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Center for Health Care Strategies

State Approaches for Medicaid Specialty Plans to Support Whole-Person Care

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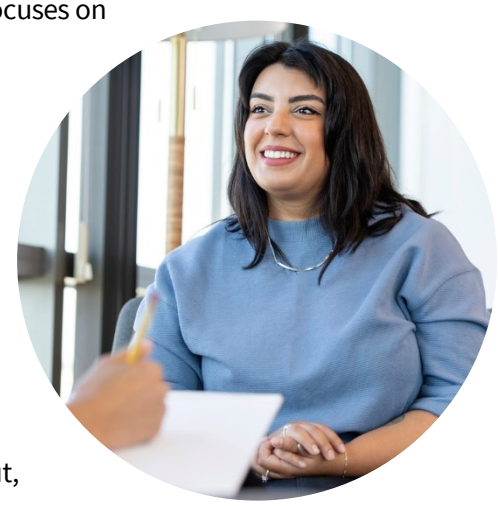
TAKEAWAYS

- Specialty plans — in which managed care entities deliver integrated, tailored benefits for specific populations — are a state policy approach to align financing and administration in support of whole-person care.
- This brief examines design and evaluation considerations for states implementing specialty plan models within Medicaid, focusing on plan administration, eligibility, benefits, stakeholder engagement, and outcome measurement.
- While specialty plan approaches are relevant for a range of populations, this brief highlights five states — **Arizona**, **Arkansas**, **Florida**, **New York**, and **North Carolina** — that developed plans specifically for people with serious behavioral health conditions.

States seeking to improve outcomes for specific high-need populations may look to specialty plans as a policy option to deliver more coordinated services and tailored benefits. These plans can be designed to bridge multiple systems of care for people with complex health needs. Almost all states contract with managed care organizations (MCOs) to cover at least some Medicaid enrollees, though the populations and services covered by managed care vary by state. States have implemented specialty plan approaches to serve a range of high-need populations, including people with serious behavioral health conditions, children and youth in foster care, and people with a specific chronic condition, such as HIV/AIDS.[1] This brief focuses on states that have implemented specialty plans for Medicaid members with serious mental illness (SMI) or other behavioral health conditions, highlighting insights into how this approach can be designed to deliver more integrated care.



Many Medicaid enrollees with SMI and/or substance use disorders (SUD) — collectively, serious behavioral health conditions — experience poor outcomes, including less preventive care and higher rates of chronic conditions.[2,3] Medicaid spending per enrollee is four times higher for people with a behavioral health diagnosis than for those without,

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with much of this excess spending attributable to increased physical health care spending in hospital settings.[4] Clinical integration of physical and behavioral health services has been shown to improve health outcomes and quality of life, and reduce acute care utilization.[5]

Physical and behavioral health care in the United States developed as separate systems of care, with behavioral health often underfunded. In Medicaid programs, which typically operate under managed care arrangements, many states historically "carved out" the administration of specialty behavioral health services to managed behavioral health organizations, which often include counties or other public entities with substantial behavioral health expertise. While this carve-out approach aimed to protect funding and access to services for this population, it also created challenges for people with co-occurring physical and behavioral health conditions, who had to navigate care managed by multiple entities. As a result, in recent years, most states have "carved in" behavioral health benefits by combining financing for behavioral health and medical care within integrated managed care systems.[6] Studies show mixed evidence for carve-in outcomes, suggesting that plan-level integration is not sufficient on its own to achieve integration. Effectiveness depends on how these approaches are designed and implemented in combination with clinical integration strategies.[7]

The Center for Health Care Strategies (CHCS), with support from the California Health Care Foundation, examined Medicaid policy approaches of five states — **Arizona**, **Arkansas**, **Florida**, **New York**, and **North Carolina** — that have launched specialty plans for adults with serious behavioral health conditions over the past 13 years. As state policymakers and other stakeholders continually evaluate how to strengthen managed care approaches for people with serious behavioral health needs, this brief offers insights into the role of tailored, population-specific programs, such as specialty plans. It focuses on how states structure plan administration, define eligibility, shape the benefit package, engage stakeholders in design, and measure outcomes. The findings presented are informed by research and interviews with leaders from state Medicaid agencies, entities sponsoring these plans, and behavioral health providers.

