The Road Ahead: A Model for Advancing High Performance in Primary Care and Behavioral Health Under Value-Based Payment

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INTRODUCTION

While the landmark passage of the Affordable Care Act increased the financial stability of the safety net nationally, it has also accelerated the pressure for and pace of care delivery and payment experimentation. While Medicaid has been slower to adopt value-based payment models than other payers,[1] the focus on value-based payment and delivery system transformations that improve cost and quality outcomes is likely to continue. To provide the best possible care to patients and thrive in this new environment, community health centers (CHCs) and community behavioral health organizations (CBHOs are inclusive of mental health and substance use disorder treatment) are redesigning their workflows, infrastructure, and partnerships. Many CHCs and some CBHOs are already participating in various value-based payment arrangements, and there will be increasing opportunities and pressures to participate in these arrangements in the coming years.

This paper presents the Model for Advancing High Performance (MAHP) 2.0 -- a clear, unified set of evidence-based actions and infrastructure necessary for CHCs and CBHOs to both provide high-quality, comprehensive primary care and succeed in value-based payment arrangements. With support from the Robert Wood Johnson Foundation through the Delta Center for a Thriving Safety Net, the original MAHP has been revised to create the Model for Advancing High Performance in Primary Care and Behavioral Health (or MAHP 2.0). This revision process reflects a greater emphasis on the bidirectional integration of primary care and behavioral health, recognizing the power and importance of both sectors working together to improve people's health and well-being and to control increasing health care expenditures. The ultimate goal of MAHP 2.0 is to describe the strategies, capabilities, and infrastructure that will help safety net ambulatory care providers thrive in new payment and care environments.

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The original MAHP:

MacColl at KPWHRI, John Snow, Inc.,Leibig Shepard LLC, Qualis Health. Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment [Internet]. California Health Care Foundation; 2018 Mar. 55 p. Available from: https://www.chcf.org/publication/partnering-succeed-small-health-centers/

OVERVIEW OF MAHP 2.0

The MAHP 2.0 model provides CHCs and CBHOs with a roadmap to improve care, demonstrate value, and perform under value-based payment arrangements. Value-based payment arrangements can include a wide range of new payment models, including performance incentives, supplemental payments for care management and coordination, shared savings, and capitated contracts with quality reporting.[2] It describes three interdependent areas of work—improving care to demonstrate value, investing in infrastructure to support improved care, and developing and leveraging partnerships—that are necessary to achieve a financially sustainable safety net that results in the quintuple aim: better whole-person care, better health, lower costs, happier staff, and reduced health disparities.

