

State Options for Integrating Physical and Behavioral Health Care

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Behavioral health conditions, including mental illness and substance use disorders, are widespread among Medicaid's high-need, high-cost beneficiaries, many of whom also have chronic physical conditions. Over half of all Medicaid beneficiaries with disabilities are diagnosed with a mental illness.¹ For those with common chronic conditions, health care costs are as much as 75 percent higher for those with mental illness compared to those without a mental illness² and the addition of a co-occurring substance use disorder results in two- to three-fold higher health care costs.³ Among individuals eligible for Medicare and Medicaid (also known as dual eligible individuals), 44 percent have at least one mental health diagnosis.⁴ For the 20 percent of dual eligible individuals with more than one mental health diagnosis, annual spending averages more than \$38K—twice as high as average annual spending for the dual eligible population as a whole.⁵ The prevalence of serious mental illness is especially high among dual eligible individuals under age 65 – at least three times higher than for those age 65 and older.⁶ Meanwhile, substance use disorder, with and without co-occurring mental illness, is also more common among dual eligible individuals than among Medicare-only beneficiaries.⁷

Yet despite the complexity of their needs and the array of services they require, most individuals with both physical and behavioral health conditions are in fragmented systems of care with little to no coordination across providers, often resulting in poor quality and higher costs. Today, as health policymakers nationwide seek to transform the delivery and cost-effectiveness of publicly financed care, states are intensifying efforts to develop managed and integrated care models for this complex need population.

IN BRIEF: As states across the country seek new strategies to improve the coordination of physical and behavioral health services for high-need, high-cost Medicaid populations, there is an emerging array of options for doing so. In determining which integration model to pursue, states can either leverage existing capacity or pursue new care delivery systems to support fully integrated, patient-centered care.

This analysis explores state options for integrating physical and behavioral health services within managed delivery systems, including examples of current state programs and critical considerations for implementation. It was developed for the **Integrated Care Resource Center**, a national initiative of the Centers for Medicare & Medicaid Services (CMS) to help states improve the quality and cost-effectiveness of care for Medicaid's high-need, high-cost beneficiaries.

Options for Integration

This brief describes existing and emerging options that are being used or considered by states for integrating the management and financing of physical and behavioral health services, with a focus on individuals with serious behavioral health needs.* The four integration models described here offer alternatives with various lead organizations serving as the core integrated care entity, including (1) managed care organizations (MCOs); (2) primary care case management programs (PCCMs); (3) behavioral health organizations (BHOs); and (4) MCO/PCCM and BHO partnerships as facilitated by financial alignment.⁸

* Inclusion of the models in this brief does not signify endorsement by the Centers for Medicare & Medicaid Services; nor do these models necessarily meet the criteria for integrated care under the financial alignment models introduced by CMS's Medicare-Medicaid Coordination Office in July 2011. For more information, see http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

Each of these individual models has strengths and weaknesses, but state choices also may differ depending on a state's existing managed care capacity. Some states may opt for a mix of models, with alternative approaches to address the needs of different communities. Opportunities for integration may be further strengthened by combining the above models with a health home or accountable care organization approach.

By design, there is considerable overlap in the models presented. As traditional program boundaries and definitions of roles and responsibilities are broken down in integrated systems of care, clear lines separating one approach from another become harder to draw. Nonetheless, all of the models incorporate certain core elements that are necessary to support fully integrated, person-centered care. These key elements, which can be enforced by state purchasing contracts, include the following:

- Aligned financial incentives across physical and behavioral health systems
- Real-time information sharing across systems to ensure that relevant information is available to all members of a care team
- Multidisciplinary care teams that are accountable for coordinating the full range of medical, behavioral, and long-term supports and services, as needed
- Competent provider networks
- Mechanisms for assessing and rewarding high-quality care

This brief focuses on incorporating these system-level elements into various service delivery arrangements. While these system-level elements are critical to establishing a fully integrated delivery system, they also must be paired with efforts to integrate services at the clinical level. Essential elements for promoting clinical integration at the point of care include (1) comprehensive physical and behavioral health screening; (2) beneficiary engagement; (3) shared development of care plans by the beneficiary, caregivers, and all providers; and (4) care coordination and navigation support. Future resources from the *Integrated Care Resource Center* will provide further details in many of these areas.

