

CHAPTER 4

# Integration of Behavioral and Physical Health Services in Medicaid

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## Key Points

- Services for physical health and behavioral health (which includes mental health and substance use disorders) historically have been financed and delivered under separate systems. As a result, Medicaid enrollees with behavioral health conditions often find themselves interacting with multiple public and private agencies and receiving care from myriad providers funded from different sources.
- Given the large numbers of Medicaid beneficiaries with a behavioral health diagnosis and the substantial costs associated with their care, state Medicaid programs are looking for ways to improve care and reduce expenses. Clinicians and program administrators are also looking for better ways to treat behavioral health conditions and prevent these conditions from getting worse or contributing to a decline in physical health.
- Integrating physical and behavioral health has been shown to reduce fragmentation of services and promote patient-centered care for adults with depression and anxiety disorders. However, current evidence is limited or inconclusive for children and adolescents and for individuals with substance use disorders or serious mental illness. The growing number of behavioral health integration evaluations underway will provide additional information on how these efforts are affecting outcomes and costs.
- There is no one-size-fits-all model for behavioral health integration. Efforts to integrate care can encompass clinical, financial, and administrative domains. State Medicaid programs are adopting different approaches to integrate behavioral health and physical health care, including comprehensive managed care, health homes, and accountable care organizations.
- Legal, administrative, and cultural barriers can discourage integration efforts. These barriers include billing restrictions, privacy requirements and data sharing restrictions, the Medicaid institutions for mental diseases (IMD) exclusion, and separate professional training of physical health and behavioral health providers.
- The Commission plans to explore approaches to integrating additional services, such as pharmacy, long-term services and supports, and social determinants of health. We also intend to examine the impact of the Medicaid IMD exclusion on behavioral health services and Medicaid's interaction with other systems that provide behavioral health services to the Medicaid population, such as the criminal justice system.

## CHAPTER 4: Integration of Behavioral and Physical Health Services in Medicaid

Historically, services for physical health and behavioral health (which includes both mental health and substance use disorders) have been financed and delivered under separate systems. That means Medicaid enrollees with behavioral health conditions often find themselves interacting with multiple public and private agencies and receiving care from myriad providers funded from different sources. This fragmentation can impede access to care and result in inappropriate use of services, poor health status, and increased costs (Melek et al. 2014, IOM 2006, deGruy 1996). As policymakers, program administrators, clinicians, and patient advocates consider ways to improve the delivery of services for individuals with behavioral health disorders, some are pointing to integration of the delivery of behavioral and physical health services as critical to both providing care more cost effectively and improving health outcomes.

The term behavioral health integration is used to describe a wide range of activities designed to provide care to the whole person (including physical health, behavioral health, and other services) in contrast to approaches that focus on specific body systems, diagnoses, or conditions. Efforts to integrate behavioral and physical health extend across the continuum of care, from prevention to rehabilitation. These efforts include colocating physical and behavioral health providers, sharing data and information, blending funding streams, and consolidating Medicaid and state behavioral health agencies. The Agency for Healthcare Research and Quality (AHRQ), in its *Lexicon for Behavioral Health and Primary Care Integration*, defines integration as “the care that results from a practice team of primary care and

behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization” (Peek and NIAC 2013). This broad definition can be used to characterize the many different approaches that clinical providers and state Medicaid programs have used to implement integration, which can occur across varying levels (e.g., clinical, payment, and administrative).

There is a burgeoning evidence base that suggests integration efforts can lead to improved care and reduced costs when focused on certain populations or certain circumstances. For example, randomized control trials, systematic literature reviews, and meta-analyses have documented the effectiveness of integrating behavioral health into primary care settings for adults with depression and anxiety disorders (Miller et al. 2013, Archer et al. 2012, Woltmann et al. 2012). The evidence base supporting integration models for individuals with substance use disorders or serious mental illness, however, is limited and has shown mixed results (Asarnow et al. 2015, Gerrity 2014). Additionally, there are relatively few studies examining the effect of integration models on outcomes for children and adolescents (Asarnow et al. 2015). Furthermore, most studies have focused on clinical integration at the practice level, leaving many questions unanswered about the effects of financial and administrative integration efforts that are underway in Medicaid programs.

There is no one-size-fits-all model for behavioral and physical health integration due to the variation in recommended treatment and treatment location for different behavioral health conditions. The National Council for Community Behavioral Healthcare’s Four Quadrant Model suggests that individuals who are at the lowest risk for behavioral

and physical complications are best served in a physical health setting with on-site behavioral health clinicians. Individuals with high behavioral health needs and low physical needs might be better served in behavioral health settings that have linkages to physical care. Those with high physical and high behavioral health needs may benefit most from bidirectional models of care, in which the individual is served in both health care settings with close collaboration between the two sites (Mauer 2009).

The integration of behavioral and physical health should not be viewed as a panacea. Breaking down silos in the payment and administration of behavioral health does not ensure that individuals with behavioral health disorders will receive appropriate services in the most cost-effective manner. Moreover, compared to physical health, there are fewer performance measures for behavioral health and fewer proven strategies for implementing measures that do exist to improve quality and outcomes (Barry et al. 2015, Kilbourne et al. 2010). Such knowledge gaps make it difficult to evaluate the effectiveness of interventions, generalize about the benefits of integration, and determine which integration elements can lead to improved health care outcomes or cost savings.

Even so, state Medicaid programs are increasingly adopting varying degrees of behavioral health integration to address the needs of the 20 percent of Medicaid beneficiaries with behavioral health disorders (MACPAC 2015a, SHADAC 2015). Federal efforts, such as the Centers for Medicare & Medicaid Services (CMS) Medicaid Innovation Accelerator Program, are encouraging state integration initiatives by providing program support and funding to states to improve or expand their current mental and physical health integration efforts (CMS 2015a). These efforts take different approaches and focus on different levels of integration—clinical, payment, and administrative. However, the ability to implement specific integration strategies may be affected by state and federal policies as well as the structure

of clinical practice. Medicaid programs are working with partners to overcome some of these barriers. In addition, the 114th Congress is considering legislation to address known barriers to integration efforts—including policies about data sharing and same-day billing for physical and behavioral health services—and to provide incentives for mental health professionals to adopt electronic health records.

