling $107 million were awarded, while in 2012 an addition $70 million was awarded to 40 communities.[35]	First grants awarded in 2011	Centers for Disease Control and Prevention
Health Homes for Enrollees with Chronic Conditions [36]	Medicaid State Plan Option to create Health Homes. Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. Health Homes are limited to Medicaid beneficiaries with multiple chronic conditions.	First State Plan Amendment approved in late 2011	CMS
Meaningful Use Criteria for Electronic Health Records[37]	Providers who transition patients to another setting of care should provide summary care record for each transition/referral.	Incentive payments to providers began in 2011	Office of the National Coordinator for Health Information Technology

Initiative	Description	Status	Responsible Agency
State Innovation Models Initiative[38]	The Center for Medicare & Medicaid Innovation is providing 25 states with up to $300 million in grants to support the design and testing of state-based models for multi-payer payment and delivery system reform.[39]	Grants awarded in early 2013	CMS Innovation Center
New Medicare Care Coordination Codes for Primary Care Providers in 2013[40]	Primary care providers reimbursed for post-discharge transitional care services that include: • Assessment of the need for and assistance in coordinating follow up visits with providers/other necessary services in the community; • Establishment of needed community resources; Assistance in scheduling required follow-up with community providers and services.	In effect as of 2013	CMS
Community Health Needs Assessments[41]	The ACA requires non-profit hospitals to conduct a community needs assessment every three years to maintain their tax-exempt status.	Proposed rule was released for public comment in spring 2013	Internal Revenue Service
Primary Care Extension Program[42]	Offers support services to state-level initiatives and primary care practices to support practice transformation and ongoing quality improvement, with a focus on "preventive medicine, health promotion, chronic disease management, mental and behavioral health services…in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors."	Authorized but not yet funded	N/A
Community Health Teams[43]	Grant program to establish health teams to "collaborate with local primary care providers and existing State and community based resources"	Authorized but not yet funded	N/A

Appendix B: Select State Initiatives Supporting Primary Care and Community Integration

State	Initiative	Description	Status
Alabama	Patient Care Networks[44]	Four community networks are paid a per member per month fee by Medicaid to—among other things—help promote effective use of community resources and provide population health management. These nonprofit networks coordinate providers, provide care management, and facilitate care between primary care and community mental health centers or substance abuse providers.	Implementation began in 2011
Colorado	Accountable Care Collaborative[45]	Regional Care Collaborative Organizations receive a per member per month payment to work with patients' Primary Care Medical Providers to coordinate care, ease care transitions between settings, and connect Medicaid fee-for-service beneficiaries with specialist services. A Statewide Data Analytics Contractor provides analytical support to participating primary care providers.	Implementation began in 2011
Maryland	State Health Improvement Process[46]	Maryland's SHIP seeks to provide a framework for accountability, local action, and public engagement to improve health. Local Health Improvement Coalitions seek to leverage primary care and community interventions in pursuit of a range of public health objectives.	Implementation began in 2011
Michigan	Pathways to Better Health[47]	Pathways Community Hubs will identify and connect at-risk persons with chronic conditions to CHWs who will work with the HUB's Registered Nurse and Clinical Social Worker (CSW) to coordinate access to health care services and human services (e.g. housing, nutrition, and transportation). The initiative is funded by a Health Care Innovations Grant from the Centers for Medicare & Medicaid Services.	Funds for 3-year project awarded in mid-2012; county programs began in early 2013

State	Initiative	Description	Status
Minnesota	Health Care Delivery System Demonstrations[48]	Minnesota's Department of Human Services has launched a voluntary Medicaid demonstration in which a shared savings payment model is supporting more integrated delivery of services, including mental health and chemical dependency services.	Implementation began in 2011
Montana	Health Improvement Program[49]	Montana Medicaid pays Federally Qualified Health Centers (FQHCs) a per member per month fee to serve as a "community utility" that supplements primary care offered by the FQHC and private Medicaid providers. The FQHCs hire care managers who provide beneficiaries a number of services including connecting patients with safety-net resources in the community (e.g. food pantries and housing authorities).	Implementation began in late 2009
North Carolina	Community Care of North Carolina[50]	Fourteen regional, non-profit Community Care Networks comprised of providers, practices, local health departments and community resources serve over 1 million Medicaid recipients across the state. Primary care providers and the networks receive a per member per month fee to provide patient care, population management strategies (such as disease and care management, population stratification, preventive services and coordination across delivery settings), as well as support in implementing practice improvements.	Began as a pilot project in 1998; ongoing

State	Initiative	Description	Status
Oklahoma	Health Access Networks[51] and a referral tracking web portal[52]	Nonprofit administrative entities reimbursed on a per member per month basis work with providers to coordinate care for Medicaid beneficiaries through either formal affiliation agreements or partnerships at the community-level with traditional and non-traditional providers. As part of the Assuring Better Child Development III project, Oklahoma built a web portal that allows pediatric and community providers to track referrals for children identified as at-risk for developmental problems.	Implementation began in 2010
Oregon	Coordinated Care Organizations[53]	Coordinated Care Organizations (CCOs) are responsible for integrating and coordinating physical, mental, behavioral, and dental services for Oregon Health Plan enrollees (including dual eligibles). The CCOs receive capitated payments, transformation incentive payments, and Medicare funding to blend with Medicaid funding for dual eligibles, and they are expected to move beyond fee-for-service payment relationships with their provider networks.	Implementation began in 2012
Texas	Various[54]	Texas' health and human services system offers a range of long-term services and supports for adults and children. This services system includes state plan amendments, 1915 (c) waivers, 1115 waiver and proposed 1915 (i) and (k) waivers to provide supports to individuals in their own home, a Program of All-Inclusive Care for the Elderly that includes preventive, acute, and long-term services and support, the 1115 Delivery System Reform Incentive Program, and the STAR+PLUS managed care program that combines primary care and long-term services and supports coverage.[55]	In effect

State	Initiative	Description	Status
Vermont	Community Health Teams and Support and Services at Home (SASH)[56]	Multi-disciplinary teams (may include behavioral health counselors and social workers) work to coordinate community-based support services for participants in the state's multi-payer patient-centered medical home program, the Blueprint for Health. In addition, a SASH Coordinator and Wellness Nurse are part of a larger team of representatives of local Home Health Agencies, Area Agencies on Aging, mental health providers and others connecting the primary and long-term service systems in Vermont. The teams provide interventions to participants who may live in subsidized housing or out in the community. The teams are supported as part of the federal Multi-Payer Advanced Primary Care Practice Demonstration and receive payment based on a given panel size.	Community Health Teams launched in 2008; SASH program began in 2011

Endnotes

1 Use of the word "patient" at various points in this paper is not intended to indicate a bias in favor of medical models, as opposed to broader models of integrated physical health, behavioral health, long-term services and supports, and socioeconomic supports.

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