In the pages that follow, a brief description of each option is accompanied by examples of current state programs and pilot efforts, considerations for implementation, and the pros and cons of using each option. Each description also addresses specific considerations for integrating physical and behavioral health services for beneficiaries who are dually eligible for Medicare and Medicaid—considerations that are particularly relevant since many individuals with serious mental illness (SMI) are eligible for both programs.

OPTION #1: MANAGED CARE ORGANIZATION AS INTEGRATED CARE ENTITY

Description

One of the purest approaches to integrating physical and behavioral health is to include both benefits in managed care contracts, rather than carving out behavioral health care from MCO contracts and providing it separately. State experience with such integration is more common for coverage of beneficiaries with limited behavioral health needs than for those with serious mental illness (SMI). However, with the growing interest in integrating care, states are increasingly moving toward integrated contracts with their managed care partners. By combining the benefits and financing for physical and behavioral health services in a comprehensive managed care arrangement, states can ensure greater accountability for managing a more complete range of beneficiary needs. Such integration can be achieved by integrating benefits within mainstream MCOs (see Tennessee below) or by contracting with more “specialized” MCOs or Medicare special needs plans (SNPs) that offer the behavioral health capacity required to effectively manage populations with significant behavioral health needs. These plans would enroll only individuals with serious behavioral health needs and manage both physical and behavioral health benefits.

Examples

TennCare: In 2009, Tennessee’s Medicaid program, known as TennCare, completed the integration of behavioral health services within its mainstream managed care system. More recently, the State has integrated long-term services within these contracts. With statewide mandatory managed care (via an 1115 waiver), all Medicaid beneficiaries in Tennessee are enrolled in these integrated MCOs, including individuals with serious behavioral health needs. For contracting purposes, the State is divided into three regions, with two MCO contractors per region operating at full risk for all services. MCOs are allowed to subcontract for the management of behavioral health services, although subcontractors are required to operate on site within the MCO’s offices to ensure coordinated management across all services.

Washington Medicaid Integration Partnership: The Washington State Department of Social and Health Services (DSHS) has integrated services through a single MCO contract (with Molina Healthcare) to manage care for Supplemental Security Income (SSI) or SSI-related Medicaid enrollees (age 21 or older) in Snohomish County. The Washington Medicaid Integration Partnership (WMIP) project began in 2005, initially integrating medical services and chemical dependency services. DSHS expanded the model to include mental health services later that year, and long-term care services a year later. Enrollment in WMIP is voluntary, including an opt-out model for Medicaid-only beneficiaries and an opt-in model for Medicare-Medicaid and American Indian/Alaskan Native enrollees.

Minnesota Preferred Integrated Network Program: Through the Preferred Integrated Network (PIN), Minnesota is pilot testing a partnership between Medica, a Medicare SNP serving dual eligible beneficiaries with disabilities, and Dakota County to integrate Medicare and Medicaid physical health services with behavioral health services. Program goals are to improve the physical and mental health of dual eligible individuals with SMI by offering: access to the full continuum of services; a single point of contact for health care system navigation; and shared program accountability through a public/private partnership. The program has successfully achieved integration of behavioral health services; however, it has had challenges maintaining full integration of Medicare benefits, since Medica is no longer operating its SNP. The partners are currently operating the PIN with Medicaid services provided through the Medica MCO and Medicare services provided through the fee-for-service (FFS) system, coordinated to the extent possible through the PIN. Thus, although short of full integration, the PIN is still seeking to coordinate the full range of benefits for its members with SMI.

OPTION #1: MANAGED CARE ORGANIZATION AS INTEGRATED CARE ENTITY *(continued)*

Considerations

Readiness and Capacity. In developing an integrated program through MCOs, states need to consider the readiness and capacity of participating plans to manage behavioral health services. For Tennessee, two of the three participating plans had prior experience operating integrated plans in other markets. To encourage development of this capacity, states can incorporate highly prescriptive contract requirements that address specific behavioral health competencies (for example, clinical qualifications of utilization review staff, access to care standards, adoption/promotion of evidence-based practices, etc.).