This chapter builds on the Commission's earlier work documenting the compelling need to find more cost-effective ways to treat individuals with behavioral health conditions—compelling because of the number of Medicaid beneficiaries in need of care and their share of total Medicaid expenditures. These individuals comprise a diverse group, ranging from young children who need screening, referral, and treatment for attention deficit hyperactivity disorder or depression to chronically homeless adults with serious mental illness (MACPAC 2015a).

In this chapter, we provide an overview of the different ways that behavioral health can be integrated at the clinical, payer, and administrative levels within Medicaid programs. Our review of recently implemented models includes comprehensive managed care arrangements, health homes, and accountable care organizations (ACOs) (SHADAC 2015). We do not draw conclusions about which models of physical and behavioral integration are most effective. Rather, we discuss the factors that impede behavioral and physical health integration at both the practice and the program levels, such as billing and data sharing restrictions, variation in covered services, and licensing requirements—areas the Commission will investigate more fully in future work analyzing how behavioral health services are delivered in Medicaid.

## Why Focus on Integrating Behavioral and Physical Health in Medicaid?

Integrating physical and behavioral health is one approach that states and the federal government are turning to in order to improve care and reduce expenses for high-cost, high-need beneficiaries. Clinicians and program administrators are looking for better ways to treat behavioral health conditions and better ways to prevent behavioral health conditions from getting worse or contributing to a decline in physical health.

As noted in the Commission's June 2015 report to Congress, Medicaid is the single largest payer in the United States for behavioral health services, accounting for 26 percent of such expenditures in 2009. In 2011, one in five Medicaid beneficiaries had a behavioral health diagnosis, but care for these individuals accounted for almost half of total Medicaid expenditures. Certain Medicaid eligibility groups have the highest prevalence of, and expenditures for, behavioral health services. For example, in 2011, almost half of non-dually eligible adults enrolled in Medicaid on the basis of a disability had a behavioral health diagnosis. Similarly, the 44 percent of children eligible on the basis of receiving child welfare assistance who had behavioral health diagnoses accounted for 78 percent of total expenditures for this eligibility group. Enrollees with a behavioral health diagnosis have higher total expenditures than their counterparts with no behavioral health diagnosis in every eligibility group examined. Furthermore, many people with serious behavioral health disorders have a substantial number of comorbid acute or chronic medical conditions (MACPAC 2015a).

Hundreds of collaborative and integrated care initiatives are now underway, as evidenced by the growing number of new clinical practice manuals and websites offering information on how to integrate behavioral health and medical care as well as the development of new business

ventures to help providers integrate care (Miller et al. 2014a). State Medicaid programs that contract with managed care organizations are increasingly moving toward carve-in models, meaning that behavioral health services are covered along with physical health services under a managed care benefit package, capitation rate, and network, rather than being covered separately. At least seven states (Alabama, Colorado, Iowa, Louisiana, Nebraska, New York, and Washington) are currently planning to end their Medicaid behavioral health carve outs (OpenMinds 2016). There also is movement within Medicaid programs to use health homes and ACO models to integrate the delivery of physical and behavioral health services (SHADAC 2015).

While there is general agreement among researchers, advocates, and clinicians that the integration of physical and behavioral can improve health outcomes and reduce spending, the research supporting this belief is inconclusive and does not support one model of integration as being superior to others. The majority of research examining behavioral and physical integration has documented the effectiveness of collaborative care and integration for adults with depression and anxiety disorders (Archer et al. 2012, Woltmann et al. 2012, Miller et al. 2013). Results from these evaluations suggest that collaborative models demonstrate improvements in depression and anxiety, mental and physical quality of life, medication use, and social role function. However, in practice, clinical settings have a unique set of patients with different severities of behavioral health disorders resulting in different approaches to integration. Given the diversity of patient populations and approaches to integration, no single element has emerged as essential to the success of the model, and researchers have not been able to identify specific populations, settings, or trial implementation factors associated with better or worse performance of the integration model (Miller et al. 2013, Woltmann et al. 2012).

There are fewer studies that examine the effect of collaborative care and integration models on improving health care outcomes for children and adolescents with behavioral health disorders (Asarnow et al. 2015). Available research suggests that integrating behavioral health care within primary medical care for children and adolescents with depression, anxiety, or behavioral disorders can improve behavioral health outcomes; however, the benefits of integrating medical and behavioral health have not been shown to be statistically significant for children and adolescents with substance use disorders (Asarnow et al. 2015, Kolko et al. 2014).

In general, published research has not focused on examining the effects of integration on individuals with serious mental illness or substance use disorders. One literature review suggests that the approaches of fully integrating care and enhancing collaboration through care management both appear to improve mental health outcomes for and use of preventive services by adult patients with serious mental illness (Gerrity 2014). However, colocating primary care in chemical-dependency treatment settings without further integration of services or collaboration between providers may have little impact on outcomes for individuals with substance use disorders (Gerrity 2014). Programs focusing on integrating behavioral and physical health for individuals with serious mental illness have produced improvements in control of diabetes, cholesterol, and hypertension, but have not shown improvements in obesity or smoking, and have not suggested a clear connection between integrated care and most behavioral health outcomes (Scharf et al. 2014).

Of note, none of the above studies explicitly discusses how or if Medicaid beneficiaries were included in the study populations. However, as Medicaid programs begin implementing behavioral health integration initiatives, case studies are surfacing that highlight the effects of these programs. For example, Hennepin Health, an ACO in Minnesota that was created specifically to serve

adults newly covered under the state's Medicaid expansion, has assembled multidisciplinary care teams, initiated data sharing through unified electronic health records, and embedded behavioral health providers in primary care settings to integrate behavioral and physical health. The program has documented decreases in emergency room and inpatient admissions and increases in outpatient visits and the number of patients receiving optimal diabetes, vascular, and asthma care (Sandberg et al. 2014).

