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Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators

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IN BRIEF

Medicaid enrollees with behavioral health needs have a high prevalence of chronic conditions and are often frequent users of physical and behavioral health services. This brief, made possible by Kaiser Permanente Community Benefit, provides insights from Medicaid officials and health plan representatives in five states — **Arizona, Florida, Kansas, New York** and **Texas** — that are pursuing innovative approaches to integrate behavioral health services within a comprehensive managed care arrangement. It explores key lessons to guide state integration efforts designed to improve outcomes and reduce costs:

- Evidence of a movement toward integrating, a.k.a., "carving-in," physical and behavioral health services to address "whole-person" care.
- Three emerging options for integration, including comprehensive managed care carve-in, specialty plans for individuals with serious mental illness (SMI), and hybrid models.
- Strategies to facilitate integration, with a focus on engaging key stakeholders, balancing oversight and collaboration in state-plan relationships, and advancing clinical integration and cross-system accountability.

Medicaid is the single largest payer in the United States for behavioral health services, accounting for roughly 26 percent of behavioral health spending nationally.[1] As many as one in five Medicaid beneficiaries has a behavioral health diagnosis — encompassing both mental health and substance use disorders — with this small subset of the overall population incurring almost half of total Medicaid expenditures. Spending for those with a behavioral health diagnosis is nearly four times higher than for those without.[2] High service use and spending for this group, however, does not reflect behavioral health service utilization only. Medicaid enrollees with behavioral health diagnoses often have an array of physical health needs, including conditions associated with tobacco and alcohol use, such as chronic obstructive pulmonary disease, asthma, and chronic liver disease and cirrhosis.[3] The addition of a mental illness to one or more common chronic physical conditions can increase health care costs by up to 75 percent.[4] Finally, individuals with serious mental illness (SMI) have significantly higher medical costs, yet only a small percentage of overall costs for this population are attributed to mental health services.[5]

Although this Medicaid population has a complex array of behavioral and physical needs and high associated costs, many are served in fragmented systems of care with little to no coordination across providers, often resulting in poor health care quality and high costs. Increasingly states are seeking ways to better coordinate physical and behavioral health services with the goal of improving outcomes and reducing unnecessary utilization. One strategy gaining traction is the move to integrate behavioral health services within a comprehensive Medicaid managed care environment

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that traditionally covered physical health services only. This brief explores how five innovator states — **Arizona, Florida, Kansas, New York**, and **Texas** — have integrated behavioral health within comprehensive managed care arrangements. It reviews practical program design and implementation considerations to inform additional states' efforts to "carve-in" behavioral health into existing managed care arrangements or provide an alternative integrated arrangement. These new approaches to integration are particularly valuable as states expand Medicaid and recognize the benefits of Medicaid coverage for individuals with behavioral health needs.[6]

Background: Medicaid Managed Care and Behavioral Health

Managed care is the predominant financing model for state Medicaid programs, with nearly 40 states contracting with managed care organizations (MCOs) to provide all or some physical health benefits for beneficiaries.[7] Most states, however, provide Medicaid behavioral health services outside of these managed care arrangements. Under this approach, states "carve-out" behavioral health services from managed care contracts and risk arrangements to provide services via either a separate managed behavioral health organization (BHO) or fee-for-service (FFS).

More states in recent years have adopted integrated payment and delivery models that cover all or some combination of physical, behavioral health, long-term services and supports (LTSS), and other social supports needs. A rapidly growing number of states are adopting managed care models in which a single entity is responsible for both behavioral and physical health services, thus "carving-in" behavioral health services. As of January 2016, 16 states currently provide or are planning to offer behavioral health services through an integrated managed care benefit — up from just a handful a few years prior.[8] By combining physical and behavioral health services in a comprehensive managed care arrangement, Medicaid programs can align system incentives and increase accountability for managing a more complete range of services. In doing so, states can provide more seamless care for beneficiaries.