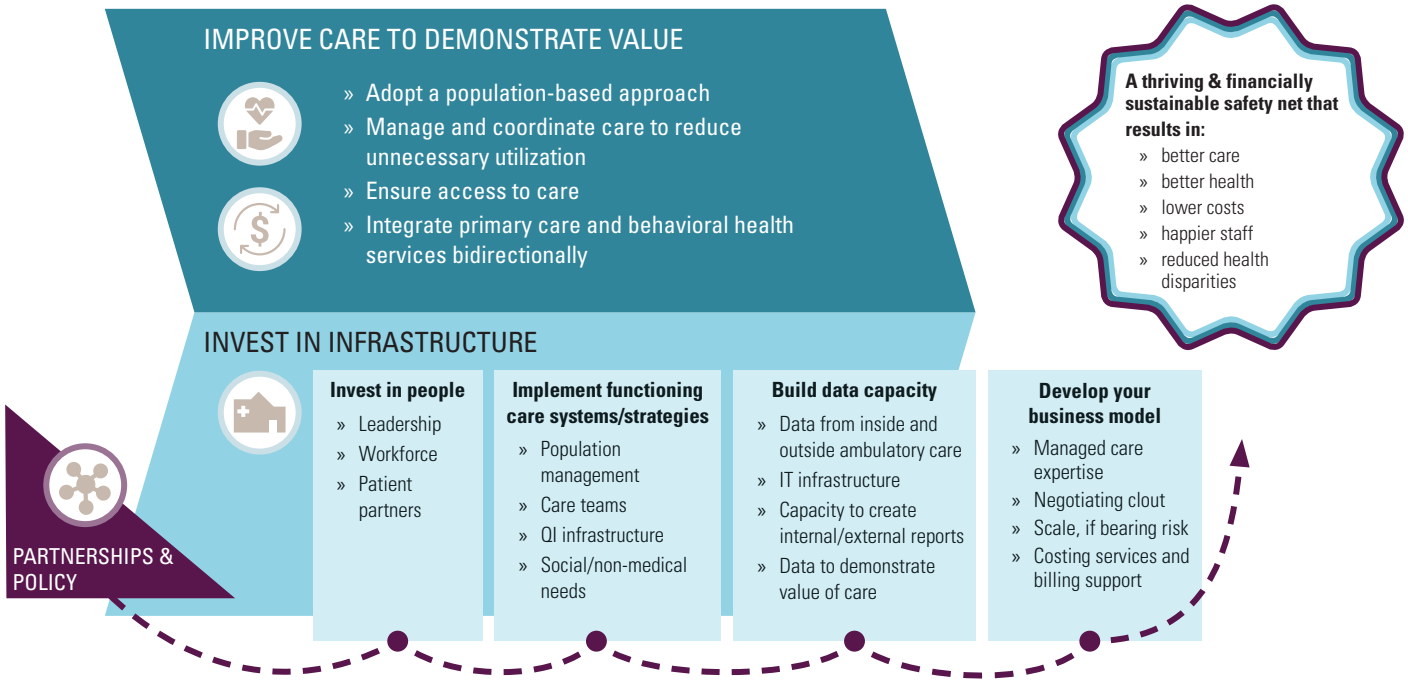
Within the area of improving care to demonstrate value, the MAHP 2.0 offers four strategies: adopt a population-based approach, manage and coordinate care to reduce unnecessary utilization, ensure access to care, and integrate primary care and behavioral health services bidirectionally. While many CHCs and CBHOs are already pursuing some or all of these strategies, more systematic efforts may be necessary in order to prepare for value-based payment and care.

The second area of work is investment in infrastructure in order to successfully pursue these key strategies. CHCs and CBHOs must invest in, improve, and maintain four key components of supporting infrastructure related to people, care systems/strategies, data capacity, and business model. By investing in this infrastructure, organizations will be better poised to improve care, manage cost, and demonstrate value.

The third area of work involves partnerships and the policy environment, which affect provider capacity to improve care and demonstrate value. By participating in various partnerships and monitoring policy developments in their environments, safety net providers can better position themselves to invest in infrastructure to support care improvements.

Together, these three areas of work—improving care to demonstrate value, investing in infrastructure to support improved care, and developing and leveraging partnerships—can support ambulatory care providers as they work to achieve the quintuple aim.

MAHP 2.0: A Model for Advancing High Performance in Primary Care and Behavioral Health*



*Adapted 8/20/2018 from The MacColl Center for Health Care Innovation and JSI Research & Training Institute, Inc. (2018). ***Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment,*** California Health Care Foundation. Available at: https://www.chcf.org/publication/partnering-succeed-small-health-centers/

UNIQUE CHALLENGES AND OPPORTUNITIES FOR CBHOS

The MAHP 2.0 highlights that the overall payment and delivery reform goals and efforts of CHCs and CBHOs overlap, as do the infrastructure components that are needed to support these goals and efforts. However, the steps that CHCs and CBHOs need to take to operationalize these approaches and put in place this supporting infrastructure will often differ, as the behavioral health and primary care fields have different funding sources, data reporting requirements, regulatory policies, and partnerships. The MAHP 2.0 gives CHCs and CBHOs a shared framework to understand how their goals overlap, despite their differences in organizational culture, clinical language, and processes. By highlighting shared goals, this framework can help guide conversations both within and between primary care and behavioral health organizations that are pursuing improvements in care through value-based payment.