Why Pursue a Specialty Plan?

Specialty plans for people with serious behavioral health conditions are Medicaid managed care plans designed for a specified high-need population with a benefit that integrates physical and behavioral health care. The entities operating specialty plans may be Medicaid MCOs, public or private behavioral health plans, providers, or partnerships between multiple organizations.

State goals when designing these plans often include improving access to community-based recovery services and supports, attending to population-specific service needs, and achieving cost predictability and savings for populations that incur high costs. For example, when **North Carolina** found that health care costs for a small group of Medicaid enrollees with behavioral health conditions were "exponentially higher" than for other enrollees, state policymakers decided that this population would benefit from having a single entity manage their services and supports.[8] Similarly, **Arkansas** chose to focus on individuals in the "tail of the spending distribution"— the approximately 20 percent of beneficiaries with behavioral health conditions or intellectual and developmental disabilities (I/DD) who account for half of overall Medicaid spending for this group.[9] To identify this group, the state focused on people with higher levels of functional needs.

The profiled states pursued different approaches based on their Medicaid environments and priorities. **Exhibit 1** presents a high-level summary of each approach. The sections that follow explore policy design and stakeholder considerations, including how states: (1) determine which entities will manage specialty plans; (2) identify the eligible population; (3) tailor the covered services; (4) engage stakeholders; and (5) assess outcomes.

Exhibit 1. Characteristics of Profiled States

State	Special Entity Plan Name	Population of Focus	Launch Date	Prior Behavioral Health Financing
Arizona	Integrated Regional Behavioral Health Authority (RBHA)*	People with SMI	Beginning in 2014	RBHAs managed only mental health and substance use services
Arkansas	Provider-Led Arkansas Shared Savings Entity (PASSE)	People with complex behavioral health or I/DD	2018	Fee-for-service
Florida	Serious Mental Illness Specialty Plan	People with SMI	2012	Carve-out prepaid mental health plan
New York	Health and Recovery Plan (HARP)	People with SMI or SUD	Beginning in 2015	Fee-for-service
North Carolina	Behavioral Health and I/DD Tailored Plan	People with significant behavioral health needs and/or I/DD	2024	Regional Local Management Entity-Managed Care Organizations (LME-MCOs)

*In October 2018, the integrated RBHAs became part of AHCCCS Complete Care (ACC) managed care plans; individuals with SMI to be served by the integrated RBHAs.

Designing Policies to Ensure Specialty Plan Entities' Expertise and Capacity

How states design specialty plan programs will determine the extent to which these models deliver on the goals of improving outcomes for the targeted population. The examples below — focused on specialty plans for people with serious behavioral health conditions — illustrate how states have developed and refined policies to strengthen accountability for integrated care.

Specialized Expertise

A specialty plan approach offers an opportunity for states to leverage the existing expertise of entities with experience in managing and/or providing care for the population of focus, while expanding their professional capacity to manage an integrated benefit. For example, **Arizona** and **North Carolina** both required that the only applicants allowed to bid for specialty plan contracts were existing public regional behavioral health managed care entities, in partnership with traditional managed care plans. These behavioral health entities had decades of experience managing care for the populations of focus, strong relationships with behavioral health providers, and trusted community partnerships. The **Arkansas** PASSE model required each specialty plan to be majority-owned by providers with a health plan owner to manage administrative functions. The state focused on creating a strong role for provider leadership and driving accountability for integrated care by aligning provider incentives across all services.[10]

Alignment with Managed Care Environments

Specialty plan approaches must be aligned with their respective managed care environments, including regional distinctions, number of plans, and procurement strategies. As states determine how many specialty plans will operate, they must evaluate the potential short-term disruptions to members and providers, as well as the long-term impacts to achieve the desired benefits of this model.

Arizona and **North Carolina** both created a structure where a single specialty plan served each designated region with the goals of preventing member confusion, minimizing the administrative burden for providers, and ensuring an appropriate number of total members. Prior to the transition to a specialty plan model, each state merged multiple regions of the public behavioral health system to consolidate resources and promote administrative efficiencies.