Administering integrated systems of managed care for high-need beneficiary populations is, however, a complex undertaking. These programs require: (1) specialized clinical expertise at the health plan level; (2) state capacity for robust oversight and monitoring; (3) innovative strategies for advancing whole-person care to address beneficiaries' complex needs; and (4) mechanisms for achieving and maintaining provider and other stakeholders' support.

Overview of States

The five states profiled in this brief use three different approaches to integrate physical and behavioral health services[†] into managed care (see Exhibit 1 for details):

1. **Comprehensive Managed Care Carve-In:** Kansas and Texas "carved-in" behavioral health services into comprehensive managed care plans that provide physical health services and/or LTSS to all or most Medicaid beneficiaries. Managed care plans in these states may subcontract with behavioral health organizations (BHOs) that manage behavioral health needs, but bear the risk for managing these benefits.

[†] We use the term "behavioral health" to reflect that most states interviewed for this paper have implemented programs that address both mental health and substance use disorder treatment needs. However, some reforms focus on individuals with serious mental illness only.

2. **Specialty Plan for Beneficiaries with SMI:** Arizona and Florida pioneered integrated models designed specifically for individuals with SMI. These specialized plans enroll those with SMI or other serious behavioral health needs as well as provide physical health services.
3. **Hybrid Model:** New York uses a hybrid approach in which the state is: (1) carving-in all state plan behavioral health services into its mainstream managed care plans; and (2) designating a subset of these plans as Health and Recovery Plans (HARPs) that will offer a separate product line and additional specialized services for individuals with serious behavioral health needs.

EXHIBIT 1: Overview of State Behavioral Health Integrated Care Models

State	Model	Launch Date
Arizona‡	Specialty plan for beneficiaries with SMI	Apr. 2014: Maricopa County.; Oct. 2015: Greater Arizona
■ Implemented an integrated physical and behavioral health program for Medicaid beneficiaries with SMI. ■ Behavioral health services previously carved out of managed care and managed by Regional Behavioral Health Authorities (RBHA). ■ Awarded a competitive contract to Mercy Maricopa Integrated Care (or Mercy Maricopa) to serve as an integrated RBHA and coordinate behavioral and physical health services for beneficiaries with SMI in Maricopa County. ■ Following Maricopa, Arizona expanded this platform for Medicaid enrollees with SMI statewide and awarded integrated RBHA contracts in the state's rural northern and southern regions. ■ Requires Medicaid health plans that cover physical health to provide some behavioral health benefits to Medicare-Medicaid enrollees.		
Florida	Specialty plan for beneficiaries with SMI	Jul. 2014
■ Part of legislatively mandated Statewide Medicaid Managed Care, a comprehensive managed care reform that required the Agency for Health Care Administration to release a competitive procurement that allowed specialty plans (e.g., plans focused on specific populations such as individuals with HIV/AIDS, SMI, and recipients in the child welfare system) to bid on acute care contracts. ■ Magellan Complete Care of Florida selected to serve as a fully integrated specialty plan to manage Medicaid benefits for individuals with SMI in eight of 11 regions. ■ Provides all medical and behavioral health services.		
Kansas	Comprehensive managed care carve-in	Jan. 2013
■ Implemented a comprehensive managed care program via an 1115 waiver, KanCare, including all physical, behavioral, and LTSS. ■ Previously provided behavioral health services via carved-out, specialized mental health prepaid ambulatory plans through local behavioral health clinics. These clinics remain the primary source for behavioral health services, and contract with KanCare. ■ Released an RFP in 2012 to identify plans to provide "whole person care" via interdisciplinary teams; selected three plans.		
New York	Hybrid model	Oct. 2015: New York City; expected 2016 phase-in statewide
Two-part managed behavioral health reform: ■ Integrating all Medicaid behavioral health services currently provided via FFS into its mainstream Medicaid managed care plans. All 10 plans serving the New York City region manage behavioral health services internally or contract with a BHO. The rest of the state regions will phase-in during 2016. ■ These plans can apply to serve as Health and Recovery Plans (HARPs) that will offer community-based benefits to individuals age 21 and older with significant behavioral health needs. The HARPs will function as separate lines of business within each designated health plan.		
Texas	Comprehensive managed care carve-in	Sep. 2014
■ Carved-in Medicaid mental health rehabilitation and case management services into existing 19 Medicaid health plans (20 plans by November 2016) as mandated by 2013 Senate Bill 58. ■ Allows health plans to provide services in-house, or contract with a BHO. ■ Prior to enactment of SB 58, provided services via FFS by Local Mental Health Authorities (LMHAs), the state's network of community mental health centers. Plans now directly contract with LMHAs and other behavioral health entities to provide services.		