Use of Subcontractors. States should carefully consider whether to allow subcontracting, since it can sometimes be a primary factor undermining true integration, with management continuing in separate silos. If subcontracting is permitted, states should ensure that subcontracts are awarded based more on qualifications than cost and other factors, and that the prime contractor is fully accountable for the performance of the subcontractor on enumerated access and quality standards.

Effective Payment Policy Alignment. States need to ensure that underlying payment policies facilitate effective coordination at the point of care (for example, allowing same-day billing of physical and behavioral health services for individual enrollees).⁹

Special Considerations for Dual Eligible Individuals. In order to effectively coordinate the health care needs of dual eligible individuals, integrated MCOs might also need to be Medicare SNPs—or at a minimum have access to Medicare data for dual eligible enrollees. While access to these data has been a major issue for states historically, new opportunities are being developed through the Medicare-Medicaid Coordination Office to make these data available.¹⁰ To the extent enrollment is voluntary, it may be challenging to achieve sufficient scale for these programs to be financially viable.

Pros

- Incentives are aligned across all systems and coordinated care is promoted.
- Fully integrated and accessible administrative data are available for care management purposes.
- Beneficiaries have seamless access to benefits and services.
- This option may lead to true clinical integration (WMIP has evolved to support co-location of primary medical care in a mental health clinic).

Cons

- Mainstream MCOs may not have the clinical capacity or sufficient provider networks to effectively manage behavioral health services.
- When behavioral health services are included in a broader benefit package, strong oversight is needed to ensure that behavioral health needs are recognized and appropriately cared for, and to prevent a reallocation of funds away from behavioral health services.
- Subcontracts may undermine true integration. Potential problems can be alleviated through contract provisions and other incentives.
- “Specialized” MCOs/SNPs targeted to the SMI population are an emerging model yet to be tested in this context.

OPTION #2: PRIMARY CARE CASE MANAGEMENT PROGRAM AS INTEGRATED CARE ENTITY

Description

States operating PCCM programs may be interested in models of integration that do not require MCOs. In this case, the state would either contract directly with providers, or procure services through a PCCM subcontractor (that is, an entity that administers the state PCCM program), to ensure delivery of integrated physical and behavioral health care to enrollees. Integration can be achieved through a number of mechanisms, often in combination, including (1) paying primary care providers (PCPs) enhanced fees to support care coordination/care management functions; (2) supporting the development of community-based care teams to extend the reach of practice-based care; (3) investing in health information technology to support electronic health information exchange, population management, and performance measurement; and (4) developing incentives designed to promote integration. Given the provider-based focus of this model, it is potentially well aligned with the development of accountable care organizations, where accountability for care coordination resides closer to the point of care than in traditional managed care approaches.

Examples

Community Care of North Carolina: In 2010, North Carolina added an enhanced per member per month (PMPM) payment to its existing PCCM program, Community Care of North Carolina (CCNC), to support integration of behavioral health services into the 1,400 primary care practices in CCNC networks across the State. The enhanced payment allowed each of the 14 CCNC networks to hire a psychiatrist and behavioral health coordinator to focus on integration at the local level. The network psychiatrists (1) develop collaborative relationships with local behavioral health systems; (2) identify best practices in screening and psychopharmacology for use in provider networks; and (3) facilitate engagement with community psychiatrists and key stakeholders. The behavioral health coordinators (1) identify enrollees requiring care management; (2) help enrollees navigate the mental health/substance abuse system; (3) employ motivational interviewing with enrollees to encourage self-management; and (4) assist primary care providers in managing behavioral health needs. In addition, CCNC incorporated behavioral health flags into an existing electronic care management tool (for example, emergency room visits for mental health, psychiatric medication prescriptions) to help identify members in need of assistance.