Alternatively, **Arkansas** and **Florida** prioritized member choice and competition when launching their models, and each contracted with multiple statewide plans. If states prioritize member choice of plans, they may need to create statewide plans to ensure

that the plans have a large enough number of enrollees to ensure plan viability. For members to experience the benefits of multiple plans, they must be able to access and easily compare provider networks as well as uniform quality metrics across plans. As **New York** does not competitively procure managed care plans, the state required all Medicaid plans in the state to respond to a request for qualification to administer a HARP — as a result, there are some counties with more than 10 HARP options.[11] To address the challenges of behavioral health providers newly contracting with a large number of plans, the state Department of Health began funding the Managed Care Technical Assistance Center to support providers with training and resources on managed care billing and processes.[12]

Provider Network Development

Ensuring a robust specialist network is a key component of specialty plan design. Given the high rates of chronic physical conditions among people with serious mental health conditions, specialty plans for this population must be comprehensive across physical and behavioral health care. Some state strategies to increase member access to care include:

- Requiring specialty plan entities without provider contracting experience across both physical and behavioral health to partner or subcontract with entities that bring complementary expertise;
- Ensuring implementation timelines account for the necessary time to build new provider networks;
- Requiring that specialty plans contract with any willing provider at guaranteed rates for a designated period of time; and
- Beginning with small pilots to build experience within the plan.

Tailored Plans in **North Carolina** were initially scheduled to go live in December 2022, but the state delayed the launch until July 2024, due to slow rates of plan contracting with physical health providers. During this process, the state reduced the number of plans from seven to four to ensure that each had sufficient members and large enough risk pools to drive contracting and innovation.[13] This consolidation allowed North Carolina to meet its Centers for Medicare & Medicaid Services 1115 waiver condition, which required at least 90 percent of plan participants to have in-network primary care providers.[14] **Florida** selected a specialty behavioral health managed care organization to serve as the first contracted SMI plan, but required this plan to pilot the model in a single region. During this pilot, the plan gained experience and expertise in physical health provider contracting and other managed care functions related to physical health that informed efforts to scale this model statewide.

After plans are approved to launch, it is important to ensure ongoing network adequacy, as some states with these models reported that network issues related to primary or specialty care providers led to higher-than-anticipated member opt-out rates during early implementation. In particular, specialty plans with low member enrollment may face contracting challenges due to their relative lack of market power.

Beyond health care providers, these specialty plans need to develop strong relationships with social services providers and invest in linkages to these services. As people with serious behavioral health conditions are more likely to experience homelessness and other health-related social needs, specialty plans can be effective coordinators of services and have a clear incentive to invest in linkages to, and direct provision of, social services given the potential to reduce member costs of care.[15]

Specialty Plan Subcontracting and Staffing Requirements

Launching a specialty plan requires expertise related to the different systems of care for the population of focus to be embedded in all plan functions, such as provider contracting, utilization management, and billing. Recognizing the importance of these qualifications — and given that specialty entities often assume new responsibilities — many states have developed requirements for specialty plans that are more detailed than those for traditional health plans. States should carefully evaluate subcontracting requirements to ensure that they are designed to achieve accountability for integrated care, and that the respective entities will have the capacity to manage all aspects of care. During the transition process, states should also monitor potential administrative, communication, and billing issues that may be more common in subcontracting arrangements.

Arizona and **North Carolina** required formal relationships between regional behavioral health entities and managed care organizations to lead an integrated specialty plan. While **Arizona** identified guidelines for partnerships between these entities, **North Carolina** had a less prescriptive approach in how Tailored Plans subcontract with Standard Plans. Some Tailored Plans are managing all claims payment, prior authorizations, and primary care contracting, while others have their Standard Plan partner take on these roles.[16] Some Tailored Plans oversee the physical health network of their Standard Plan partner, thus reducing the need for a separate provider contract.

States may also require specialty plans to employ specific positions, and specialty plans often develop strategies to advance organizational capacity to manage their tailored approach to care for targeted populations. For example, in **New York**, specialty plans are lines of business for traditional managed care. The state used staffing requirements as well as behavioral health performance metrics and incentives to focus on improved outcomes for specialty plan members.[17] At the plan level, a **Florida** specialty plan with previous

experience in behavioral health described how specialty plan operation required greater internal understanding in member activity, utilization, and journeys across physical, behavioral, and social care systems. To support the successful launch of this model, plans will need to facilitate cross-department collaboration and communication in addition to building capacity within each department for integrated managed care.