‡ The Arizona state agencies that oversee behavioral health services for Medicaid beneficiaries will also be integrating their responsibilities. Previously the Division of Behavioral Health Services (DBHS) in the Department of Health Services managed RBHA contracts, while the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid agency, contracted with DBHS to manage behavioral health services for Medicaid enrollees. Via legislative mandate, after the Greater Arizona platform launched on October 1, 2015; DBHS will integrate into ACCCHS and combine officially on July 1, 2016.

Key Themes

To inform state integration efforts, this brief examines issues these five states faced in designing and implementing integrated behavioral health programs. Key considerations include:

- Determining program design and structural elements;
- Engaging stakeholders to facilitate implementation and ease program transitions;
- Balancing oversight and collaboration in state-health plan relationships; and
- Advancing clinical integration and cross-system accountability.

Design and Structural Elements to Guide Behavioral Health Integration

Once a state has decided to pursue an integrated behavioral health program, several factors can drive program implementation and design. These include current political and cultural attitudes toward managed care, existing managed care market characteristics, and willingness and readiness of provider organizations to contract with Medicaid managed care organizations, among others. Three major design decisions are: (1) program size and scope; (2) plan selection and participation; and (3) "prescriptiveness" of program requirements.

Program Size and Scope

States needed to decide whether to pilot the program in a few regions or launch statewide. Arizona and New York chose to limit initial implementation, because piloting new programs in smaller geographic regions — even in populous areas like Phoenix in Maricopa County, Arizona or New York City — provides an opportunity to test which program features work well and to identify vulnerabilities. Arizona applied lessons from its Maricopa County pilot to inform requirements for a subsequent "Greater Arizona" expansion. Although Texas launched statewide in 2014, it divided implementation into two phases. Working closely with its Behavioral Health Advisory Committee,[9] the state focused Phase 1 (before implementation) on revising managed care contracts, actively communicating with stakeholders, and developing its oversight approach. During the second phase, which launched in fall 2014, it focused on increasing physical-behavioral health service integration and designing integrated quality measures. In contrast, Kansas — with a much smaller population — opted to launch integration statewide so that oversight structures and delivery system supports could be implemented system-wide.

Plan Selection and Participation

Another key decision is whether to select new health plans through a competitive bidding process, or to expand the current managed care infrastructure and require existing plans to provide behavioral health services. Factors that influence this decision include the existing managed care environment (i.e., the impact that a competitive process could have on destabilizing managed care enrollment), and contracted plans' capacity to manage benefits or subcontract with a specialty behavioral health organization. States interviewed choose different paths for selecting plans:

- **Arizona and Kansas** issued requests for proposals (RFPs) to choose new contractors. Arizona wanted to identify plans with experience supporting individuals with SMI. State officials noted

that its competitive process pushed bidders to think creatively about new strategies for: (1) supporting the state's whole-person vision for integrated service delivery; (2) maintaining a member and family focus; and (3) providing the full spectrum of care coordination. Kansas had previously carved-out mental health services, so it sought plans that could demonstrate ability to manage care across the entire continuum. The state designed contract requirements to ensure effective operation within the existing behavioral health infrastructure and promote linkages to the rest of the system.