The paper describing the original MAHP model described challenges and opportunities that CHCs faced in pursuing care improvements and investments in infrastructure. With the incorporation of behavioral health into the MAHP 2.0, this paper highlights some of the distinct challenges and opportunities facing CBHOs. For example, the healthcare field is still coming to consensus about uniformly agreed-upon metrics for quality, patient outcomes and other behavioral health measures. Many aspects of measurement, data capacity, and value articulation will require additional steps on the part of many CBHOs when negotiating value-based payment arrangements. While both CHCs and CBHOs operate on thin margins, CBHOs have had fewer opportunities to leverage payment mechanisms such as a prospective payment system (PPS rate) or take advantage of incentive programs to adopt the necessary technology to operate successfully in a value-based payment environment. For this reason, CBHOs will likely place a great deal of emphasis on shoring up the critical infrastructure that organizations must have to participate in value-based payment arrangements. With this in mind, the steps that behavioral health providers take to operationalize and achieve their goals may differ from those taken in primary care. Ultimately, these differences mean that—although primary care and behavioral health providers may align in terms of their long-term goals—behavioral health organizations may need additional support, time, and resources to reach the same goals as primary care providers.

THE MAHP 2.0 MODEL

A. Improve Care to Demonstrate Value

The goal of exploring payment reforms for primary care and behavioral health safety net providers is to align financing to support improved care and reduced costs for the healthcare system. Considerable work has been done to understand how care delivery can be organized to better meet patient needs. Four priority strategies to support care improvement concurrently enable practices to demonstrate the value of their services, a crucial part of participating in value-based pay arrangements. These are: 1) shifting to a population-based approach; 2) providing care management and coordination services to reduce unnecessary and costly utilization; 3) ensuring access to care; and 4) integrating primary care and behavioral health services bidirectionally.[3, 4] Though many safety net organizations already aspire to pursue these strategies, systematic implementation may be more challenging. These efforts to improve care not only help patients but may also help reduce downstream utilization of costly services (e.g. inpatient hospitalization or emergency department visits); as such, these strategies can better position CHCs and CBHOs to articulate the value of their care.

1) Adopt a Population-Based Approach

When providers and care teams take a population-based approach to care, as opposed to an acute care mindset, the care is viewed as a long-term relationship rather than a set of independent, acute care visits. Population management includes using registries and risk stratification to determine which patients need what kind of care, when, and how much. For CBHOs, risk stratification may involve some unique challenges, including defining risk beyond the clinical risk of a patient experiencing poor health outcomes to include services utilization risks (e.g., the risk of unneeded costly care).

A population-based approach also requires providers and care teams to proactively reach out to patients who have not received needed preventive or chronic care, such as screenings for cancer, hypertension, depression, and substance use disorder, to connect them to services. Among CBHOs, new population health care pathways for people with mental health and substance use disorders might incorporate physical health services and social determinants of health and define the frequency and intensity of the intervention as compared to traditional behavioral health interventions.

2) Manage and Coordinate Care to Reduce Unnecessary Utilization

Most CBHOs and many CHCs have long provided care coordination or care management services for some patients. Traditionally, receiving reimbursements for these services has been rare; however, value-based payment arrangements increasingly recognize the importance of such services and may offer the opportunity for CHCs and CBHOs to be reimbursed for these services, particularly if providers can demonstrate that these services lead to reduced morbidity and utilization of costly services such as hospitalizations, emergency department visits, involvement in the criminal justice system, and/or skilled nursing facility stays.

Managing and coordinating care involves developing and utilizing a standard process for making referrals and ensuring that appointments have been completed (i.e., closing the loop), using risk stratification and care management to target resources to the highest need individuals, and integrating medication management into routine care. For many CHCs and CBHOs, this likely means expanding their care management and coordination skillsets and workforce to be able to stratify their population and then provide intensive care management services to individuals at the highest risk for experiencing avoidable, high-cost utilization. For those CHCs and CBHOs that already have a wide range of care management and coordination services in place, this might mean more work to demonstrate the value of this care management and coordination. Accessing real-time data from outside of ambulatory care and building data analytics capabilities can help to demonstrate the effectiveness of these existing services in reducing unnecessary utilization.