There are a limited but growing number of case studies that specifically examine Medicaid integration initiatives and their effects on costs.<sup>1</sup> For example, Missouri's Community Mental Health Center Health Homes initiative, which is designed to provide integrated, patient-centered care to Medicaid beneficiaries with serious mental illness and those with other behavioral health problems combined with certain chronic conditions or tobacco use, decreased costs by \$7.4 million after 18 months (Parks 2014). More information on the effects of behavioral health integration on costs to Medicaid will become available through an independent, five-year evaluation of the new health home model that was authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and as longitudinal data from other initiatives become available (Spillman et al. 2014).

Research suggests that integrating physical and behavioral health can reduce fragmentation of services and promote patient-centered care. However, integrating care is complex and the success of the endeavor will depend on variables such as population characteristics, geography, market infrastructure, and types of behavioral health services delivered. We explore physical and behavioral health integration efforts, especially those being implemented within the context of the Medicaid program, in the following sections.

## Levels of Integration in Medicaid

Integration of behavioral and physical health can occur at different levels. Clinical integration occurs at the point of service and refers to the actions clinicians and care coordinators take to bridge the divide between the physical and behavioral health delivery systems and provide person-centered care. System integration occurs at the program policy and administration level and includes actions payers and administrators of behavioral health services take, such as blending funding streams and consolidating the administration of services.

### Clinical integration

Physical and behavioral health providers typically practice in separate facilities and have different philosophies and training on how best to treat patients. (A divide can exist even among behavioral health providers; for example, mental health and substance use services are often provided in separate settings, by different providers, with diverse expertise.) Separate systems for physical and behavioral health can result in beneficiaries with comorbid conditions bouncing between care settings. Such fragmentation can be confusing for patients to navigate and confusing for providers who are unaware of treatment plans or prescriptions recommended by other professionals. It can result in inappropriate, uncoordinated, and often inefficient care and lead to poor health outcomes and increased costs (IOM 2006).

Behavioral health conditions are often first diagnosed and treated in a primary care setting or in the emergency room (Anderson et al. 2015, Kessler 2012, Downey et al. 2009, Kessler and Stafford 2008). This reliance on primary care diagnosis for behavioral health conditions may reflect the high prevalence of comorbid physical conditions, limited access to behavioral health providers, or the prevailing stigma associated with seeking and receiving behavioral health

treatment (MACPAC 2015a, Klein and Hostetter 2014). Complicating matters, physical health providers may not be trained to diagnose or treat behavioral health conditions or make referrals to appropriate clinicians, and as a result, individuals with behavioral health conditions may leave a health care setting without receiving appropriate treatment or referrals (Klein and Hostetter 2014).

Clinical integration can occur in three ways—bringing physical health care into traditional behavioral health settings, bringing behavioral health care into traditional physical health settings, or doing both. At its best, clinical integration can change the focus of care delivery from isolated episodes of treatment to a comprehensive approach in which services are delivered in a consistent and coordinated manner with accountability not only for health outcomes but also for costs (Cohen et al. 2015). Integrating physical and behavioral health services can promote patient referrals and follow-up, foster collaboration in decision making, and connect beneficiaries to needed resources, resulting in more effective and efficient care (Heath et al. 2013, Peek and NIAC 2013, Brown et al. 2012).

Although there is no one model of clinical integration or definitive set of core features that will always lead to improved health outcomes and reduced costs, components of integration at the clinical level can include the following:

**Care coordination/care management.** Care coordinators (also referred to as care managers) act as single points of contact for patients and as hubs for the multiple providers treating a patient. They can facilitate the appropriate delivery of behavioral and physical health services to patients by assessing patient needs and goals, creating care plans, helping the patient transition from an institutional setting to the community, following up after appointments, monitoring compliance with doctors' orders, supporting the patient's self-management goals, and linking patients to community resources (Nardone et al. 2014, Heath

et al. 2013, Peek and NIAC 2013, IOM 2006). Care coordinators can be located in behavioral health, physical health, or other settings, for instance, within the state or local Medicaid program office.

**Colocation.** Colocation refers to physically locating behavioral health and physical health providers in the same facility (Miller et al. 2014b). For the Medicaid population, colocation can decrease out-of-pocket costs, such as transportation and child care associated with making trips to multiple locations, and encourage follow-up with referred providers (Nardone et al. 2014). For providers, colocation can encourage face-to-face contact between providers; foster communication about shared patients; improve the efficiency of services through sharing intake, billing, and administrative services; and enhance quality through a team-based approach to care (Heath et al. 2013).

**Data sharing.** Sharing clinical and other patient information can help care managers and providers from different disciplines communicate and coordinate care (Cifuentes et al. 2015). Electronic health records can give authorized individuals immediate access to patient data and support knowledge transfer and informed decision making among providers (Cifuentes et al. 2015, Peek and NIAC 2013, IOM 2006). The state of Michigan, for example, developed the Michigan Health Information Network Shared Services system to share electronic health information between health care providers, Michigan's health insurance exchange, CMS, Department of Veterans' Affairs, and the Social Security Administration (MiHIN 2015). The system connects networks of providers focused on physical health with behavioral health and substance abuse treatment organizations, allowing providers to share a range of patient data, including demographics, type of insurance coverage, hospital admissions, medications, lab results, diagnoses, allergies, treatment plans, clinical documentation, appointments, care team information, and activity logs (MiHIN 2015, SAMHSA-HRSA 2015).

**Formal or informal agreements with external partners.** Formal and informal arrangements between providers of behavioral health, physical health, or auxiliary services (e.g., transportation, housing) can ensure beneficiary access to a full complement of services. For example, a substance use treatment center or mental health organization might contract with a medical group to provide physical examinations and routine medical care for its patients, or health care providers might create referral relationships with community partners providing transportation services. Such arrangements would allow providers to use community resources without collocating services, which can be difficult and costly to implement.

