

Framework for Whole-Person Care Integration in State Medicaid Programs

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Summary

Whole-person care is an approach to coordinate physical health, behavioral health, and social services to meet the needs of complex patients. This approach encourages clinicians and health systems to look beyond an individual health encounter to examine family, community and population-level factors that impact health. Whole-person care is increasingly important as health systems grapple with improving care for high-cost, complex patients and addressing disparities among those with complicated health and social needs. State Medicaid agencies have an important role to play in health care system transformation by supporting the delivery of whole-person care for people covered by Medicaid. This brief outlines a framework that state Medicaid agencies can use to develop approaches to integrating care and provides examples of efforts to advance whole-person care.

Introduction

Whole-person care takes a holistic view of health and encourages health providers and systems to consider the individual-, family-, community-, and population-level factors that help or hinder a patient's health.ⁱ State and federal health care policy increasingly supports efforts to integrate and coordinate physical and behavioral health care services, as well as social services. Up to 90 percent of a person's health can be attributed to factors outside of the health care setting, including health behaviors, social determinants of health, and environmental factors.^{ii,iii}

Whole-person care also puts patients at the center of their own care by working to understand what matters most to each person and building trusting, ongoing relationships between the patient and the service provider.

No Wrong Door. Attaining whole-person care requires reimagining the health care system so that people's physical, social, behavioral and socioeconomic needs can be identified and addressed using a multi-disciplinary approach no matter where they present in the health care system. Instead of focusing solely on treating people's symptoms or presenting conditions, the "no wrong door" model is designed to address root causes of chronic

disease and complex health issues. The goal is that no matter where people present for care—from a primary care clinic to the emergency department—they will receive or be connected to the health and social services they need. People will have all of their needs met as the health care system becomes more adept at coordinating care and offering lifestyle and behavioral interventions.

Policy Efforts to Integrate Health and Social Needs.

Efforts to redesign the health care system to better address the full scope of a person's health-related needs have grown over time. For example, the 2010 Affordable Care Act (ACA) catalyzed a focus on integrating physical and behavioral health care delivery incentivizing integrated and coordinated models of care, such as accountable care organizations, and by promoting delivery models that reduce fragmentation in the delivery of health services. Since then, policy interest has broadened to begin addressing the social determinants of health (SDOH)—the conditions where people live, learn, work, and play^{iv}—by recognizing health-related social needs. For example, the concept of "social prescribing," where a clinician refers a patient to a range of nonclinical community services—from exercise or cooking classes to help with housing

security—has been shown to have positive effects on patients’ mental and physical wellbeing.^{v,vi}

Today’s efforts to improve whole-person care focus on populations with complex needs, including people living with disabilities,^{vii} children who have experienced trauma,^{viii} and people experiencing homelessness.^{ix} The U.S. Department of Veterans Affairs has adopted a whole-health approach to “improve the health and well-being of veterans and to address lifestyle and environmental root causes of chronic disease. The approach shifts from a disease-centered focus to a more personalized approach that engages and empowers veterans early and throughout their lives to prioritize healthy lifestyle changes in areas like nutrition, activity, sleep, relationships, and surroundings. Conventional testing and treatment are combined with complementary and integrative health approaches that may include acupuncture, biofeedback, massage therapy, yoga, and meditation.”^x There are also efforts being made at the state level. For example, California has implemented the CalAIM program which aims to promote a whole-person, person-centered strategy to assess each enrollees’ health risks and health related social needs to promote wellness and prevention and support care coordination across delivery systems and settings.^{xi}

preventive care and to deliver care effectively and efficiently for people with multiple, often chronic, conditions. Because true care integration requires cross-system transformation, which is difficult to achieve in the fragmented U.S. health care system, with its patchwork of public and private payers, care integration has advanced incrementally. The Center for Integrated Health Solutions, funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), has developed a framework (first published in 2013 and updated in 2020) demonstrating the continuum for achieving care integration. The continuum includes six basic levels of integration, beginning with minimal collaboration and evolving to the level of a fully transformed/merged practice (see **Exhibit 1**).^{xii}

The framework illustrates that as care delivery becomes increasingly integrated, practices move from coordinating care through communication in a level 1 or 2 system (traditional models of care and care management are good examples of this) to working in closer physical proximity in a level 3 or 4 system (co-located models of care), and finally toward a more integrated or transformed/merged practice in a level 5 or 6 system. Finally, the system approaches full transformation, which requires Medicaid to align with other agencies and payers.

