

**Integrating Behavioral and  
Physical Health Care in  
Medicaid:**  
Lessons from State Experiences

---

**Michigan Association of Health Plans Summer Conference  
Traverse City, MI**

**July 23, 2016**

---

**Melanie Au**

# Agenda

---

- **Background**
- **Emerging themes**
- **Summary**
- **Questions**

---

# Background

# Reasons to Integrate BH and PH in Medicaid

---

- Medicaid pays for more than a quarter of behavioral health spending nationally
- One in five Medicaid beneficiaries have a behavioral health diagnosis
- Beneficiaries with behavioral health diagnosis account for almost half of total Medicaid expenditures
- Spending can increase up to 75% when beneficiaries with a chronic physical condition also have a mental illness

Source: *Report to Congress on Medicaid and CHIP*, Medicaid and CHIP Payment and Access Commission, June 2015; *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*, CHCS, Dec 2010.

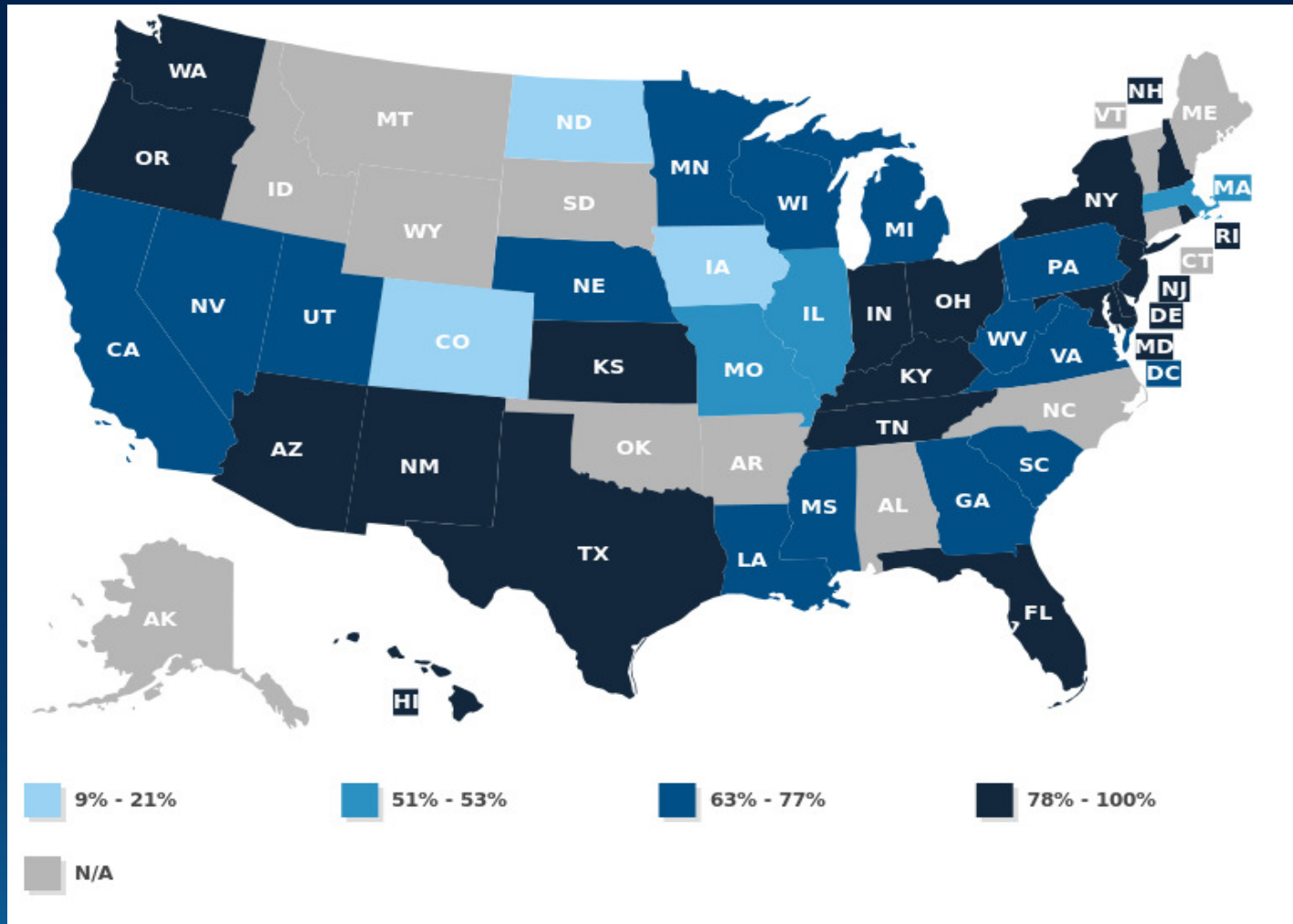
# The Changing Landscape

---

- **Managed care is primary delivery system for state Medicaid programs**
- **Most states still “carve-out” behavioral health services into separate delivery systems**
- **But a growing number of states have moved to “carve-in” behavioral health services in managed care models**

Sources: *Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators*, CHCS, April 2016; *State Health Facts*, Kaiser Family Foundation, March 2016; *What State Medicaid Plans Carve-Out Behavioral Health Services?: An OPEN MINDS Market Intelligence Report*, Jan 2016.

# Most States Now Using Medicaid Managed Care: % Medicaid Pop in MCOs By State (July 1, 2015)



Source: State Health Facts, Kaiser Family Foundation, March 2016

# Approach to Developing this Overview

We reviewed managed care programs in states that have made strides toward integration to understand their experiences with and approaches to integrating behavioral health and physical health services

**Arizona**

Interviewed state official

**Texas**

**Pennsylvania**

Interviewed health plan representative

**Tennessee**

**California**

**Other sources included public reports, issue briefs, news articles, waiver documents, and contracts**

---

# Emerging Themes



# Integrated BH and PH Delivery Models Continue to Evolve

Model	Description	State Example