Identifying the Eligible Population for a Specialty Plan Approach

States can holistically evaluate service patterns and co-occurring needs to identify which members would benefit most from a specialty plan model and then assess population eligibility. As applicable, criteria may also be informed by pre-existing criteria of the prior managed specialty programs to minimize disruptions during a transition.

States can serve broader or more narrow groups of individuals in specialty plans, depending on eligibility criteria. For specialty behavioral health plans, most states incorporate a combination of behavioral health diagnoses, functional status measures, trigger events, and/or utilization trends, as detailed in **Exhibit 2**.

Exhibit 2. Profiled States' Specialty Behavioral Health Eligibility Criteria

State	Behavioral Health Eligibility Criteria	Age Criteria	Referral Pathway
Arizona	Qualifying SMI diagnosis and functional impairment criteria[18]	Age 18 and above	Evaluated by qualified clinician
Arkansas	Behavioral health diagnosis and determination of service needs that exceed counseling and medication management to address functional needs[19]	All ages	Independent assessment
Florida	SMI diagnosis combined with specific utilization requirements within lookback periods[20]	Age 6 and above*	SMI case-finding algorithm on claims and encounters limited to specific diagnosis codes
New York	SMI diagnosis with specific recent behavioral health services utilization, trigger events, or utilization of specific services[21]	Age 21 and above	Medicaid data review
North Carolina	Behavioral health diagnoses as standalone qualifiers or in combination with service utilization within lookback periods; other criteria such as past suicide attempt or use of antipsychotic medication[22]	All ages	Medicaid data review; individuals and providers can also request a review for eligibility

*Florida defines serious mental illness as applicable to ages six and older. While most states use the term serious emotional disturbance (SED) to describe serious behavioral health conditions for individuals up to ages 18 or 22, the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders has not defined SED. Instead, the diagnostic categories are relevant across SMI and SED.

States will need to balance having broad enough specialty plan criteria to ensure that individuals who would be best served by this model are identified, while also limiting the criteria to not include those who may be more effectively served by another model. Regardless of the enrollment approach, states should develop and implement a quality measurement strategy to evaluate whether eligibility criteria should be refined.

Age Criteria

Some specialty plans cover adults and children while others have more narrow age requirements. **Arizona**, **Florida**, and **North Carolina** each designed age coverage to maintain existing policies for prior behavioral health managed care plans. Among the states transitioning from a fee-for-service approach, **Arkansas** elected to enroll both adults and children in specialty plans due to the similarities in the mental health service delivery system across the age spectrum, while **New York** limits enrollment to adults. One challenge of a specialty plan is that they require most families to navigate multiple plans for their health coverage, as all family members are unlikely to individually meet the inclusion criteria. States that consider a specialty plan approach may explore how to improve beneficiary experience and support integrated services across the age continuum for members and their families.

Inclusion of I/DD Populations in Specialty Plans for People with Serious Behavioral Health Needs

As with age criteria, the history of managed care delivery for populations with I/DD will inform specialty plan design. Among states with a specialty plan approach for people with serious behavioral health conditions, both **Arkansas** and **North Carolina** include people with primary I/DD diagnoses among specialty plan enrollees. States considering this approach may analyze data to better understand the prevalence of dual diagnoses of serious behavioral health conditions and I/DD, and to compare existing versus desired utilization of specialty services to be included in benefit packages.

Referral Pathways

Most states rely on data review to identify eligible members, and some also create additional pathways for enrollment. As states create and refine their processes for eligibility determinations, they will need to ensure that these systems identify people who would benefit most from specialty plan enrollment. Including a mechanism for provider referrals and member self-referrals may help to identify people who could benefit based on their current level of need and very recent utilization that would not show up immediately through data review processes.

Transitions Out of Specialty Plans

Most states have created mechanisms to transition enrollees out of specialty plans if their functional needs change, such as **Arkansas** which uses an annual independent assessment to confirm whether a person should remain in the specialty plan or transition out. **Arizona**, however, leaves the SMI designation in place until a member, guardian, or clinical provider requests it to be removed.[23] Stakeholders should consider policies that establish member continuity of care requirements for robust care management and for payments to out-of-network providers during a transition out of a specialty plan, especially for people who have more acute care needs.