Many state Medicaid programs initially focused on improved integration of physical and behavioral health services. As mental health and substance use services have become increasingly integrated into Medicaid, policymakers became interested in broadening the scope of services offered in this integrated framework. For example, recently there has been increasing interest in including the integration of health-related social needs into this framework.^{xiii}

Whole-Person Care and Care Integration

The concept of whole-person care builds on advancements in care integration. Initially, efforts to improve care integration were sought to identify behavioral health needs among patients seeking primary and

Exhibit 1. SAMHSA-HRSA Center for Integrated Health Solutions Framework



Medicaid’s Role in Integrating Physical and Behavioral Health Care—First Steps Toward Whole-Person Care

Many states have worked in earnest to improve care integration over the past decade, in large part spurred by the ACA, which authorized delivery system and payment reforms designed to advance high-quality, affordable patient-centered care. The ACA also expanded Medicaid’s purview over behavioral health services, leading to more integration of behavioral health into the traditional physical health delivery system.^{xiv} A major focus of these innovations includes alternative payment models and multi-payer alignment efforts. The Mental Health Parity Act of 1996, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the ACA required parity between physical and mental health.^{xv} The ACA also expanded Medicaid coverage to childless adults with incomes below 133 percent of the federal poverty level, which created new demand for behavioral health services and provided additional financial resources to support state behavioral health systems. As a result, states aimed to reduce fragmentation between physical and behavioral health systems and deliver more integrated care.

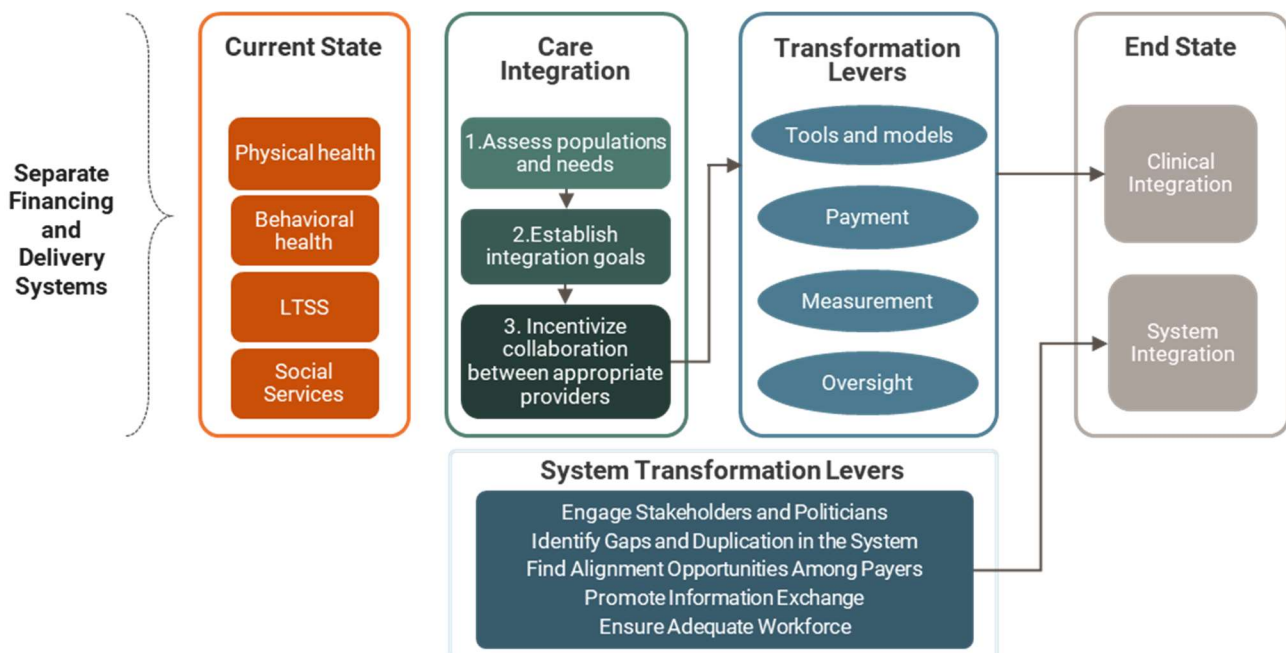
Major efforts to integrate care have incorporated the inclusion of behavioral health services in Medicaid managed care contracts^{xvi}; investments in Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for substance use disorders^{xvii}; the creation of certified community behavioral health clinics designed to improve community-based treatment services^{xviii}; investments in