- **Texas and New York** sought to expand behavioral health benefit responsibilities for existing managed care contractors. Since the Texas legislature required the state to include all 19 existing health plans, the state developed guidance and contract requirements to incorporate the newly carved-in services. Because plans had already been working with Local Mental Health Authorities (LMHAs) — the state's network of community mental health centers — to coordinate limited behavioral health services (e.g., inpatient and other physician services), health plans were familiar with the current system and enthusiastic about the opportunity to better coordinate care. Texas required health plans to pass a readiness review before program launch to demonstrate capacity for providing these services. New York has a robust Medicaid managed care program for physical health services, with 10 health plans operating in New York City alone. To avoid destabilizing the current system, New York issued a request for qualifications to all existing contracted health plans, requiring them to describe how they could meet a minimum threshold for providing behavioral health services independently or in partnership with a contracted BHO. All plans had to complete a comprehensive readiness review prior to implementation. Six out of 10 plans demonstrated capacity for meeting the rigorous criteria required to earn a HARP designation.

Initial Program Requirements

Balancing "prescriptive" versus "flexible" contract requirements was a key goal for the interviewed states. States and plans reported that initial requirements should clearly reflect a state's policy goals, allow plans the space to develop innovative approaches, and be very prescriptive in a few key areas. These areas include:

States and plans both noted that it was critical to have explicit continuity of care requirements to safeguard beneficiaries during program transitions.

- ***Continuity of care.*** Both states and plans noted that it was critical to have explicit continuity of care requirements to safeguard beneficiaries during program transitions. Several states require a transition period that allows members to retain access to existing out-of-network providers for at least a few months and also require flexible prior authorization requirements during transitions. Florida credits minimum service disruptions to their 60-day continuity of care period, during which time prior authorization requirements are waived. This transition period applies to all new members enrolling in a plan at any time, not just during program launch. Through its readiness review, New York ensured that health plans contract with all behavioral health providers who currently serve five or more members. New York also requires participating health plans to reimburse services delivered by mental health and substance abuse service providers at the Medicaid FFS rates for 24 months.
- ***Sub-contracting*.** Most states allow health plans to subcontract with BHOs to manage specialty behavioral health services. Clear requirements that advance coordination among entities is important to support integrated care efforts. States noted that it is essential to review contracts between health plans and their subcontractors to ensure robust standards for coordination and communication that provide a seamless experience for

One state adopted a simple mantra to which they credit a successful transition period: "Customers get services and providers get paid."

beneficiaries. Kansas required that plans demonstrate the capacity of subcontracting BHOs to meet relevant requirements. New York's readiness review includes an extensive assessment of policies and procedures between health plans and BHOs around information sharing, required reporting, staffing requirements, network adequacy and integrated performance indicators. Texas' Behavioral Health Advisory Committee recommends that all health plans, regardless of their BHO subcontracting arrangement: (1) reimburse integrated provider sites through one contract with the health plan; and (2) have integrated technology and care coordination systems for physical and behavioral health.[10]

- ***Care coordination and beneficiary protections*.** Interviewees noted that certain requirements may require more detail spelled out in the RFP and/or contract to ensure consistent adoption. Examples include: access to care standards; care coordination requirements; and collection of certain administrative data elements such as around grievances and appeals and utilization management.

The subset of states that offer specialty behavioral health plans further noted that eligibility and enrollment protocols, including development of algorithms to determine program eligibility, are another important program design consideration. For example:

- **Florida** uses an algorithm, developed by the state, its health plan, Magellan Complete Care, and contracted actuaries that is based on two years of utilization history as well as diagnostic and pharmacy data. The state uses this methodology to identify new members on a monthly basis and to set program rates. Individuals new to Medicaid who meet eligibility criteria are automatically enrolled with an option to opt-out. Florida also decided that once individuals are deemed eligible for the SMI specialty plan, they may enroll indefinitely, regardless of changes to service needs. This reduced the need for frequent eligibility re-determinations and potential churning in and out of different plans, thus providing more stability to health plan membership.
- **New York** developed an algorithm for HARP eligibility based on mental health and substance use disorder service utilization, inpatient psychiatric stays, diagnostic codes, and medical conditions associated with substance use disorders, among other variables. It uses an assessment tool to determine eligibility for and scope of different HARP community-based services once individuals are enrolled.