**Screening and referral to treatment.** Screening and referral to treatment refers to a comprehensive and integrated approach to identifying appropriate treatments and preventive care and recommending the appropriate source of care for identified treatments (Kessler et al. 2014). Screening and referrals can occur in both physical health and behavioral health settings. For example, physical health providers can use tools to identify specific behavioral health conditions and then help the patient take steps to get additional treatment. Conversely, behavioral health providers can be trained to monitor basic physical health conditions (Nardone et al. 2014). An evidence-based method called Screening, Brief Intervention, and Referral to Treatment (SBIRT) can be used to identify, reduce, and prevent problematic use of alcohol and illicit drugs (SBIRT Colorado 2011). Providers can use SBIRT to assess patients for risky behaviors, engage patients who exhibit risky behaviors, and make referrals to additional treatment as needed. It also helps providers and patients understand the potential health consequences of substance abuse and take steps to reduce risky behaviors. SBIRT has been shown to reduce emergency room usage and health care costs (SBIRT Colorado 2011). SBIRT is covered by some Medicaid programs (CMS 2014a); it is used by other programs, such as coordinated care organizations in Oregon, as a benchmark and improvement measure (Oregon Health Authority 2015).

**Provider education and training.** Introducing concepts of behavioral health, interdisciplinary care teams, and integration to provider education and training programs can influence the future health care workforce's expertise and expectations about clinical practice (Box 4-1). Residency training in family medicine and psychiatry is evolving to address these barriers to integration. Family medicine residents are now required to receive training in behavioral health, and psychiatry residents are required to complete a portion of the first year of residency training in a primary care setting (ACGME 2014a, 2014b). However, such training is not required in other medical specialties (ACGME 2013, Leigh et al. 2008).

Clinical integration of behavioral and physical health is being implemented at the federal and the state level. At the federal level, the Protecting Access to Medicare Act of 2014 (P.L. 113-93) authorized a demonstration of a new provider

type: certified community behavioral health clinics. These clinics are designed to provide community-based behavioral health services and are required to support care coordination, partner with other state and federal agencies delivering behavioral health services, hire staff with diverse disciplinary backgrounds, and develop formal relationships with other providers to ensure appropriate referrals and delivery of necessary treatment. Certified clinics are eligible for enhanced Medicaid funding through a prospective payment system that supports the delivery of evidence-based and integrated care. Additionally, states can receive an enhanced Medicaid federal match for services delivered by certified community behavioral health clinics (SAMHSA 2015a). As of October 2015, 24 states received planning grants to support the development of the demonstration. After the planning grant ends, up to eight states will be eligible to participate in the demonstration (SAMHSA 2015b).

### **BOX 4-1. Project TEACH (Training and Education for the Advancement of Children's Health)**

In 2007, New York State created Project TEACH as a way to strengthen and support the ability of primary care physicians to provide mental health services to children, adolescents, and families. Project TEACH provides primary care providers with 15 hours of in-person training over 3 days, a 6-month case-based clinical distance learning program (including 12 hour-long consultation calls), and a set of web-based learning tools. Project TEACH has two component programs: Child and Adolescent Psychiatry for Primary Care and Child and Adolescent Psychiatry Education and Support. Both component programs provide primary care providers with training, education, and assistance as well as information about specialized mental health centers located in their practice region (IDEAS Center 2015).

An evaluation of the programs found that participating primary care providers reported more confidence interacting with families, assessing the severity of behavioral health conditions, prescribing medication, and developing treatment plans for children and adolescents with mental health conditions. Providers also reported better interactions with mental health specialists. There were, however, reports of barriers to implementing Project TEACH practices. Providers reported that time constraints and competing priorities limited their ability to talk to patients about mental health conditions and to treat mental health conditions holistically. Some providers also expressed the belief that negative patient impressions or the stigmas associated with mental health disorders and treatment would limit their ability to implement Project TEACH practices (Gadomski et al. 2014).

At the local level, providers are implementing clinical integration efforts. Cherokee Health Systems, a community mental health center and federally qualified health center with 45 clinical locations in 13 Tennessee counties, is one of the most well-known Medicaid providers doing so. Cherokee Health Systems has embedded licensed behavioral health consultants as members of its primary care teams. It also makes psychiatrists available for consultation on site or through telepsychiatry, promotes and encourages provider communication and comanagement of shared patients, and uses shared electronic medical records (Cherokee Health Systems 2015, Freeman 2010). Cherokee Health Systems also provides consultation to other practices, providing both financial and technical support in linking physical health practices with behavioral health services (Takach et al. 2010). Cherokee Health Systems reports that its model has improved health outcomes, decreased referrals to specialty mental health care, increased patient compliance, and increased provider and patient satisfaction. Cherokee Health Systems has also documented reduced costs, hospital use, and emergency room visits compared to other regional providers (Freeman 2010).

## System integration

Behavioral and physical health integration is also being achieved at the system level through changes in payment and administration. Such efforts are often led by the state Medicaid agency through collaboration with payers and other state and federal agencies (e.g., the Substance Abuse and Mental Health Services Administration (SAMHSA), or state behavioral health agencies). These efforts include blending multiple funding streams and consolidating agencies that administer behavioral health services. They can have widespread effects on the delivery of behavioral health services, and they are often difficult to implement.

**Payment integration.** Multiple government agencies are involved in the financing and delivery

of behavioral health services for low-income populations. Thus, Medicaid beneficiaries can receive services from many different federal, state, and local agencies, including mental health and substance use agencies, school systems, criminal and juvenile justice departments, and child welfare agencies. Funding for these services comes from multiple sources, including state general funds, federal Medicaid matching dollars, and grants from federal agencies such as SAMHSA, and state administrators must often work to cobble together financing for the continuum of behavioral health services. In addition, state behavioral health agencies can use state funding as a portion of the state's share of Medicaid spending, which allows the state to draw down additional federal dollars to support behavioral health services. In 2013, states used Medicaid, mental health block grants from SAMHSA, and state general funds most frequently to cover community mental health center services such as outpatient testing and treatment, crisis services, and case management services. However, many states also used state general funds to cover supported employment, residential board and care, and state psychiatric hospitals. Medicare was used most frequently to support inpatient hospital services (NRI et al. 2015).

Although different programs can work together to maximize the delivery of behavioral health services, historical, political, legislative, and regulatory barriers may impede integration efforts. For example, these programs often have their own provider networks, eligibility systems, and billing procedures and rates. Even within Medicaid, a state may provide behavioral health services through a combination of payment approaches (e.g., fee for service or managed care), and authorities (e.g., waiver or state plan). In 2013, 30 states and the District of Columbia used both fee-for-service and managed care approaches to pay for mental health services, 15 relied only on fee-for-service approaches, and 4 used only managed care (NRI et al. 2015).<sup>2</sup> Many states also use Section 1115 research and demonstration waivers, Section 1915(b) managed care waivers, Section 1915(c)

home and community-based services waivers, Section 1915(i) home and community-based services, or the state plan rehabilitation option to provide mental health or substance use services (NRI et al. 2015).