Tailoring Specialty Plan Services

Specialty plan approaches can be combined with delivery system reforms and new benefits designed to drive improved outcomes for the covered population. States and other stakeholders can begin by assessing available services and identifying opportunities to strengthen coordination of care and expand access to supportive services in community-based settings.

Enhanced Benefits

Many of the featured states paired the launch of a specialty plan model with new coverage of community-based services to support improved outcomes for their target populations. **New York** launched an enhanced benefit package under the HARP model, including adult behavioral home- and community-based services (HCBS) such as crisis respite, employment support, and peer supports.[24] In **Arkansas**, enrollees with behavioral health conditions typically had access to clinical services, but not HCBS or other wraparound supports for functional needs, while the reverse was the case for the I/DD population. The PASSE model in **Arkansas** aimed to create a comprehensive set of clinical and HCBS services for both populations. To maximize member uptake, states — in partnership with providers and member advocates — will need to develop streamlined enrollment processes for enhanced services and clear communications strategies that highlight the value of these services.

Non-Medicaid Services

Since people covered by specialty plans (as well as those not covered) may receive a range of services funded within and outside of Medicaid, states can design the management of these benefits to streamline services and their respective funding streams. For populations with serious behavioral health needs, some states have incorporated the management of non-Medicaid behavioral health services into specialty plan contracts. In states where regional behavioral health organizations are becoming

specialty plans, these entities historically delivered an array of publicly funded services and had expertise in managing a large number of funding streams including state and federal grants. When these entities assume risk for physical health, savings from reduced spending on acute physical health care and improved outcomes can be reinvested in rehabilitative services across the covered populations. For example, in **Arizona**, RBHAs manage state-only behavioral health services for covered individuals and were initially responsible for administering SMI housing programs as funded by the legislature before management of these services became centralized at the state level.

Care Management and Health Home Approaches

States that have implemented specialty plans are creating new care management programs and requirements to ensure that plans are responsive to enrollees' complex needs. One state Medicaid leader noted that care management for people with SMI requires significant investment from the plan, and ensuring this commitment is a key reason the state continues this model.

States vary in whether plans or providers lead care management programs under specialty plan models. In **Arkansas** and **Florida**, specialty plans deliver care management. Interviews with these states highlighted benefits such as improved access to health plan data and resources for care managers, and greater effectiveness in coordinating care across different provider types. When employing this approach, specialty plans will need to build strong relationships with community mental health providers to minimize duplication of services.

Other states have emphasized provider-led care management, including through health homes, to facilitate greater provider-level integration. In health home approaches for populations with serious behavioral health needs, specialty behavioral health providers often serve as the designated health home entity, and deliver services such as care coordination, including physical health services. For example, **New York** assigned all HARP enrollees to health homes for care management. **North Carolina** authorized tailored care management under a health home state plan amendment, with a glide path enabling providers to deliver most care management in community settings.[25]

When launching new care management programs, states benefit from minimizing duplication with other similar services to promote efficiency and avoid member confusion. If members do not clearly understand the added value of a new care management program, they may not engage in these services.[26] States can design care management programs to strengthen behavioral health providers' capacity to deliver integrated care, and may pursue Medicaid State Plan classification of health homes to leverage federal funds for specialty plan features that overlap with health home requirements.[27]

Engaging Stakeholders

The launch of specialty plans requires major changes for how eligible individuals and their providers navigate coverage. States can incorporate extensive stakeholder engagement into the launch and ongoing operations of these models to establish consistent communication among the state, plan entities, providers, and people with targeted conditions. In the case of specialty plans for people with serious behavioral health needs, enrollees may opt out of a specialty plan to avoid affiliation with programs that explicitly label their behavioral health condition. Ongoing engagement may help mitigate the impact of this stigma.

State Engagement Strategies

Early and ongoing stakeholder and member engagement helps maintain open communication channels, enabling members and providers to give direct feedback on specialty plan design and raise issues that arise during implementation. At the launch of the PASSE model, **Arkansas** developed a streamlined process to manage provider issues, clearly conveying resolution timelines and responsible entities. Weekly calls with all types of providers to discuss areas for improvement proved effective in addressing pain points and supporting timely resolution of issues. The state also used ombudsman offices and a ticketing system to ensure member complaints were heard and handled promptly. In **North Carolina**, stakeholders reviewed proposed policy designs and provided feedback via public webinars and presentations, policy paper comment periods, town hall meetings, email, and other engagement activities led by state officials during the development of the Tailored Plans.