3) Ensure Access to Care

Ensuring that patients can access timely care is critical to addressing patients' needs and reducing avoidable adverse events and the utilization of costlier services. CHCs and CBHOs are committed to providing access to social, preventive, chronic, and acute care services for patients, but often patients' needs for services outstrips the capacity to address them. Understanding patient demand for care relative to the available supply of services is a key first step in tackling access challenges. Addressing that gap may include adding staff in high demand areas, leveraging telehealth, re-examining workflows to ensure greater efficiency, developing scheduling protocols to address urgent issues, and engaging a wider range of professionals to be involved during and between visits (i.e., team-based care). Improving access also includes providing scheduling options that are patient- and family-centered, including same day appointments, care via phone or web portal, and facilitating patient access to care team members after hours.

4) Integrate Primary Care and Behavioral Health Services Bidirectionally

A crucial aspect of CHCs and CBHOs providing high-quality care is to address both physical and behavioral health needs, which are often deeply intertwined. Many patients have needs that cut across the boundaries of physical and behavioral health, such as a patient with a recent heart attack who experiences a new depression or an individual suffering from bipolar disorder whose medication has contributed to weight gain and a higher risk for diabetes. Recognizing this cross-cutting nature of many physical and behavioral health needs, it is critical for both primary care and behavioral health providers to be appropriately equipped to serve as a starting point for addressing both types of needs.

Bidirectional integration efforts should be designed around the range of provider-patient relationships. For example, an individual seeking behavioral health treatment might see a therapist weekly, while only seeing a psychiatrist or primary care provider intermittently. As such, this individual could be more comfortable receiving care in a setting with this therapist and might be more likely to access primary care services if they are integrated and available onsite at the behavioral health clinic. The degree and extent of these integration processes can vary significantly, with the spectrum ranging from screening for needs and linking patients to resources, all the way to full integration via a single care plan and multidisciplinary teams. Furthermore, it is crucial for both primary care and behavioral health providers to track their patients' comorbidities on a population level. Because most currently used quality metrics focus on physical health, many behavioral health providers are already tracking their patients' physical health comorbidities, but there is significant room for improvement in screening and tracking behavioral health comorbidities.[5,6]

B. Invest in Infrastructure

In order to pursue the care improvement methods outlined above, there are several major infrastructure components necessary to support this care transformation that are distinct from those required in a fee-for-service environment. This supportive infrastructure includes four major components: 1) people that can lead, staff, and partner in care transformation, 2) functioning care systems/strategies, 3) additional data capacity, and 4) thoughtful business model development. Many CHCs and CBHOs already have key elements of these infrastructure pieces in place, but each piece of this infrastructure must be well developed to support the improvement of care and the articulation of value, both prerequisites for succeeding under value-based payment.

1) Invest in People

There are three key investments in people that are necessary to build a strong foundation for improved care and payment reform: investments in leadership, workforce, and patient partners.

Leadership

Leadership is a core building block to creating high-performing ambulatory care and is essential for creating the kind of change necessary to succeed under value-based payment.[7] In high performing organizations, informed and creative leaders – or teams of leaders – are visibly engaged in care transformation efforts, whether creating meeting time to address improvements, championing the inclusion of patients' perspectives, or ensuring that financial resources are in place to enact staff recommendations.[8]

Workforce

Like leadership, workforce recruitment, retention, and training are essential to develop the care teams, workflows, and analytics required to improve care and demonstrate value. Though challenging for many CHCs and CBHOs, smaller organizations (i.e. most CBHOs and small CHCs) encounter particular workforce challenges. With limited patient volume, lesser ability to bill for many services at CBHOs, and a shortage of behavioral health providers generally, small organizations may struggle to afford hiring high-salaried staff (e.g., prescribers) or the array of skilled staff needed (e.g., disease-specific care managers). Attracting talent is also particularly challenging in rural areas. Furthermore, sending providers and staff to receive new evidence-based trainings requires CHCs and CBHOs to take staff offline--temporarily creating a care shortage and forgoing critical revenue—so trainings must be thoughtfully designed. Fortunately, some CHCs and CBHOs have been able to overcome some of these challenges through participation in alternative payment models that provide opportunities to invest in staffing, such as using 1115 waiver funds to support CHWs working in behavioral health.[9]

Patient partners

Actively partnering with patients to understand and incorporate their voices in the delivery, design, improvement, and governance of CHCs and CBHOs, as well as in the decisions that impact their care, is essential to good care and payment reform.[10] Engaging patients at multiple levels--clinical, peer support, quality improvement, and governance—ensures that they are shaping care to meet their needs, and allows more effective investment of limited dollars in ways that address patient needs.[11] CHCs have a strong history of involving patients in governance, including on the boards of health centers, while CBHOs have a long history of engaging patients to provide peer support, particularly in the treatment of substance use disorders. Both types of organizations can learn from each other about how to better engage patients in these respective areas.