The use of different purchasing models for different types of services and providers may limit the ability of states to completely blend funding streams. Medicaid pays for services under fee for service to individual providers and through capitated payments to plans, whereas behavioral health agencies traditionally either employ providers or make direct payments to a network of specialty behavioral health providers. In addition, the use of state behavioral health agency funding for Medicaid match could divert state dollars away from individuals with behavioral health disorders who do not meet Medicaid eligibility rules as well as from programs that otherwise have limited funding or no dedicated funding source (State Health Care Spending Project 2015, Garfield 2011, Frank et al. 2003).

**Integration of administration and oversight.** State mental health and substance use agencies play a large role in administering behavioral health services for Medicaid beneficiaries and their ability to work closely with Medicaid is affected by the organizational structure of the state government. In most states, either the state Medicaid agency and the state mental health agency are located in the same umbrella department, or they are located in different departments but have an interagency agreement for planning and delivering mental health services. In some states (Arizona, California, Michigan, and Pennsylvania), the state mental health agency is part of the state Medicaid agency (Betlach 2015, NRI et al. 2015).

State Medicaid agencies have authority over all Medicaid services, but they can delegate responsibility for certain services and functions to other agencies. In some states the Medicaid agency delegates responsibility for Medicaid behavioral health payment and clinical policies

(e.g., certifying and enrolling providers, defining covered services, and collecting and reporting data) to state mental health and substance use agencies. States also take varying approaches to setting rates. For example, according to SAMHSA, 19 state mental health agencies are responsible for setting Medicaid rates for mental health services, 16 are responsible for setting Medicaid rates for those services provided by state mental health agency funded providers, 15 set Medicaid rates only for mental health services provided by state mental health agency operated providers, and 4 are responsible for setting Medicaid rates for mental health services provided by organizations that do not receive state mental health agency funding (NRI et al. 2015).

Responsibility for delivery of behavioral health services can also be spread across multiple agencies depending on populations served and geographic areas. For example, in Florida, most Medicaid enrollees are enrolled in a Medicaid managed care plan. The state has contracted with a specialty managed care plan, Magellan Complete Care, in certain regions of the state to serve Medicaid beneficiaries with serious mental illness, covering and coordinating both physical and behavioral health services for enrollees. Those with serious mental illness who do not live in a county in which Magellan Complete Care operates receive both physical and behavioral health care through another managed care plan that may not offer specialized benefits or coordination (AHCA Florida 2015).

Historically, state Medicaid and behavioral health agencies served different populations that were treated by separate providers in isolated care settings using different funding streams. In addition, authority and oversight of behavioral health services were often assumed by multiple agencies. When Medicaid delegates responsibility for Medicaid behavioral health services, it further divides monitoring and provision of physical and behavioral health services within the Medicaid program. Variation in organizational mission,

expertise, and leadership across agencies may make it difficult to integrate services under one organization or to hold any one actor accountable for outcomes (Bachrach et al. 2014).

States are addressing the fragmented nature of the behavioral health system in different ways. Some states are addressing these concerns by consolidating agencies. For example, from 2012 to 2013, California eliminated the Department of Alcohol and Drug Programs and the Department of Mental Health, transferring functions and responsibilities to the state's Medicaid agency. The goal was to create efficiencies for state government, counties, and providers and to promote coordination of services (Bachrach et al. 2014, Rawson and Lee 2011, California Health and Human Services Agency 2011).

Other states are merging mental health and substance abuse agencies into a single agency or parallel agencies under the same umbrella organization. In 2013, the state of Ohio merged the Ohio Department of Alcohol and Drug Addiction Services and the Ohio Department of Mental Health (Johnson 2013, ODADAS and ODMH 2012).

States are also developing stronger or more formalized relationships between Medicaid and other agencies. Some state Medicaid programs and criminal justice departments are beginning to work together to help individuals transitioning into and out of the criminal justice system (Gates et al. 2014, Salt Lake County Local Authority 2014, Sutcliffe 2014). Although federal law prohibits federal funding for most Medicaid services provided to incarcerated individuals, Medicaid and criminal justice programs in a growing number of states and localities are working together to facilitate the Medicaid eligibility determination and enrollment process as individuals return to the community (Smith et al. 2005). Given the high prevalence of behavioral health conditions among the incarcerated population, facilitating Medicaid enrollment for eligible individuals may improve

health outcomes, reduce rates of recidivism, and lower costs to the state (Gates et al. 2014).

Along similar lines, Medicaid agencies are collaborating with the child welfare system to integrate the delivery of behavioral health services furnished by these separate agencies. Title IV-E of the Social Security Act provides federal funding for child welfare assistance for low-income children who have been removed from their homes. Individuals receiving federal child welfare assistance under Title IV-E are automatically eligible for Medicaid, and often need a range of Medicaid-covered physical and behavioral health services—in 2011, 44 percent of children who received child welfare assistance had a behavioral health diagnosis (MACPAC 2015a). Child welfare agencies, in addition to ensuring the safety of these children, must also ensure that their health needs are met. However, federal child welfare funds under Title IV-E cannot be used for health care-related services. To better serve child welfare-involved youth, therefore, state Medicaid agencies and child welfare agencies are working together to share data, facilitate Medicaid enrollment, and maximize federal funding for services provided to these children. One such state is Tennessee, where the Department of Child Services and TennCare, the state Medicaid agency, have an interagency agreement with specific provisions for coordinating the enrollment of and ongoing provision of health services to all children in state custody (MACPAC 2015a). (For more information on the intersection of Medicaid and the child welfare system, refer to Chapter 3 of the Commission's June 2015 report to Congress.)

## Medicaid Behavioral Health Integration Initiatives

State Medicaid programs vary in their approaches to integrate behavioral health and physical health care. The following section describes how states

use comprehensive managed care, ACOs, and health homes models to integrate physical and behavioral health.