Vermont Blueprint for Health: Through the Blueprint for Health, Vermont has been working to integrate physical and behavioral health services as part of a statewide multipayer initiative to transform primary care practices into patient-centered medical homes. Participating PCPs are required to obtain National Committee for Quality Assurance (NCQA) Physician Practice Connections—Patient-Centered Medical Homes recognition, and are paid a PMPM fee by all payers on a sliding scale based on their NCQA score. All payers also share the costs of Community Health Teams (CHTs), which serve as practice extenders and provide community-based care management and population management support. Although the composition of each CHT is devised locally, teams are typically comprised of nurse care managers, health coaches, and mental health and substance use counselors. Through this investment in primary care infrastructure, the Blueprint initiative is increasing the capacity of the primary care system to treat mild to moderate behavioral health issues within primary care, as well as to collaborate with the specialty mental health system for individuals with greater needs. Although focused on primary care, the Blueprint initiative encourages integration by promoting high standards around access to services, effective followup on referrals, and collaborative care management. Participating mental health providers are increasingly referring individuals with poor connections to primary care to the CHTs, in addition to responding to referrals from the other direction.

OPTION #2: PRIMARY CARE CASE MANAGEMENT PROGRAM AS INTEGRATED CARE ENTITY *(continued)*

Considerations

Readiness and Capacity. This approach to integration may make the most sense in states with existing PCCM programs that could be enhanced with additional PMPM payments and care coordination and service responsibilities. Integration of services would require a strong behavioral health lead within the PCCM system, one who understands how local behavioral systems work and who can build necessary relationships with those systems.

External Support Needs. States pursuing this approach may find it useful to actively support data sharing among providers to facilitate identification and management of enrollees using behavioral health services. In addition, depending on the structure of the PCCM, multipayer participation can be critical to leveraging Medicaid investments in primary care infrastructure and shared care management resources, and should be considered a key element toward pursuing a Vermont-style model. Finally, these models may be more successful in states with relatively high Medicaid reimbursement levels for primary care (as a percentage of Medicare rates).

Special Considerations for Dual Eligible Individuals. Given Medicare's purchasing power for primary care and acute care services more broadly, Medicare participation is critical to the successful inclusion of dual eligible individuals in this model. Medicare participation, if appropriately designed, may allow the state to share in savings resulting from integration of services.¹¹ In order to move toward financial alignment, states need to ensure that Medicare data are available to assess potential Medicare savings. If savings are achieved, they can be reinvested in the program, used for coverage expansion, or passed on to provider networks as incentives to promote integration and/or outcomes that indicate successful integration. Individuals residing in nursing homes or other non-community-based settings may not benefit from this approach unless providers work directly with these individuals.

Pros

- In states with PCCM programs, existing infrastructure for managing primary care can be expanded to promote integration of behavioral health without major system overhauls.
- Investments in provider-level infrastructure provide a foundation for integrating care delivery at the ground level (as opposed to the plan level).
- Potential involvement of all major public and private payers, if feasible, enables broad participation of community providers and leverages Medicaid investments.
- Medicaid data are available and can be used for identification and management if the PCCM has existing infrastructure for data sharing.
- The model provides a fee-for-service option for integrating services if some form of broader capitated payment is not feasible.

Cons

- Integration of primary care and behavioral health systems is dependent on the PCCM's success in developing provider-level relationships and collaborations.
- The infrastructure, if it does not already exist, could take considerable time and resources to build.
- There are scale benefits from multipayer engagement; however, such initiatives can be challenging to implement, given the need to align payment methodologies and reporting requirements across disparate organizations.
- Implementation may be more difficult in larger, more heterogeneous states.
- Medicare and Medicaid funding streams are not fully blended for dual eligible individuals, resulting in less flexibility for providers to tailor benefits than with a global or capitated payment.