2) Implement Functioning Care Systems/Strategies

With strong leadership and workforce and a commitment to patient involvement, CHCs and CBHOs can build the internal infrastructure to support high-functioning care systems, including population management, care teams, quality improvement infrastructure, and an approach to addressing social/non-medical needs.

Population management

To implement population-based care, CHCs and CBHOs must organize their approach to care differently. Risk stratification of patients, as described earlier, can be crucial in helping providers better understand which patients may need additional support, outreach, or resources. For CHCs, this includes defining patient panels for care teams and actively monitoring panel reports for continuity, access and quality metrics. In the absence of agreed upon metrics to stratify risk for chronic behavioral health conditions, CBHOs must develop and test risk algorithms for their populations and design appropriate care pathways to standardize care in their settings. CBHOs' experiences may prove to be particularly helpful in developing shared metrics well-suited to addressing whole-person care.

Care teams
All of the work needed to improve care and demonstrate value requires a team effort. Indeed, a single clinician alone cannot address all of a patient's needs. In payment models that give providers and affiliated staff additional flexibility to provide care, utilizing a well-defined care team to support patients can be both financially sound and patient-centered. Although both primary care and behavioral health providers can benefit from the use of care teams, the structure and composition of these teams is likely to be different. CBHOs and small CHCs that have challenges hiring, supporting, and retaining ancillary staff might consider innovative hiring practices such as sharing a staff member across sites, investing in cross training existing staff, or co-locating with staff from partner organizations.

QI infrastructure
Teams that are most successful in making changes and improving care choose and use a shared approach for quality improvement, whether Lean, Six Sigma, or the Model for Improvement. Regardless of the methodology, the important aspects of a QI infrastructure include: frequent review of process and outcome metrics, identification of areas for improvement, involvement of the whole team in taking specific, concerted actions to improve processes, and iterative improvement actions until improvement is achieved.[12, 13] Working closely with other CHCs or CBHOs to share best practices and leverage external quality improvement expertise can be transformative, especially for organizations without an in-house QI department.

Response to social/non-medical needs
Providing comprehensive care for patients includes addressing most of the common needs for which a patient presents.[14] As discussed in relation to bidirectional integration, this comprehensive care for CHCs and CBHOs means addressing physical needs and behavioral needs around mental health and substance use disorders. Responding to whole-person needs also includes ensuring patients are connected to social service resources related to housing, employment, food security, etc. Because CHCs and CBHOs frequently care for individuals whose health and well-being are deeply impacted by a host of social factors, many providers view responding to patients' social needs as central to their care model despite limited ability to bill for these services through traditional payment mechanisms. Many CBHOs provide a wide and varied service array as they are nestled within health and human service agencies that respond to their patient populations' social needs. Additionally, CBHOs have a long history of screening for and responding to social needs, which has often been made possible by accessing the resources of their greater organizational care continuum and through their deep relationships with other community organizations. As expectations for CHCs to respond to these needs increase—and as the field's understanding of the relationship between health and social needs deepens—CHCs can look to CBHOs for approaches to engage community partners and connect patients with resources. Both CHCs and CBHOs can take advantage of value-based arrangements that allow them to fund these services, which previously have not been reimbursable.[15]

3) Build Data Capacity
Data capacity infrastructure is crucial to support CHCs and CBHOs in improving care and demonstrating value. Data capacity infrastructure includes data from inside and outside of ambulatory care, IT infrastructure to access and analyze this data, the capacity to create internal/external reports, and the ability to render the data in ways that demonstrates the value of care.