infrastructure to support integration, including electronic health records and alternative payment models^{xix}. More recently, funds from the American Rescue Plan Act to support health care system recovery from the impact of the COVID-19 public health emergency expanded mental health and substance use treatment programs with the goal of increasing access to these services broadly.^{xx} The non-partisan National Association of Medicaid Directors also strongly supports integration of physical and behavioral health services as part of its strategic vision for the future of Medicaid.^{xxi}

Health Care System and Delivery Transformation to Support Whole-Person Care

Whole-person care transformation requires that states understand the full view of clinical and systems-level change required to support a person’s care holistically. **Exhibit 2** describes the process for health care system transformation to support improved care integration, culminating in the delivery of whole-person care. The first column on the left describes the original or current state of care delivery and financing. While this siloed structure is not universal across states, many states maintain separate administration for physical health, behavioral health, long-term services and supports to help older adults and people with disabilities live at home or in community settings, and social services. System-level transformation to deliver whole-person care requires partnerships and broader assessments of the health care delivery system.

Exhibit 2. Whole-Person Care Delivery Transformation Process



Promoting Clinical Integration. States can take multiple actions to promote *integration at the clinical level*. States can conduct needs assessments to determine which populations are most likely to benefit from improved care integration and which settings are best equipped to deliver integrated, whole-person care. High-cost populations with complex needs, who may be getting care across multiple systems—for example, people with co-occurring mental health conditions and developmental disabilities or people needing long-term services and supports and who have health-related social needs—may benefit most from improved integration. A needs assessment will help states establish goals for integrating care and understand where incentives can be better aligned to promote collaboration between providers and across settings.

The levers for incentivizing collaboration at the clinical level include providing tools, such as SBIRT, and models of care, such as the Collaborative Care Model, that support providers in identifying and addressing multiple patient needs at one time. Additionally, value-based payment arrangements that encourage or enhance care coordination are also important.^{xxii} States can also establish performance metrics to drive care integration, such as increased proportions of Medicaid enrollees receiving co-located physical and behavioral health services or decreased prevalence of food insecurity among patients with serious mental illness. Oversight mechanisms, such as managed care contracts, can be used to hold providers accountable for delivering integrated whole-person care. If levers are aligned effectively, they can improve coordination and collaboration among providers, which improves clinical integration, advances whole-person care and results in better health and life outcomes.

Achieving System-Level Integration. To achieve *system-level integration*, state Medicaid agencies need to look beyond Medicaid and engage with the broader public health and social service systems. The goal of *transforming a fragmented system* into a fully integrated one that can support whole-person care requires infrastructure development and partnerships. Engaging partners can help ensure agreement and buy-in among invested parties in the state, and political leaders can generate buy-in for legislative or executive options to address fragmented care. Assessing and identifying gaps and duplication across systems can facilitate streamlining benefits, address unmet needs, and reduce inefficiencies and waste. Engaging with other payers—such as Medicare and commercial health insurers—can help align incentives and send a stronger signal to providers for practice change. Identifying and addressing barriers to

information exchange among providers is also critical to an integrated system of care. A well-functioning interoperable Health Information Exchange is vital to the success of integrated, whole person care.^{xxiii}