<b>Comprehensive carve-in</b>	<ul style="list-style-type: none"> <li>BH services are integrated into the MCO benefit package</li> </ul>	<ul style="list-style-type: none"> <li><b>Texas:</b> Sept 2014, carved in Medicaid mental health rehabilitation and case management services in Medicaid MCOs</li> <li>Dec 2016, state ending BH Medicaid carve-out that served North Texas region for over 15 years; BH services will be carved in to Medicaid MCOs</li> </ul>
<b>Hybrid</b>	<ul style="list-style-type: none"> <li>Specialized delivery system for Medicaid beneficiaries with severe mental illness (SMI)</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>Basic BH services integrated into MCO benefit but specialty behavioral services are carved out</li> </ul>	<ul style="list-style-type: none"> <li><b>Arizona:</b> Apr 2014, Regional Behavioral Health Authority (RBHA) in Maricopa County to manage both BH and PH for beneficiaries with SMI</li> <li>Oct 2015, expanded RBHA integrated model statewide; integrated BH and PH services in health plans covering adult beneficiaries dually eligible for Medicare and Medicaid</li> </ul>
<b>Carve-out</b>	<ul style="list-style-type: none"> <li>PH and BH are managed and paid through separate delivery systems</li> </ul>	<ul style="list-style-type: none"> <li><b>Pennsylvania:</b> BH carved out of Medicaid managed care arrangements; state using contract requirements to encourage coordination in Medicaid managed care program</li> <li>Some integration activities at MCO level through demonstration and pilot programs</li> </ul>

## States and Plans Use Targeted and Frequent Communication

---

- Include in design meetings health plans, other major stakeholders and leaders from all affected areas within agency
  - **Arizona:** Inclusive and regular design meetings identified critical design considerations (e.g., crisis services)
- Target providers for communication but use multi-pronged approach, including state-plan partnership
  - **Arizona:** Identified top 100 BH providers directly affected by policy change

# States and Health Plans Set Clear BH Definitions and Transition Policies

---

- Establish clear definitions for basic BH needs and severe BH needs
  - **California:** Medicaid plans and county mental health plans collaborated to develop a common language
- Establish clear policies for smooth transitions across systems
  - **California:** Emerging practices to limit service disruptions as members fluctuate between mild-to-moderate and severe mental health needs
    - Transitions of care forms
    - BH providers from community-based clinics included in health plan network

Source: *Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members*, CHCS, June 2016.