As previously discussed, compared to primary care, behavioral health providers generally have less developed data systems, having been challenged by late adoption of electronic health record systems. In addition, the behavioral health field has not adopted a set of consistent metrics. Together these challenges will mean that building data capacity will likely require additional efforts for many behavioral health organizations.

Data from inside and outside ambulatory care
Utilizing data from inside and outside of ambulatory care to make clinical decisions can prevent costly care and poor outcomes and can bridge some of the most unsafe and costly gaps in care that can exist in the space between care settings. Value-based payment models envision that ambulatory care providers will use data from within their clinic to identify potential care gaps that span a wide spectrum of clinical topics, including cancer screening,[16] immunization,[17] chronic illness management,[18] and substance use disorder and depression screening. Closing such care gaps can help CHCs and CBHOs perform better on pay-for-performance measures and demonstrate the value of care to payers when negotiating for supplemental payment.

To reduce the likelihood of costly adverse events across the health system, CHCs and CBHOs must also use outside data to identify high-risk patients, especially during care transitions. Sharing data between ambulatory care providers and hospitals has historically been a challenge, but CHCs and CBHOs are increasingly identifying ways to leverage and use data from outside of ambulatory care. This process frequently involves

fostering novel relationships with hospitals, connecting to area Health Information Exchanges, leveraging payer preauthorization data to identify admissions, and gaining access to hospital data on admissions, discharges, and transfers. Some CBHOs have taken innovative approaches to obtaining outside data from other sources beyond hospitals, including state Medicaid agencies and organizations related to child welfare, housing, and criminal justice.

IT infrastructure
IT infrastructure is central to improving care and demonstrating value—from optimized EHRs and population health management systems, to established data interfaces with other providers that allow for communication regarding referrals or hospital discharges.

Capacity to create internal/external reports
The ability to generate meaningful information from data at the provider and patient level is crucial to guide care, quality improvement, and reporting. To be helpful for care transformation, data must feed into an organized quality improvement approach that is used by providers and care teams. To be helpful in value-based payment, CHCs and CBHOs need to be able understand, monitor, and act upon clinical quality data that are tied to financially incentivized outcome measures. If involved in arrangements that involve payment for managing specialty costs or total cost of care, CHCs and CBHOs also need to be able to create reports using claims data, the analytic capacity to identify high-risk patients, and the clinical capacity to manage these individuals.[19]

Analytic capacity covers a broad range of functions including: managing incoming data, maintenance of data, data extraction, basic and complex analysis, and data governance. Each of these functions requires an increasing level of training and experience. Research suggests reporting functionality should include both automated and customizable reports that can be run at a local level, including an ability to "drill down" to the care team level and to "roll up" to clinic or system level.[20]

Data to demonstrate value of care
Delivering high-quality comprehensive ambulatory care is necessary but not sufficient for success under value-based payment; providers must be able to prove that their care is resulting in better outcomes. Depending on the payment arrangement, such outcomes could include quality outcomes (often measured by HEDIS scores), reduced total costs (via reducing utilization of high-cost services), and improved patient experience (often measured by CAHPS). Being able to track, improve upon, and report outcomes requires increased sophistication around data analytics. It also requires being intentional and systematic about measuring and improving the effectiveness of some interventions that have long been part of the fabric of CHCs and CBHOs. In behavioral health, CBHOs may need additional time and support in specifying and collecting the data needed to articulate value.

4) Develop Your Business Model
In order to successfully engage in value-based payment arrangements, not only must CHCs and CBHOs improve care and demonstrate value, they also must be able to develop the different elements of their business model that allows them to operate outside of the fee-for-service environment and provide high-quality care within cost parameters.

Costing services and billing support
Understanding the true cost of care is a crucial first step in being able to articulate CHC and CBHO value and business model. As CHCs and CBHOs prepare to negotiate with payers for both upside and downside risk sharing contracts, this understanding will position them to demonstrate and articulate the value of their services in their communities and states. As CBHOs prepare to transition from a fee-for-service environment into a value-based payment environment, it is critical that they have a true understanding of their costs to deliver services (both individual encounters and episodes or service packages). To optimize success, CBHOs must collect baseline financial data, incorporate lean approaches to service delivery to drive down costs and benchmark progress over time. These healthy business practices will ensure that safety net providers strategically enter into sound contracts with payers.