OPTION #3: BEHAVIORAL HEALTH ORGANIZATION AS INTEGRATED CARE ENTITY

Description

Behavioral health organizations (BHOs) have specialized capacity around managing behavioral health services, particularly for individuals with SMI. Thus an alternative to integrating care through MCOs is to contract with BHOs to provide both physical and behavioral health services for individuals with SMI or other serious behavioral health needs. In this case, the state, through partnership between the Medicaid agency, the state mental health agency, and other relevant purchasers of mental health services (for example, county-level administrators) would contract with one or more BHOs to manage both sets of services and associated provider networks. To the extent that participating BHOs have the requisite experience and capacity, states can hold the plans at full risk for managing the full array of services. To date, there are no examples of a Medicaid BHO that is responsible for all behavioral and physical health services for enrolled beneficiaries, but some states, such as Arizona and Massachusetts, are currently pursuing such models. As illustrated in the Iowa example below, these efforts may begin with pilot collaborations between BHOs and physical health providers, with the hope that more comprehensive integration can be built on that experience.

Examples

Full Risk for both Behavioral Health and Physical Health: Arizona is currently considering this model for a future reprocurement of its Regional Behavioral Health Authority (RBHA) contract in Maricopa County. Under the proposed model, one or more “specialty RBHAs” would manage all physical and behavioral health services for Medicaid beneficiaries with SMI in the county, under the single authority of the State’s behavioral health agency. The State envisions that the specialty RBHAs will be closely connected to newly authorized Medicaid health homes for individuals with SMI, enabling coordination and integration of physical and behavioral health care services at the provider level. Given that approximately 50 percent of beneficiaries with SMI in this region are dual eligible, the State further intends for the new specialty RBHAs to be MA-SNPs. The State does not intend to allow the RBHAs to subcontract for any subset of the services provided. Conceivably, future bidders could be BHOs that build internal physical health capacity or MCOs that develop or expand internal behavioral health capacity. As of August 2011, Arizona is collecting responses from prospective bidders on a recently released Request for Information, with implementation slated for October 2013.

Full-Risk for Behavioral Health, Managed Fee-for-Service for Physical Health: In Massachusetts, all non-dual-eligible and noninstitutionalized Medicaid beneficiaries are mandatorily enrolled in some form of managed care. Approximately 40 percent of managed care enrollees choose the State’s primary care case management program, known as the PCC Plan; the balance enroll in one of five MCOs. The State, through the Executive Office of Health and Human Services, contracts with a single vendor (currently a BHO) to manage behavioral health services on a capitated basis for PCC Plan enrollees and to administer the PCC Plan itself. Under a reprocurement of this contract released in May 2011, the State is looking to increase the contractor’s role in providing integrated care management for high-need, high-cost enrollees in the PCC Plan. As proposed, the contractor would be charged with increasing integration among providers of medical and behavioral health care, increasing integration of treatment for mental health and substance use disorders, and implementing a care management program to assist enrollees with complex medical and/or behavioral health needs in the coordination of their care. The contractor will be eligible to receive financial incentives tied to improved outcomes among enrollees. Conceivably, the future contractor could be a BHO with capacity for medical care management, or an MCO with capacity for full-risk management of behavioral health services.

Full-Risk for Behavioral Health, Fee-for-Service for Physical Health: The Iowa Plan is a statewide Medicaid BHO that provides behavioral health services to almost all Medicaid beneficiaries under age 65. Enrollment is mandatory, with more than 80 percent of Medicaid beneficiaries enrolled. Launched in 1999, the Iowa Plan is currently administered by Magellan under a contract with the Iowa Department of Human Services (DHS). The Medicaid capitation that DHS pays to Magellan includes 2.5 percent dedicated to a community reinvestment fund that finances initiatives to improve care management. Magellan and DHS use a request for proposal (RFP) process to fund promising initiatives. The most recent RFP, issued in March 2011, sought proposals for “Integrated Health Homes” aimed at improving the coordination of behavioral and physical health services. DHS and Magellan selected four partnerships for the pilot, including three partnerships between community mental health centers and federally qualified health centers

OPTION #3: BEHAVIORAL HEALTH ORGANIZATION AS INTEGRATED CARE ENTITY *(continued)*

(FQHCs), and one between an FQHC and an organization providing Assertive Community Treatment to persons with SMI. Under this pilot, Magellan is at full risk for mental health services, while physical health services are funded by Medicaid FFS payments. Thus, while not achieving full system-level integration in its current form, this pilot could serve as a stepping stone toward more complete integration in future iterations.