All states with specialty behavioral health plans noted that some individuals were reluctant to join the plan initially due to the stigma of enrolling in — and carrying a membership card for — a health plan for individuals with SMI. Accordingly, states and plans underscored the value of concerted education efforts to work with new members to help them understand the benefits of these plans.

Interviewees noted that in some cases, states should allow health plans the flexibility to modify program elements to best meet enrollee needs. For example, in its statewide expansion of the integrated managed care model, Arizona included open-ended questions that asked bidders to creatively demonstrate how they would expand care management capabilities in crisis situations; develop new approaches for working with the criminal justice and jail systems; and create community linkages in rural areas. Regional differences across the state should also be considered in determining the stringency of requirements. In large states like Texas, it may be difficult to require plans to adopt one specific model for integration or uniform requirements for coordination and co-location of services. For example, individuals in rural regions might need to travel longer distances to receive services, warranting more flexibility for care management and coordination, such as through virtual care models.

Stakeholder Engagement to Facilitate Implementation

One theme related to stakeholder engagement was evident across all states: there is "no such thing as too much" stakeholder outreach, education, and communication. Both states and health plans noted that they often underestimated how much work it would take to create buy-in for a program paradigm shift that merges two systems into one. Accordingly, state staff may have to assume more prominent external roles to facilitate broad outreach and engagement efforts and build support for planned changes to service delivery models. Advice for engaging stakeholders during the program design and early implementation phases fell into two major buckets: (1) develop a comprehensive, overarching approach to stakeholder engagement; and (2) focus targeted engagement efforts on specific providers as needed.

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Overarching Approach to Stakeholder Engagement

- ***Engage diverse perspectives across several stakeholder groups.*** States targeted a broad audience for outreach activities, including beneficiaries and families, community organizations, plans and providers. For example, Kansas hired a contractor to conduct public meetings with various stakeholder groups across the state, and collected feedback from more than 1,700 stakeholders, including consumers and their families, among others. The contractor used this feedback to produce a report that informed development of the state's whole-person, community-based approach to integrating behavioral health. Involving provider trade organizations can open communication channels as well. State staff in Texas worked closely with trade organizations representing LMHAs to better understand how proposed program requirements would influence providers' current operations.
- ***Work closely with beneficiaries and their families.*** When Florida's new program was first implemented, Magellan Complete Care hired "health guides" as part of its care coordination team. These individuals make home visits when necessary to support members' care, facilitate discharge planning from inpatient settings, and serve as patient navigators and connectors between members and their clinical teams, community organizations and social services to ensure individuals' basic needs are met (e.g., housing, clothing, food, etc.). State officials in Florida attribute this effort to mitigating the potential stigma that some feared would limit enrollment in a specialty mental health plan. When Arizona developed its RFP for the second phase of its program, it repeated efforts that yielded important feedback during its initial procurement: seeking extensive feedback from family members and the state's large certified peer support workforce.
- ***Understand local community needs.*** Several health plan respondents highlighted their efforts to understand local community dynamics and target program design elements to support local needs. For example, several plans recommended a "grassroots" approach to building community relationships by reaching out to food banks, supportive housing organizations, peer groups, occupational training centers and other organizations. Linkages with community groups can help inform plan and providers' understanding of community channels available to connect individuals with resources to help them thrive.

Targeting Specific Provider Groups

The success of major managed care redesigns depends in large part on successfully engaging and attaining buy-in from participating providers. This is essential for collecting critical feedback to aid program design and to ensure that providers will participate in health plan networks following program launch. In addition, because providers are generally a trusted source of information for their patients, securing their support can help beneficiaries adjust to program changes or increase the likelihood of enrollment in voluntary programs.

Provider engagement is critical. Providers are often the primary source of information about health care programs for beneficiaries and have on-the-ground knowledge that is valuable to states and plans.