Managed care expertise
Because of the ubiquity of managed care in Medicaid, CHCs and CBHOs need the expertise to align and communicate their value within the managed care system.[21] CHCs and CBHOs need to be able to understand the goals and regulatory frameworks that guide managed care plans, such as service standards, quality metrics and network adequacy standards for which the MCOs are accountable. Once providers are able to demonstrate and articulate the value of the care they provide to the managed care system, they can better negotiate contracted payments. Having such managed care expertise can support relationships with health plans and can be an essential element of a business model for sustaining improved ambulatory care.

Scale for negotiating clout
Having size and scale—whether as an individual organization or as part of a network—can be important aspects of a CHC or CBHO business model for achieving economies of scale when it comes to infrastructure investments, when assuming financial risk and for having the negotiating clout to obtain favorable contract terms with a payer.[22] Small size can be a challenge when engaging with payers, because providers have less negotiating power when they approach plans individually. If a CHC or CBHO represents a small portion of a plan's total lives, it is easier for the plan to exclude them from value-based contracting. Similarly, health plans can also find the process of contracting with many small CHCs and CBHOs burdensome and may be interested in fostering CHC or CBHO networks, such as IPAs, to reduce the cost of negotiating with and managing contracts with many organizations.

Additionally, larger entities are often seen as more desirable to work with because they are perceived as having a greater capacity to implement change and as being more financially stable. And while these networks are widespread for CHCs, there are similar examples in the behavioral health space. CBHOs must position themselves to provide the full service array to complement the populations they serve and the populations attributed to their payers. In some instances, this could include joining or creating networks with CHCs and in other instances this might include joining or creating networks with other CBHOs.

C. Partnerships and Policy

Partnerships and policy can greatly influence the ability of CHCs and CBHOs to enhance their infrastructure and delivery of high-quality ambulatory care. Building the infrastructure needed to support high-quality ambulatory care is often difficult for smaller organizations, particularly if their financial and operational infrastructure is already strained. However, relationships with agencies and stakeholders outside of the CHC or CBHO offer opportunities in infrastructure development, care delivery, participation in value-based payment arrangements, securing flexible or additional revenue, and policy development that would be impossible to achieve alone. Partnerships can range from mergers; to linking to community agencies or schools for services like behavioral health; to working with other health centers through consortia to share clinical and/or administrative services; to networking through IPAs or ACOs to negotiate for investments from payers, pay-for-performance, or risk-based contracts. It is also important to note that different partnership strategies are not mutually exclusive, and many organizations will choose to pursue multiple partnership strategies concurrently.

Other partnerships with community-based agencies and organizations (local government and nonprofit) can help to offer patients comprehensive care that addresses medical, behavioral, and social needs. Partnerships with hospitals can improve care coordination; data sharing; access to specialists, lab services, and pharmacy services; additional funding for staff positions; and potential grants from a hospital community benefit program. These relationships can greatly enhance the quality of care and value of a CHC or CBHO.

Finally, the policy environment—at the local, state, and national level—can greatly influence the work and capability of CHCs and CBHOs in value-based payment and care. It is beneficial for CHCs and CBHOs to monitor policy developments to be aware of potential opportunities. Strategic and community partners may become allies in working together to influence local or state policy, particularly through a state primary care or behavioral health association.

CONCLUSION

The MAHP 2.0 illustrates how care strategies, investing in infrastructure, and partnerships and policy are necessary to succeed in value-based payment arrangements for both CHCs and CBHOs. The incorporation of behavioral health in the MAHP 2.0 highlights the shared goals, infrastructure components, and partnerships between CHCs and CBHOs. Relative to CHCs, CBHOs have had fewer opportunities to participate in value-based payment arrangements and adopt the necessary technology to operate successfully in a value-based payment environment, and therefore may require additional support, time, and resources to reach the same goals as primary care providers. However, from these challenges, new opportunities for partnerships arise for CHCs and CBHOs—within, between, and beyond primary care and behavioral health—that will be crucial to improving health outcomes for patient populations while succeeding in value-based payment models.