Much of the presented information is drawn from a scan of Medicaid efforts to integrate behavioral and physical health services that was conducted for the Commission by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota School of Public Health. This project consisted of a comprehensive web search of state program information, as of March 2015, across all 50 states and the District of Columbia. The scan found that most behavioral health integration efforts could be categorized as one of the following delivery approaches: comprehensive managed care, health homes, ACOs, primary care case management, and patient-centered medical homes.

The research team focused on identifying behavioral health integration efforts implemented through state Medicaid programs and policies. These could include statewide or county efforts, but not initiatives driven by providers or plans. The review also excluded programs that integrated other services concurrently, such as long-term services and supports, to be sure that any effects seen in individuals with behavioral health disorders could be attributed primarily to behavioral health integration efforts.<sup>3</sup>

Although this review is not a comprehensive list of all behavioral health integration efforts underway that might affect Medicaid beneficiaries, it illustrates the types of payment models, integration mechanisms, target populations, and provider types that characterize Medicaid behavioral health integration initiatives.<sup>4</sup> In total, the effort detailed 19 behavioral health integration efforts across 17 states. Most of these programs are relatively new; only 3 date to 2010 or earlier, with 16 having been developed since 2011, including 8 programs implemented since 2014. Half of the programs are classified as health homes, and half target individuals with serious mental illness. (A summary of all findings can be found in Appendix 4A.)

The review also shows the variety of approaches that states are testing and how each approach uses different mechanisms to integrate care. About half of the programs we studied chose to integrate physical health into behavioral health care environments; several integrated behavioral health into physical health care settings; and a few opted for two-way integration. Only a few of the programs were using a colocation approach. However, most of the documentation we found described efforts at a programmatic level, so it is possible that more individual practices have colocated providers than we could detect.

We found little information on how the goals and elements of integration are implemented at the practice level, particularly for data sharing, care coordination, and case management. There was also limited information on the effects of these programs on health outcomes and costs. More time and study are needed to determine the effectiveness of these programs and to understand which components of integration are most conducive to achieving program goals. The complete catalog of Medicaid initiatives has been posted on the MACPAC website (SHADAC 2015).

## Comprehensive managed care

For many years, state Medicaid programs have contracted with managed care organizations to provide physical and behavioral health services. The reliance on managed care is increasing and its use varies widely by states, both in the arrangements used and the populations served. Some states carve behavioral health services completely out of their managed care contracts or separate the delivery of mental health services from substance use services by including only one set of services in the state's primary Medicaid managed care contract. But a growing number of states are moving toward carve-in models, so that a single managed care entity holds financial and administrative responsibility for both behavioral and physical health services.

**Carve in.** In recent years, many states have carved behavioral health services into their primary Medicaid managed care contracts, and at least seven states are either planning or currently implementing carve in of behavioral health services (OpenMinds 2016). Behavioral health carve in centralizes accountability for quality and costs within one organization. Tennessee's Medicaid program integrates physical health, behavioral health, and long-term services and supports for all Medicaid beneficiaries into its managed care contracts, putting plans at full risk for all services. (Previously, behavioral health benefits were managed by the Tennessee Department of Mental Health and Substance Abuse Services.) The state reports that this approach has reduced inpatient utilization and emergency room visits and has led to improvements in care and decreased costs (TennCare 2015, Stanek 2014, Hamblin et al. 2011).

Carve-in structures are sometimes limited to individuals with certain behavioral health conditions, such as serious mental illness. The Minnesota Preferred Integrated Network Program is a public-private partnership between Dakota County and a Medicaid managed care organization that coordinates physical and behavioral health care services for Medicaid-eligible adults under age 65 who have serious mental illness and for children with serious emotional disturbances. Enrollees have access to the full continuum of services, and a single point of contact is held accountable for delivery of services (SHADAC 2015).

Some stakeholders have raised concerns that carving behavioral health services into a comprehensive managed care contract does not guarantee successful integration of physical and behavioral health services, particularly if the managed care organization does not have stable relationships with appropriate providers or expertise or experience in managing behavioral health conditions. Additionally, stakeholders have commented that in such arrangements, coverage of behavioral health services can be limited,

especially if plans focus on other aspects of care or take other steps to keep costs within the limitations of a capitated payment (Bachrach et al. 2014, National Council 2011).

**Carve out.** Many states are unable to carve behavioral health services into their managed care contracts due to a combination of financial constraints, policy restrictions, historical precedent, managed care experience and penetration in the state, and stakeholder opposition. As a result, some states or localities contract separately with specialized provider networks or with managed behavioral health organizations to provide these services, which may operate under capitated or fee-for-service arrangements.

Another reason carve outs have been used is that these services can be capitated, which may help keep down spending growth relative to fee for service. Carve outs also allow managed behavioral health organizations to create a network of experts experienced in managing behavioral health problems of specific populations, and the managed behavioral health organization can focus on developing performance standards and monitor quality of care specific to behavioral health populations that may be overlooked or emphasized less by other providers (Bachrach et al. 2014, Mechanic 2003).

For example, in 2011, Maryland started the stakeholder process of developing a model of integrated behavioral and physical health (Maryland Department of Health and Mental Hygiene 2012a). Previously, mental health services for Medicaid were carved out of Medicaid managed care, and an administrative services organization was responsible for the provision of mental health services. Substance use services were managed separately by eight Medicaid managed care organizations as part of an integrated benefit with physical health. In addition, management responsibilities for mental health and substance use disorder services were shared among three

state agencies—the Alcohol and Drug Abuse Administration, the Mental Health Administration, and Medicaid—all within the Maryland Department of Health and Mental Hygiene (McMahon 2015).

In 2012, the state changed its approach, consolidating the Mental Hygiene Administration and the Alcohol and Drug Abuse Administration into a new Behavioral Health Administration. It also carved both mental health and substance use services out of Medicaid and began delivering these through one administrative services organization. Now, Medicaid oversees the financing of behavioral health services while the administrative services organization is responsible for delivery of services. As a result, the state benefits from the behavioral health experience of a specialized administrative services organization and shifts financial risk to the managed care organization (Maryland Department of Health and Mental Hygiene 2012b, 2011).