States recommended building additional time into program design and implementation work plans for provider outreach and education. As they noted, it often takes more time and resources than expected to adequately prepare providers for program transitions, particularly for providers who are new to managed care. It is important to account for providers' varying levels of experience with, trust of, and willingness to work within a managed care structure, and to target outreach and education approaches accordingly. State-plan partnerships to support provider engagement and education can help to build provider trust. Several states also recommended soliciting assistance from provider champions — those familiar with managed care constructs and who support increased coordination and system transformation. Magellan Complete Care analyzed FFS data prior to implementation to identify where new members had been receiving care, and reached out to those providers to secure participation in their networks.

While all states noted that they had to address stigma at the physical health provider level about working with individuals with SMI, this concern was most pronounced among respondents from specialty integrated behavioral health plans. One health plan representative reported with some surprise that physicians who already contracted with the state's Medicaid managed care program and served individuals with SMI were reluctant to participate in the network of the specialty plan that exclusively serves those with SMI.

States and health plans sought to build provider support during and after implementation with a focus on strong customer service and quick resolution of prior authorizations and timely payment.

States and health plans described several strategies for continuing to build provider support post-implementation. One effective strategy was to adopt a "we are all in this together" approach to working with providers, focusing on strong customer service and quick resolution of prior authorizations and timely payment issues. For example, right after program launch, Kansas state staff and health plans held joint, daily provider calls to connect providers to live support, which tapered to less frequent calls as providers' comfort levels increased. Termed "rapid cycle response calls," these calls offered hands-on, real-time responses to providers' operational issues, and established accountability and a high level of trust with providers. Health plans also noted that in-person, personal outreach to providers is also an important component of a provider engagement strategy.

Investing in strong state capacity for provider relations can help build provider trust and involvement. Florida created a centralized feedback hub to better track and respond to all concerns made by beneficiaries, providers, or other stakeholders relating to the Statewide Medicaid Managed Care program. Within the hub infrastructure, a provider oversight unit was created to assist with complaints and inquiries.

Balancing Oversight and Collaboration in State-Health Plan Relationships

Building strong oversight infrastructure is critical for states launching newly integrated managed care programs for high-need beneficiaries. Several state interviewees described their multi-faceted approach to monitoring and oversight, including approaches for reviewing plans' reports and deliverables and gathering stakeholders' feedback. Suggestions for building a comprehensive oversight infrastructure include:

- ***Allow time to develop a comprehensive oversight system*.** Kansas reported that it took longer than expected to develop its oversight methodology, but credited the extra time to developing a more complete approach that includes on-site reviews, internal systems validation and survey work, Performance Improvement Plan monitoring, and EQRO review of submitted reports.
- ***Prioritize document and report review*.** Arizona's Department of Behavioral Health Services developed a comprehensive system to track plan reports and other deliverables for Mercy Maricopa, and assigned staff with specific subject matter expertise to review related plan activities. It implemented a tiered review cycle that included a mix of time-sensitive, quick turn-around and longer routine reviews (e.g., daily, weekly, monthly, annually), and a risk assessment process to reassess whether certain reports should be reviewed more or less frequently.
- ***Include feedback from sources other than health plans*.** Some states, for example, recommended a feedback loop for members and providers to be part of the monitoring approach.
- ***Check-in with health plans regularly*.** Systematic check-ins with health plans help ensure they are well supported and that state resources are sufficiently targeted to offer adequate support. Interviewed states held regular meetings with health plan staff — at least weekly right after implementation and thereafter monthly — to discuss beneficiary and provider concerns, approaches to mitigate them, and other system or infrastructure issues.
- ***Ensure an adequate provider network*.** Texas requires monthly reports from health plans on the number of network providers for mental health rehabilitative and targeted case management services.