ENDNOTES

1. The MITRE Corporation. APM Measurement, Progress of Alternative Payment Models: LAN Insights into APM Adoption. Accessed January 17, 2019. http://hcp-lan.org/workproducts/apm-discussion-2018.pdf
2. John Snow, Inc. Health Centers and Payment Reform: A Primer [Internet]. National Association of Community Health Centers; 2013 Oct. 24 p. Available from: http://www.nachc.org/wp-content/uploads/2015/11/Health-Centers-and-Payment-Reform.pdf
3. Thomas Bodenheimer et al. "The 10 building blocks of high-performing primary care." The Annals of Family Medicine 12.2 (2014): 166-171.
4. Edward H. Wagner et al. "The changes involved in patient-centered medical home transformation." Primary Care: Clinics in Office Practice 39.2 (2012): 241-259.
5. Chuck Ingoglia et al., "Using Medicaid Accountable Care Initiatives to Improve Care for People with Serious Behavioral Health Conditions", National Council for Behavioral Health, 2017.
6. Shandra Levey et al., "Behavioral health integration: an essential element of population-based healthcare redesign," Translational Behavioral Medicine. 2012 Jul 26;2(3):364-71.
7. Bodenheimer et al., "10 Building Blocks," 166-71.
8. Safety Net Medical Home Initiative. "Engaged leadership: strategies for guiding PCMH transformation. Safety Net Medical Home Initiative Implementation Guide Series. 2nd ed." Qualis Health and The MacColl Center for Health Care Innovation at the Group Health Research Institute. 2013.
9. Texas Health and Human Services Commission. "Medicaid 1115 Waiver". https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver. Accessed January 14, 2019.
10. "Health Policy Brief: Patient Engagement," Health Affairs, February 14, 2013, doi:10.1377/hpb20130214.898775.
11. Nadereh Pourat et al., "In California, Primary Care Continuity Was Associated with Reduced Emergency Department Use and Fewer Hospitalizations," Health Affairs 34, no. 7 (July 2015): 1113-20, doi:10.1377/hlthaff.2014.1165
12. Bodenheimer et al., "10 Building Blocks," 166-71.
13. Wagner et al., " Changes Involved in Patient-Centered," 241-59.
14. Katie Coleman et al., "Redefining Primary Care for the 21st Century, Agency for Healthcare Research and Quality", October 2016, www.ahrq.gov (PDF).
15. Anna Spencer et al., "Using Medicaid Resources to Pay for Health-Related Supportive Services: Early Lessons". Center for Health Care Strategies, Inc., December 2015.
16. Gloria D. Coronado et al., "Using an Automated Data-Driven, EHR-Embedded Program for Mailing FIT Kits: Lessons from the STOP CRC Pilot Study," Journal of General Practice 2 (2014), doi:10.4172/2329-9126.1000141.
17. Jessica S. Ancker et al., "Associations Between Healthcare Quality and Use of Electronic Health Record Functions in Ambulatory Care," Journal of the American Medical Informatics Association 22, no. 4 (July 2015): 864-71, doi:10.1093/jamia/ocv030.
18. Jason C. Goldwater et al., "Open Source Electronic Health Records and Chronic Disease Management," Journal of the American Medical Informatics Association 21, no. e1 (February 2014): e50-e54, doi:10.1136/amiajnl-2013-001672.
19. John Snow Inc., "Using Data to Manage Population Health Under Risk Based Contracts", June 2017, https://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=18633&lid=3 (PDF).
20. Erica A. Smith et al., "Using Health Information Technology and Data to Improve Chronic Disease Outcomes in Federally Qualified Health Centers in Maryland," Preventing Chronic Disease 13 (December 29, 2016): E178, doi:10.5888/ pcd13.160445.
21. Centers for Medicare and Medicaid Services (CMS), " Medicaid Managed Care Enrollment and Program Characteristics," 2014.
22. Accelerating and Aligning Population-Based Payment Models: Patient Attribution, The MITRE Corporation, 2016, www.mitre.org (PDF).