Considerations

Readiness and Capacity. BHO-based integration models may make the most sense for states with established BHOs, and thus with experience managing BHO contracts at the state level. As with integrating care through MCOs, states need to consider the capacity of potential contractors to manage the full array of physical and behavioral health services and to develop sufficient provider networks. BHOs typically are not at financial risk for prescription drugs (with the Arizona RBHAs as one exception) and thus may need to build capacity to manage pharmacy benefits (for example, in areas such as formulary development and pharmacy network management). However, it is worth noting that many BHOs have existing capabilities around clinical pharmacy management, particularly around the use of psychotropic medications (for example, data analysis, quality monitoring, consumer and provider-directed interventions to address polypharmacy, etc.).

External Support Needs. States looking to build this model around provider-level integration initiatives (such as health homes) need to address how the plans are expected to interface with, support, and oversee this broader set of coordination activities.

Special Considerations for Dual Eligible Individuals. States that wish to include dual eligible individuals in integrated BHO models may be well served by incorporating the requirement that the BHO also be a Medicare SNP. Given the high representation of dual eligible individuals among the SMI population, efforts to integrate physical and behavioral health care for individuals with SMI will likely fall short without full integration of acute care benefits (including prescription drugs) for Medicare beneficiaries.

Pros

- Integration of services creates alignment of financial incentives across physical and behavioral health systems.
- Full integration of administrative data for care management purposes is possible.
- Beneficiaries have seamless access to benefits and services.
- This option leverages specialty capacity of the behavioral health system to serve a population that it may know best, and where consumer engagement may be greatest.
- BHOs have core managed care capacity that can be leveraged across a broader array of benefits, namely information systems, quality management/ utilization management functions, experience in building and managing provider networks, and communicating with beneficiaries.

Cons

- It may be difficult to identify/attract plans with sufficient capacity across both domains, as BHOs generally have very limited experience in providing physical health and prescription drug services.
- Questions regarding oversight authority may arise between Medicaid and mental health agency counterparts. An inclusive design process, engaging all relevant agencies and other stakeholders, can mitigate risk of contentious debates.
- There is limited experience to draw from, as these models are still emerging.
- Many Medicaid BHOs do not have experience with Medicare – a capacity that they would need to develop in order to serve dual eligible individuals effectively.

OPTION #4: MCO/PCCM AND BHO PARTNERSHIP FACILITATED BY FINANCIAL ALIGNMENT

Description

This option retains the existing separation in many states between medical and behavioral health care, but aims to better align payment in each program to enhance coordination. Specifically, many states carve out behavioral health services to a BHO, either for all beneficiaries or for the subset with SMI or other significant behavioral health needs. Although carve-outs can present obstacles to effective physical/behavioral health integration, states can create aligned financial incentives across systems by implementing shared savings models or other performance-based incentives that reward integration. Shared savings models allow all relevant parties (for example, MCOs/PCCM providers, BHOs, state) to participate in the financial gains associated with improved care coordination across systems, for example, savings associated with reductions in avoidable hospitalizations and emergency room visits. In a capitated environment, shared savings may be most readily implemented prospectively, through front-end rate adjustments that presume certain levels of achievable savings. In fee-for-service settings, shared savings can be allocated on the back end, once realized savings are calculated. An alternative to shared savings is a performance-based incentive program, with one or more incentives tied to activities that promote integration and/or outcomes that indicate successful integration (for example, reductions in avoidable admissions).

Example

Pennsylvania SMI Innovations Project: Pennsylvania operates a county-based, capitated behavioral health carve-out for all Medicaid beneficiaries statewide. In its urban and suburban regions, the State also operates a separate capitated managed care delivery system for physical health services. In 2009, to better integrate care for adults with SMI across these systems, the State launched the SMI Innovations Project, a two-year pilot initiative in which it partnered with MCOs, BHOs, and county behavioral health systems in two regions. To facilitate coordination of care in the pilot regions, the State established a shared incentive pool tied to joint performance on four process measures (joint risk stratification, creation of integrated care plans, real-time hospital notification, and management of antipsychotic medications) and two outcome measures (reduced admission and emergency room visit rates). To receive the incentives, the partners had to (1) work together to identify shared members who could benefit from collaborative care management; (2) develop systems to support real-time, routine data exchange; and (3) implement effective interventions to improve care coordination at the clinical level.