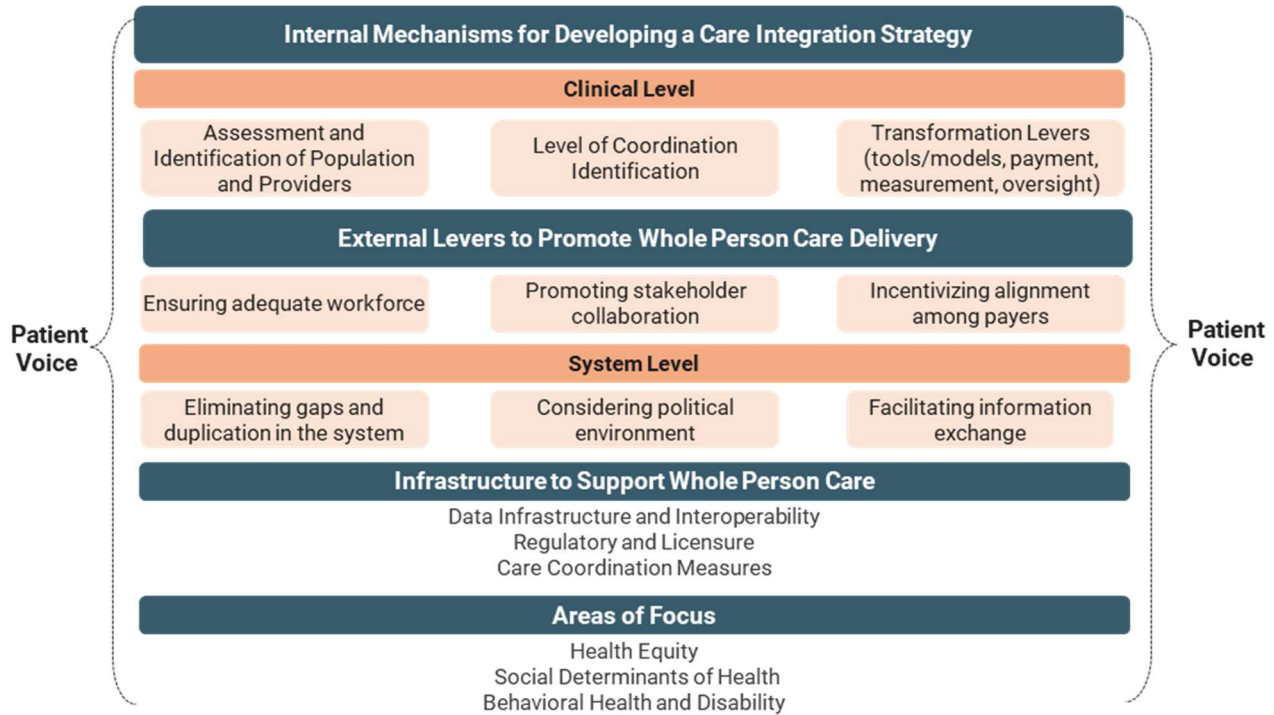
Finally, ensuring there is an adequate workforce to address all populations' health needs is critical. For example, the available workforce to address mental health and substance use issues is often inadequate in states, which can pose a significant barrier to meeting behavioral health care needs. Adequate must mean not just that there are enough providers available at the state level but also that access is equitably available economically, geographically, culturally, and linguistically.

Framework for Advancing Whole-Person Care in State Medicaid Programs

Building on the SAMHSA-HRSA framework to establish a continuum along which care integration occurs, NORC at the University of Chicago has developed a framework that can be used by state Medicaid agencies to guide planning and decision-making toward system-level whole-person care delivery. While care integration is an important aspect of addressing the full scope of patient needs, whole-person care delivery requires system-level transformation, collaboration across stakeholders, and alignment across systems to be fully realized. The framework demonstrates that state Medicaid agencies have a suite of tools available to directly influence clinical-level integration and need to work closely with partners and across sectors to achieve integration across systems to support whole-person care.

The NORC Framework for Advancing Integrated Care in State Medicaid Programs presents the internal mechanisms that agencies can use for developing a clinical-level care integration strategy as well as the external levers for promoting care integration across the system to support whole-person care. Opportunities to ensure adequate infrastructure to support whole-person care are presented, along with areas of focus to consider in designing and implementing a strategy. Importantly, the framework incorporates patient voices throughout all options for advancing care integration, acknowledging that people will have different needs, experiences, preferences, and goals for their health and health care.