Maryland’s change in approach allowed the state to reach all Medicaid beneficiaries, including dually eligible beneficiaries who are not mandatorily enrolled in Maryland’s Medicaid managed care program. These dually eligible beneficiaries would have been excluded from a behavioral health carve in model, creating the need for a separate behavioral health carve out for this population. Also avoided was the situation in which Medicaid-only beneficiaries turning 65 and becoming dually eligible would have been forced to leave their existing plan and providers. A carve-out model allows individuals to stay with their administrative service organization to access behavioral health services regardless of transitions from Medicaid-only to dually eligible status. Additionally, in a behavioral health carve-out model, behavioral health providers are spared the administrative burdens associated with complying with the credentialing, prior authorization, utilization review, payment rates, and contracting practices of each of the state’s eight managed care organizations. Finally, the carve-out model is helpful in situations

where income changes cause individuals with behavioral health conditions to churn between Medicaid coverage and exchange plans. Given that the administrative service organization serves as the single point of contact for entities outside Medicaid interfacing with the Medicaid behavioral health system, this may allow coordinated transitions for individuals between Medicaid and exchange plans. Smoother transitions are also expected when individuals transition from local and state behavioral health programs to Medicaid (Boozang et al. 2014, Maryland Department of Health and Mental Hygiene 2012a).

However, carve-out models can lead to segmentation of care, poor coordination, restrictions on choice, and disruptions in continuity of care (Bachrach et al. 2014). Carving behavioral health services out of managed care plans can create complications for providers and beneficiaries. If behavioral health services are carved out and the plan has a separate behavioral health network, providers may not know that behavioral health benefits are carved out of the patient’s primary Medicaid managed care plan, or even if they themselves are within the managed behavioral health organization’s network. Behavioral health providers may also need separate prior authorizations to be paid for non-emergency behavioral health services. In such situations, providers simply may not get paid if prior authorization procedures are not followed (AMA 2015). For beneficiaries, carve-out models involve multiple points of contact for accessing services.

## Health homes

As noted earlier, the health homes program created by the ACA is designed to ensure whole-person care, integrating primary, acute, and behavioral health care as well as long-term services and supports and social and family supports. The law also provides a fiscal incentive in the form of a temporary

enhanced 90 percent federal match for the first two years of state health home programs.<sup>5</sup> States are increasingly using health homes to integrate physical and behavioral health (CMS 2015b).

The health homes option provides flexibility for states in program design but is available only for individuals with certain chronic conditions—those with two or more chronic conditions, one chronic condition and risk factors for another, or serious mental illness (Box 4-2). As of December 2015, 20 states and the District of Columbia were operating a total of 27 approved Medicaid health home models, serving over 1 million enrollees. Of these 27 health home models, 14 are targeted to a specific mental health or substance use population (CMS 2015b, 2015c).

## ACOs

ACOs have recently emerged in Medicaid, and a few states are using these structures to integrate behavioral and physical health. An ACO is typically a provider-led organization comprised of different types of providers who deliver care across multiple care settings for a defined population. Providers contract directly with payers. The ACO structure often marries care delivery reforms with new provider payment strategies, such as shared savings/risk programs and global payments or budgeting (Brown and McGinnis 2014).

States can encourage behavioral health integration by including behavioral health services in ACO payments, or requiring ACOs to include behavioral health providers or behavioral health into quality

### BOX 4-2. Health Homes That Integrate Behavioral Health Services

**Missouri Community Mental Health Center Healthcare Homes.** The Missouri Community Mental Health Center Healthcare Homes initiative is focused exclusively on high-cost Medicaid beneficiaries with either serious mental illness or other behavioral health problems combined with other chronic conditions or tobacco use. Only community mental health centers are eligible to participate as health homes under this initiative. Participating community mental health centers provide comprehensive care management, care coordination, health promotion, transitional care, patient and family support, referral to community and social support services, and use of health information technology to link services for Medicaid beneficiaries. The program has reported decreased blood pressure, low-density lipoprotein cholesterol levels, and hemoglobin A1C levels (a blood test used for diabetes management) in enrollees and has been shown to reduce hospitalizations, emergency room visits, and spending (SHADAC 2015).<sup>6</sup>

**West Virginia Health Homes.** West Virginia's health homes program is currently limited to Medicaid beneficiaries with bipolar disorder who are at risk of or are infected with hepatitis type B, type C, or both who reside within a six-county region (the six counties with the largest number of enrollees with bipolar disorder). Approved behavioral health homes include federally qualified health centers, other specialty care centers, and community mental health centers. The program provides Medicaid beneficiaries with comprehensive care management, care coordination, health promotion services, transitional care, patient and family support, and referrals to community and social support services (SHADAC 2015).

### **BOX 4-3. Medicaid Accountable Care Organizations Integrating Behavioral Health Services**

**Accountable Care Collaborative, Colorado.** Through its Accountable Care Collaborative initiative, Colorado contracts with five regional care collaborative organizations to establish networks of primary care providers and to provide care coordination for Medicaid enrollees at the regional level. In the first phase, behavioral health was carved out of the Accountable Care Collaborative and financed through capitated payments with behavioral health organizations. However, in 2015, the initiative entered the second phase, which is realizing the long-term vision of the program to integrate behavioral health and long-term services and supports with physical health. Regional care collaborative organizations have improved the referral process by providing enrollees with timely referrals to behavioral health services and have instituted a communication feedback loop with primary care providers. They are also developing telehealth video conferencing options for linking behavioral health providers to primary care provider sites, and they are aiding primary care providers by bringing behavioral health professionals on site (Colorado Department of Health Care Policy and Financing 2015, SHADAC 2015).