Considerations

Readiness and Capacity. The option maintains existing behavioral health carve-outs and may be an option for states that want to promote integration without pursuing a major system overhaul.

State Support Needs. In addition to aligning incentives, states can also use performance standards in MCO and BHO contracts to encourage integration. Given the maintenance of separate systems under this approach, states will also need to establish clear data sharing/privacy guidelines to facilitate information exchange across systems. States should consider policies that encourage data sharing to the greatest extent possible within legal/regulatory constraints and also consider providing integrated data directly to the plans on each side of the system as needed.

Special Considerations for Dual Eligible Individuals. To effectively integrate care for dual eligible individuals under this model, states need to ensure that data from Medicare as well as Medicaid are available to share with BHOs. As noted earlier in this brief, there are new opportunities to access these data through the Medicare-Medicaid Coordination Office.¹² In addition, states may pursue opportunities to benefit from Medicare savings that might emerge from integration initiatives under this and other models—particularly if new Medicaid investments in care coordination/care management activities are required to deliver more integrated care. One mechanism for developing such arrangements with Medicare is through CMS’s recently launched financial alignment initiative.¹³

Pros

- Where carve-outs exist, shared savings/incentives can be used to promote integration without requiring major system overhauls.
- Savings/incentives can be shared with providers to support investment in care management capacity.
- Performance measures can promote specific activities and priorities, and can evolve over time.
- Maintaining a carve-out for SMI populations may facilitate greater access to necessary behavioral health services.

Cons

- Shared savings can be challenging to implement (for example, developing methodology, reconciling costs); however, standardized and replicable approaches are emerging at federal and state levels.
- Information exchange may be subject to greater restrictions in carve-out environments.
- Separate systems remain, with resulting potential for fragmented care.
- BHOs (typically regional) will likely need to partner with multiple MCOs.

Conclusion

The models in this document can help states take advantage of efforts to coordinate the delivery of physical and behavioral health care for Medicaid populations. Each of the options can be adapted to support system- and clinical-level integration. States therefore have considerable flexibility to pursue integration under the model that best leverages existing capacity and accommodates future goals. In some cases, states may opt for different approaches for different regions of the state or for various population subsets, for example, dual eligible individuals under and over age 65.

In determining which option(s) to implement, states may consider the following:

- 1) ***Whether to leverage existing delivery systems or build new capacity.*** States with strong managed care capacity on either the physical or behavioral side of the system may be well served by leveraging existing infrastructure to support integration, particularly if time is a critical factor for implementation. In other cases, a wholesale new approach to organizing care delivery might be warranted, as in the context of more comprehensive, statewide health care reform. As evidenced by the growth of Medicaid managed care over the last two decades, managed care capacity can be developed over time in both physical and behavioral health systems. New rollouts of managed care can now leverage a wealth of experience from other states and a catalog of best practices to support implementation. As a first step, states can also opt for pilot programs that integrate care in more limited and incremental ways, as stepping stones toward larger-scale and more comprehensive system redesign.
- 2) ***Whether to have MCOs or BHOs take the lead in integration.*** The specialty knowledge and capacity of BHOs around managing behavioral health could suggest that BHOs may be the better lead for individuals with SMI; however, it remains to be tested whether BHOs can develop the requisite capacity to effectively manage physical health services. Likewise, for beneficiaries with less serious behavioral health needs—for example, most over-65 dual eligible individuals and many of those under 65 who have relatively minor or no behavioral health problems—MCOs may be the better choice. Over time, Medicare SNPs may be the best option for dual eligible individuals, to the extent new or existing SNPs can develop the capacity to manage the full range of needs for individuals with significant behavioral health needs.
- 3) ***Whether to develop a single integrated system or multiple, specialized systems of care for subsets of beneficiaries.*** Some states may opt for a single, statewide approach to integrating physical and behavioral health care for all beneficiaries. Others could vary model selection by geography, particularly for urban versus rural settings. Other states could establish multiple distinct models of care for various subsets of high-need beneficiaries—for example, a specialized system for individuals with SMI, and potentially a separate system altogether for individuals eligible for both Medicare and Medicaid, given the additional complexities associated with Medicare-Medicaid integration. In weighing these options, states must consider a range of issues, including the specialized capacity required to serve specific population subsets, the feasibility of determining eligibility for one system or another, mechanisms for ensuring continuity of care during eligibility transitions, and the administrative burden of operating multiple systems.