# States Balance Flexible and Prescriptive Requirements To Build Provider Capacity

---

- Give health plans flexibility and support to build new BH infrastructure
  - **Arizona:** State supported plans in offering higher provider rates to encourage participation in networks
- Include clear contract requirements to support coordination when plans subcontract with BHOs
  - **Texas:** State recommended that health plans have integrated technology and care coordination systems for physical and behavioral health
  - **California:** MCOs embedded subcontracted BHO personnel with health plan staff

## States Balance Flexible and Prescriptive Requirements to Build Provider Capacity *(Cont.)*

---

- Support and encourage streamlined BH provider credentialing
  - **Arizona:** Arizona Association of Health Plans created a credentialing alliance that sets up one centralized process for credentialing that applies to all participating plans
  - Some states have changed credentialing rules to allow “nontraditional” providers to bill Medicaid for services

## State and Health Plans Partner to Invest in Provider TA

---

- BH providers need support and TA to improve infrastructure and competency within managed care environment
  - **Arizona:** Health plans allowing providers some flexibility to adjust to system of pre-authorization for transportation and other services
  - Providers, especially small providers, will need help with new policies and procedures that affect day-to-day activities (billing and reporting requirements, working with care coordinators)

# Health Plans Develop Tools and Infrastructure to Facilitate Data Exchange

---

Establishing interoperability among systems and providers to support seamless and timely data exchange is a big lift for most integrated delivery systems, but there are examples of initial strategies.

- Philosophical and legal issues regarding enrollee privacy can inhibit information exchange
- Create tools to help with data exchange at the individual beneficiary level
  - **California:** PH and BH health plans developing standard release of information forms
- Develop infrastructure to help with information exchange
  - **California:** Health plan granted BH providers access to web-based provider portal system

Source: *Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members*, CHCS, June 2016.

# Mitigate Philosophical and Organizational Differences Between BH and PH systems

Regardless of where states are on the spectrum of integration, there are strategies to mitigate philosophical and organizational differences between BH and PH systems and providers

## Arizona

- July 2016, merger of Division of Behavioral Health Services and Arizona's Medicaid Agency

## Pennsylvania

- BH carved out of managed care arrangement; but encouraging integration of BH and PH through contract requirements

### Emerging strategies:

- Engage leaders from both systems as champions
- Invest in outreach and education for internal staff, providers, and members
- Develop personal and trusting relationships with partners across the systems



## States Develop Strategies to Incorporate Social Services

---

- States are supporting initiatives to coordinate and facilitate access to social services and housing supports for Medicaid beneficiaries
  - **Arizona:** Mercy Maricopa (RBHA) offers temporary and permanent supportive housing services and supported employment services
  - **Tennessee:** MCOs cover supported housing and employment services under psychiatric rehabilitation services for beneficiaries with SMI
  - **Texas:** 1115 waiver directs funding to support services for individuals in supportive housing or those experiencing homelessness and mental illness

Sources: *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, Kaiser Family Foundation, Nov 2015; *Strategies for Integrating and Coordinating Care for Behavioral Health Populations: Case Studies of Four States*, ASPE, Jan 2014.

---

---

# Summary

# Summary

---

State integrated behavioral health and physical health care models continue to evolve

States and plans are using targeted and frequent communication to engage stakeholders; establishing clear definitions for levels of mental health needs and transition policies

States are balancing flexible and prescriptive requirements to build BH provider capacity; supporting and encouraging investment in provider technical assistance

Health plans developing tools and infrastructure to facilitate data exchange

States and plans are using strategies to mitigate philosophical and organizational differences between BH and PH systems and providers

States beginning to develop strategies to integrate social services for beneficiaries with behavioral health needs

# Questions Facing States and Health Plans

States and health plans will continue to face important questions on how to integrate behavioral health and physical health services

- How to better coordinate and integrate behavioral and physical health services?
- Whether to carve in or carve out behavioral health services from MCO benefit packages?
- For carve-in states, what requirements are needed to ensure integration is occurring at the clinical level?
- For carve-out states, how to promote coordination between BH and PH systems?
- How to help physical health MCOs build BH capacity?
- How to ensure BH providers are prepared to meet Medicaid requirements and contract with MCOs and BHOs?
- How to support and encourage data exchange among systems and providers?
- How to combine different cultures of BH and PH systems?
- How to address social service needs of managed care beneficiaries with BH needs?

---

**Melanie Au**

**MAu@mathematica-mpr.com**