All interviewees recognized that maintaining a collaborative environment under a state's oversight umbrella was important to program success. States noted that their partnerships with health plans supported smooth implementation, bolstered state capacity where resources were thin, provided on-the-ground insight about beneficiary needs, and encouraged innovation. Both states and health plans provided examples of innovative efforts plans can undertake when allowed some flexibility. Several health plans offer supplemental benefits to support individuals with needs that might not be met by Medicaid, such as certain community supports, prevention services and expanded substance use disorder treatment benefits. New York noted that it is encouraging plans and their contracted providers to establish outcomes-based incentives through financial or other mechanisms. The state has also encouraged HARPs to work closely with Medicaid health home providers, which provide community-based care coordination services to beneficiaries, to better coordinate care management efforts.

Some interviewees highlighted the value of collaboration in the development of reporting requirements. For example, Kansas identified data elements already collected on individuals who used services at community mental health centers, and then led collaborative discussions with its

health plans and providers to identify which data elements were most useful for program monitoring and care management. The group also worked together to identify additional data that could be secured from other agencies or community entities to help target interventions.

Finally, states and health plans reported that collaborating on provider training activities was particularly valuable. New York is working with the Managed Care Technical Assistance Center to help providers improve their business and clinical practices during the transition to managed care.[11] Health plan interviewees described their efforts to work with providers to translate how state program requirements would influence provider office staffing, operations, and finances. Plans worked with providers to assess if and how their business models could adapt to new clinical requirements, and how to address potential gaps. For example, Mercy Maricopa offered robust training, education, and coaching services to help providers identify administrative areas in need of bolstering to support new service delivery models. Optum Behavioral Health, a subsidiary of United Healthcare Community Plan of Kansas, organized regular provider training calls in partnership with the state to connect providers to plan and state staff directly. Lastly, all health plans noted that getting providers up-to-speed on billing in a managed care setting was a slow but critical process. There was a steep learning curve for many providers, and building in sufficient training time prior to program launch was important. Some plans offered one-on-one training with providers to help "connect the dots on claims submission," as well as office hours during which providers could contact plans for billing assistance.

Advancing Clinical Integration and Cross-System Accountability

Delivery system integration reaches beyond state requirements and health plan policies. Interviewees discussed several program features that support integration at the delivery system level for beneficiaries and providers:

- ***Adopt an integrated organizational approach at the health plan level.*** Health plans noted that investments in internal organizational capacity could enhance their ability to support systems integration, recommending that plans build an integrated infrastructure at the outset. Optum includes plan leadership for physical and behavioral health services and functions at all relevant systems meetings, projecting a clear message that they are one system working together. They also use a single secure data platform to merge medical and behavioral health data. Magellan Complete Care reiterated the importance of integrating all physical and behavioral functions. Its member services department follows a "one call resolution" policy as well; members have one phone line to call regardless of their issue. States underscored the importance of internal integration within the plans. Notably, several states reported that it was challenging to work with health plans that clearly bifurcated functions.
- ***Maximize alternative support services.*** Some interviewees use non-traditional providers or other resources — such as peer counselors and family members — as system supports. For example, Arizona noted that a major early mortality indicator for individuals with SMI was lack of engagement in preventive services and other treatment. It uses peer counselors to deliver a Chronic Disease Self-Management Program,[§] which has helped to increase engagement in

[§] The Stanford Chronic Disease Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves. http://patienteducation.stanford.edu/programs/cdsmp.html

physical health services. In addition, when Mercy Maricopa experienced higher-than-expected call volume to member/provider hotlines, they expanded call center capacity by hiring trained peers. Similarly, Magellan Complete Care relies on a strong peer support model to serve as health guides. They also hired community outreach specialists, who are responsible for building relationships with community providers who do not traditionally serve Medicaid populations.

- ***Invest in care management tools and data capacity to advance whole-person care.*** Maximizing data collection and IT capacity are critical to effective implementation of integrated managed care models. Mercy Maricopa and Optum developed analytic tools that review spending and utilization among the highest-cost enrollees to better target interventions. Optum analyzes the impact of these interventions on performance indicators, such as adherence to appointment schedules and engagement at the right level of care (e.g., appropriate use of outpatient services versus emergency departments).

As one health plan representative noted, "just calling a provider from a different system to talk about an ad hoc issue with a patient is not integration, that's consultation."