Plan Engagement Strategies

Specialty plans — and states, through their oversight — can also ensure robust representation of member and provider perspectives to inform ongoing plan monitoring and decision-making. **North Carolina** included Tailored Plan contract provisions outlining specific member engagement goals, such as implementation of member advisory and member and family engagement committees, as well as guidelines on disseminating information to align key messages and overall communication. Specialty plan representatives in other states, such as **Arizona** and **Florida**, also shared how they gather feedback on their respective plans through various approaches, including monthly community forums with members and families, partnerships with peer and family agencies, and a member advisory council.

Impacts of Stigma

Some people with complex needs, such as SMI, may avoid receiving care due to concerns about being treated unfairly.[28] Insights from some states suggest that people with behavioral health diagnoses may be hesitant to enroll in specialty plans due to concerns about stigma. However, there are opportunities to address this through policy design, marketing and communications strategies, and provider training. To mitigate stigma, many states adopted similar names for their specialty and general plans and emphasized new or enhanced specialty plan benefits. In **New York**, an evaluation found that some individuals did not want to be identified as someone with a behavioral health diagnosis or associated with a plan for people with behavioral health needs, and recommended placing greater emphasis on social rather than clinical benefits to encourage enrollment and reduce stigma.[29] Since specialty plans often serve as the lead network coordinating across provider types and offering education on integrated care, they can help reduce stigma through strategies such as offering training for primary care providers.

Evaluating Specialty Plan Outcomes

Specialty plan models are designed to increase access to integrated care (especially community-based services), reduce preventable acute care utilization and costs, improve health outcomes, and strengthen provider capacity. The considerations outlined in this brief — related to plan requirements and partnerships, enrollment criteria, delivery system changes, and stakeholder engagement — shape how a specialty plan model delivers on these goals. States have limited capacity to assess the impact of these models without independent evaluations that include comparison groups and extended timeframes. Any evaluation must also account for member level of need and opt-out rates, which influence outcomes. Overall, there is limited evidence on these models due to wide variation in state evaluation approaches, though two states have released external evaluations. As these models mature, additional research will be needed to better understand their impact.

New York

There are two published evaluations on outcomes for specialty plan enrollees in **New York**, including a preliminary analysis on the impacts of enrollment on emergency department visits, inpatient stays, and outpatient visits, and an interim evaluation that analyzed quantitative and qualitative data to assess a wider range of research questions.[30,31] The first study, published in 2021, reported that people enrolled in the HARP for two years had: (1) significant reductions in hospitalizations; (2) increased access to and use of outpatient physical and behavioral health services; and

(3) reductions in average inpatient stays.[32] However, results from the interim evaluation were more mixed. This evaluation reported no impact from HARP enrollment on primary care access, though it noted that HARP enrollment may have reduced some barriers to accessing primary care. Other findings were inconclusive regarding quality of care, costs, and enrollee satisfaction, and the evaluation found no clear effect of HARPs on acute care utilization.[33] The interim evaluation, published in 2022, did report that HARP enrollees who received HCBS services or were enrolled in a health home experienced improved outcomes, however enrollees faced challenges accessing these services.

Arizona

An independent pre-post analysis of **Arizona's** specialty plan, published in 2018, found enrollee improvements across all measures of ambulatory care, preventive care, chronic disease management, and patient experience.[34] The rate of 30-day follow-ups after a behavioral health inpatient stay also increased. However, measures related to physical acute care utilization showed mixed results — while readmissions declined, inpatient utilization increased substantially. The evaluation suggested that these findings may reflect long-standing untreated physical health needs among specialty plan members, leading to greater acute care use after the transition to integrated care.

Conclusion

Specialty plans are a state approach to advance integrated care and address population-specific needs within a managed care model. The effectiveness of these plans depends on key factors such as how they are structured, the populations they target, the benefits offered, and the extent to which they engage key stakeholders in design and implementation. States seeking to develop or refine specialty plan approaches — along with health plans and providers operating within these policy environments — can draw on lessons from the five profiled states to inform future efforts.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

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