Exhibit 3. Framework for Advancing Integrated Care in State Medicaid Programs



INTERNAL MECHANISMS FOR DEVELOPING A CARE INTEGRATION STRATEGY

The internal mechanisms for developing a strategy include understanding where the greatest need is for care integration—which populations, conditions, providers, services or settings. Identification of the current level of coordination and integration can help the state set goals for advancing along the SAMHSA-HRSA framework for a population of interest. The state can then use any of the system transformation levers to advance clinical integration of different types of services, moving toward the delivery of whole-person care.

EXTERNAL LEVERS TO PROMOTE WHOLE PERSON CARE DELIVERY

State Medicaid agencies also must partner with providers, health plans (Medicaid, Medicare and commercial), care coordinators, community-based organizations, advocates, sister agencies, and elected and appointed leaders and policymakers to forge a common vision for whole-person care. Partners must then work together across systems, sectors, and settings to change service delivery. Key pillars of this work include ensuring that there is an adequate workforce in the state to provide the level of care needed for the population of focus; identifying where incentives can be aligned across payers; pinpointing gaps and duplication of services across systems; and removing barriers to appropriate information exchange. States can encourage workforce changes by refocusing Graduate

Medical Education funds to programs that produce the types of health care professionals needed and with backgrounds similar to those of Medicaid members and make changes to educational programs and standards, as well as licensing and certification requirements. Once a shared vision is established, it is helpful to have political support from key legislators and other figures to ensure that the legal and regulatory environment is supportive of the end goal.

INFRASTRUCTURE TO SUPPORT WHOLE PERSON CARE

In addition to the strategic levers, infrastructure is needed to support whole-person care delivery. States can build out their data infrastructure to be more comprehensive and can focus efforts to identify and communicate key data metrics that are most helpful for primary care providers and others who are coordinating care on behalf of a patient. Service providers in states with separate agencies or systems that license and fund different providers and services—physical health, behavioral health, disability services—may face a complex array of policies overseen by multiple authorities. To incentivize whole-person care, states need to be able to measure the full continuum of care from access and care coordination to patient outcomes and through the lens of health equity. To drive quality improvement and promote joint accountability for outcomes, the use of meaningful quality metrics should be aligned and coordinated across accountable entities.^{xxiv, xxv} States can consider how to streamline and eliminate regulatory barriers, including those related to licensing and financing policy.^{xxvi}

AREAS OF FOCUS

Health Equity

Providing whole-person care can help a state achieve health equity goals. As state Medicaid agencies continue to address disparities in health outcomes among populations—especially among patients from marginalized and historically underserved groups—ensuring that care is integrated and designed to meet the entirety of a patient’s needs can help improve the care experience. States can use a health equity lens to understand the specific challenges that Medicaid enrollees face in accessing care through population stratification analysis and then provide incentives for closing gaps in health outcomes as a component of a whole-person care strategy.

Social Determinants of Health

True whole-person care addresses non-medical, social causes of illness and addresses barriers to health, ranging from food and housing insecurity to a lack of reliable transportation to health care visits to the impacts of toxic stress and trauma on health. States are building capacity to provide services to address social determinants of health within the Medicaid population by encouraging (or requiring) relationships between managed care organizations and community-based organizations. For example, Oregon’s Coordinated Care Organizations include teams of physical health, addiction, and mental health providers who work together with communities to improve prevention and chronic disease management.

Behavioral Health and Disability

States that have multiple agencies providing Medicaid, behavioral health, and disability services may want to pay

particular attention to consolidating the administration of these services and processes to simplify navigation for providers and Medicaid enrollees.

CONCLUSION

Whole-person care transformation is a complex and multifaceted process. States embarking on this journey should start by identifying where their focus is most needed and can be most effective. This brief presents an array of options for states to consider as they work to advance whole-person care in a way that is meaningful for their populations and within the parameters of their own system. States can use this framework to establish strategies for improving care integration to better serve a person’s whole health needs. Ultimately, the nation’s health will be served by understanding and addressing health and social needs in a comprehensive and coordinated way.

ABOUT NORC

NORC at the University of Chicago conducts research and analysis that decision-makers trust. As a nonpartisan research organization and a pioneer in measuring and understanding the world, we have studied almost every aspect of the human experience and every major news event for more than eight decades. Today, we partner with government, corporate, and nonprofit clients around the world to provide the objectivity and expertise necessary to inform the critical decisions facing society.

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