- ***Establish aligned performance measures.*** Performance measures should advance shared provider accountability for care coordination and health outcomes across physical and behavioral health systems. Several states chose quality metrics that supported a "big picture" goal of improving overall health — across both physical and behavioral health conditions as well as more holistically. For example, Kansas' robust quality measurement approach focused on one initial goal for individuals with SMI: improving life expectancy. The state examined factors that contribute to high mortality rates, and identified which seemed feasible to measure and change. Some indicators included rates of preventive physical health services that are often under-utilized by individuals with SMI (such as flu shots) and utilization of inpatient mental health services. They also selected metrics from the National Outcomes Measurement System (NOMS)[**] to address certain social determinants of health, such as employment status and housing. Some of these measures have pay-for-performance incentives attached to them.

Kansas noted some challenges with developing measures that span behavioral, physical, and social outcomes, including how to assess which data will be most easily available and measurable. For example, it was difficult for health plans to collect and report on some of the original NOMS measures that require data from several entities, such as social service agencies (e.g., housing and law enforcement). Although health plans continue to engage members via various social systems, Kansas revised its KanCare Evaluation Design in March 2015 to account for some of these data collection and measurement concerns, along with other program updates and changes to HEDIS measure specifications.[12]

Another consideration in developing performance measures is provider burden. For example, in states with multiple health plans, it can be challenging for providers to collect information and report information in various formats to several plans. Some states recommend incorporating flexibility into measure development, or allowing measures to be tested and modified post-implementation as necessary based on program needs. Exhibit 2 provides examples of states' performance measures that advance shared provider accountability for care coordination and health outcomes across physical and behavioral health and other social support systems.

[**] The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Outcome Measures (NOMS) initiative is seeking to develop a reporting system to establish a national picture of substance abuse and mental health services. The NOMS serve as performance targets for state and federally funded programs for substance abuse prevention and mental health promotion, early intervention, and treatment services. For more information, visit: http://media.samhsa.gov/co-occurring/topics/data/nom.aspx.

EXHIBIT 2: Examples of State Performance Measures

State	Quality/Performance Measure Examples
Florida Florida Specialty Plan-Specific Performance Measures[13]	■ Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotics ■ Diabetes monitoring for people with diabetes and schizophrenia ■ Cardiovascular monitoring for people with cardiovascular disease and schizophrenia ■ Adherence to antipsychotic medications for individuals with schizophrenia
Kansas KanCare Evaluation Final Evaluation Design[14]	■ Number/percent of: » Adults with serious and persistent mental illness (SPMI) who were homeless at the initiation of Community Supports and Services (CSS) and experienced improvement in their housing status; » KanCare members diagnosed with SPMI whose employment status increased » Members using inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services ■ Healthy Life Expectancy measures for persons with SPMI: includes indicators of prevention (e.g., screenings, vaccinations, preventable emergency visits) and treatment/recovery (e.g., diabetes management, HbA1C testing; eye exams, blood pressure)
Arizona Mercy Maricopa RFP: Performance Measures for SMI Members Receiving Physical Health Care Services[15]	The plan must meet and sustain Minimum Performance Standards in several areas, including but not limited to: ■ Inpatient and emergency department utilization ■ Hospital re-admissions ■ Follow-up after hospitalization after 7 and 30 days ■ Access to primary care and behavioral health providers ■ Comprehensive diabetes management ■ Use of appropriate medications for people with asthma ■ Flu shots for adults

Conclusion

Medicaid beneficiaries with behavioral health conditions comprise a high-risk, high-cost population that must often navigate fragmented delivery systems to address their complex behavioral and physical health needs. This brief highlights key considerations to guide implementation of comprehensive managed care models that integrate physical and behavioral health services, particularly for individuals with serious behavioral health needs. An increasing number of states are pursuing these models that offer flexibility to leverage existing capacity, accommodate future goals, and account for variations in managed care landscapes. Lessons from the five early innovator states profiled can offer valuable insights to other states pursuing similar initiatives.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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