We encourage states to adapt these options based on their unique situations. It is our hope that, in so doing, they may find long-awaited solutions for overcoming the detrimental consequences of fragmented physical and behavioral health services for many of Medicaid's highest-need, highest-cost beneficiaries.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicaid's high-need, high-cost beneficiaries. The state technical assistance activities provided within the **Integrated Care Resource Center** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

This brief was made possible by the Centers for Medicare & Medicaid Services through the *Integrated Care Resource Center*; additional support for CHCS' work in this area comes from the *Rethinking Care Program*, a project of Kaiser Permanente.



www.integratedresourcecenter.com

Endnotes

¹ R. G. Kronick, M. Bella, and T. P. Gilmer, *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions* (Center for Health Care Strategies, Inc., October 2009), [http://www.chcs.org/publications3960/publications_show.htm?doc_id=1058416].

² C. Boyd, B. Leff, C. Weiss, J. Wolff, A. Hamblin, and L. Martin, *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations* (Center for Health Care Strategies, Inc., December 2010), [http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261201].

³ Ibid.

⁴ J. Kasper, M. O'Malley-Watts, and B. Lyons. *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*. Kaiser Commission on Medicaid and the Uninsured, July 2010. Available at <http://www.kff.org/medicaid/8081.cfm>. This includes 16 percent with diagnoses of Alzheimer's or other dementia.

⁵ Ibid.

⁶ Ibid.

⁷ W. Lin, J. Zhang, G. Leung, and R. Clark, "Twelve-Month Diagnosed Prevalence of Behavioral Health Disorders Among Elderly Medicare and Medicaid Members," *American Journal of Geriatric Psychiatry*. Published Ahead-of-Print November 25, 2010.

⁸ A managed care organization is a broad term used for a health plan that coordinates health care services through a defined network of providers in return for a capitated monthly fee; a behavioral health organization is a health plan that coordinates mental health services for beneficiaries for a capitated monthly fee; and a primary care case management program is an arrangement whereby the state contracts with primary care providers to provide some degree of service coordination for beneficiaries for a set monthly fee, with most services paid for directly by the state on a fee-for-service basis.

⁹ It is common practice for states to deny payment for multiple services rendered on the same day by the same provider to a given beneficiary.

¹⁰ For more information on how to request timely Medicare data for dual eligible individuals to support care coordination, see Health and Human Services, press release, "HHS Offers New Tools to Help States Lower Medicaid Costs, Provide Better Care, May 11, 2011, [<http://www.hhs.gov/news/press/2011pres/05/20110511a.html>]; and Centers for Medicare & Medicaid Services, "Medicare Data for Dual Eligibles for States," May 16, 2011, [http://www.cms.gov/medicare-medicare-coordination/06_MedicareDataforStates.asp#TopOfPage].

¹¹ In July 2011, the CMS Medicare-Medicaid Coordination Office announced opportunities to better align financing between Medicare and Medicaid to support improvements in the quality and cost of care for dual eligible individuals. Information on the financial alignment models can be found at Centers for Medicare & Medicaid Services, "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees," August 9, 2011, [https://www.cms.gov/medicare-medicare-coordination/08_FinancialModelstoSupportStatesEffortsInCareCoordination.asp#TopOfPage].

¹² Ibid.

¹³ Ibid.