**Southern Prairie Community Care, Minnesota.** Southern Prairie Community Care is a collaborative effort among 12 Minnesota counties that share the desire to enhance the quality of life for citizens through the integration of services and supports provided throughout their communities. The collaborative is the first multicounty partnership to join Minnesota's Medicaid accountable care organization demonstration, called the Integrated Health Partnerships program. Under a contract with the State of Minnesota, Southern Prairie Community Care's total cost of care for Medicaid enrollees will be measured against targets for both cost and quality, and providers in its network can share in savings resulting from the program. Southern Prairie Community Care collects, analyzes, and uses clinical data across collaborating partners to improve outcomes, engages patients to manage their own health and outcomes, and facilitates coordination across providers. Southern Prairie Community Care providers assess Medicaid enrollees for medical and psychosocial issues. Medicaid enrollees are identified by three levels of risk. Individuals identified as high risk receive care coordination for 6–12 months to address complex medical and psychosocial issues; individuals identified as intermediate risk receive care coordination for 1–3 months; and individuals identified as low risk receive usual care (SHADAC 2015).

and performance metrics (Box 4-3) (CHCS 2015). Most Medicaid ACOs are in their infancy, and they vary significantly based on a state's health care environment. More research is needed to understand how these models can successfully integrate behavioral health and if they can improve outcomes and reduce costs for individuals with behavioral health conditions.

## **Behavioral Health Integration Efforts for Dually Eligible Beneficiaries**

The 10 million people dually eligible for Medicare and Medicaid account for a disproportionate share of Medicare and Medicaid spending (MedPAC and MACPAC 2016). Their high costs are associated with complex health needs, including high

prevalence of behavioral health disorders. In 2009, approximately 44 percent of dually eligible Medicare and Medicaid enrollees had at least one mental or cognitive condition, compared to 19 percent of all other Medicare beneficiaries (Kasper et al. 2010). Like other dually eligible beneficiaries, those with behavioral health disorders must navigate a Medicare benefit that is usually provided through two separate programs—original Medicare (Parts A and B) for acute and postacute care services and Medicare Part D for prescription drugs—while also managing separate Medicaid coverage for certain out-of-pocket costs and services that Medicare does not cover, including the home- and community-based services often needed by this population.<sup>7</sup> Several initiatives are underway to align Medicare and Medicaid program financing, administration, and care delivery for dually eligible beneficiaries, including the Financial Alignment Initiative, the Dual Eligible Special Needs Plans, and the Program of All-Inclusive Care for the Elderly. The goal of these initiatives is to fully integrate the clinical delivery of Medicare and Medicaid behavioral health services while aligning the financial and administrative structures of Medicare and Medicaid.

## Financial Alignment Initiative

The Financial Alignment Initiative, a three-year demonstration, is testing models of integrated care and payment. As of October 2015, 13 states are participating, with over 380,000 individuals enrolled (CMS 2015d, 2011). Each state model is unique, with different target populations, benefits, care coordination services, and payment frameworks. Ten states are participating under the capitated model, two are participating under managed fee for service, and one is participating under an alternative model.

A key component of the capitated model of the Financial Alignment Initiative is the coordination and integration of Medicare and Medicaid benefits, including behavioral health services, through a single health plan. Required elements include care coordination, health assessments, individualized

care plans, interdisciplinary care teams, and methods for ensuring care continuity. Some states also have chosen to expand behavioral health and other benefits under the demonstration. Under the demonstration, the state of Massachusetts is expanding diversionary behavioral health services to demonstration enrollees.<sup>8</sup> It is also requiring participating plans to complete a health risk assessment and a care plan for each enrollee, to maintain enrollees' current providers and service authorizations for a period of up to 90 days (or until the health risk assessment and care plans are completed), and to contract with community-based organizations for the coordination of long-term services and supports (MACPAC 2015b).

However, some states in the Financial Alignment Initiative demonstration have elected to continue to separate Medicare and Medicaid payment of behavioral health services by carving behavioral health out of the demonstration. For example, in California, although plans are financially responsible for all Medicare behavioral health services, some Medicaid specialty mental health services that are not covered by Medicare and certain Medi-Cal drug benefits are not included in the capitated payment.<sup>9</sup> These services are financed and administered by county agencies under the state's Medicaid managed care waiver and its state plan (MACPAC 2015b, California Department of Health Care Services 2013).

## Dual Eligible Special Needs Plans (D-SNPs)

Dual Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage plan that enable better coordination of services for dually eligible beneficiaries. D-SNPs must provide a coordinated Medicare and Medicaid benefit package that offers more integrated care than regular Medicare Advantage plans or Medicare fee for service. In each state in which they operate, D-SNPs must have a contract with the state Medicaid agency to provide Medicaid benefits or must arrange

for benefits to be provided (Verdier et al. 2015). However, D-SNPs often do not clinically or financially integrate Medicaid benefits, and most D-SNP contracts do not cover all of Medicaid's behavioral health services (MedPAC 2013). As a result, even plans that are designed to integrate behavioral health benefits across Medicare and Medicaid for dually eligible beneficiaries can be limited in their ability to do so (MedPAC 2013).

Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) are a special type of D-SNP authorized by the ACA that are designed to promote the full integration and coordination of Medicare and Medicaid benefits for dually eligible beneficiaries by a single managed care organization. FIDE SNPs must meet several specific requirements, including coordination of Medicare and Medicaid physical health services, behavioral health services, and long-term services and supports (Verdier et al. 2015). However, there are relatively few of these plans. Compared to 336 D-SNPs serving over 1.7 million enrollees, there are only 37 FIDE SNPs, which serve under 113,000 beneficiaries across seven states (Verdier 2015).

## Program of All-Inclusive Care for the Elderly (PACE)

The PACE program provides comprehensive medical and social services to certain frail, community-dwelling individuals age 65 and older who are dually eligible for Medicare and Medicaid. The program is designed to provide beneficiaries with a comprehensive service package that enables them to remain in the community rather than receive care in a nursing home. PACE is a Medicare program, although states can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit. The PACE financing model combines payments from Medicare and Medicaid and private pay sources into one flat-rate payment to cover a range of treatments and services, including behavioral health services. PACE organizations provide care and services in the home, in the

community, and in PACE centers. Although PACE programs are allowed to contract with separate behavioral health specialists, some have begun including behavioral health providers in their on-site care teams. One study showed that integrating behavioral health providers within a PACE program increased the number of appointments to mental health clinicians, and reduced psychiatric inpatient utilization (Ginsburg and Eng 2009). Overall, the PACE program has shown that integrating the financing of Medicare and Medicaid, coupled with integrating care for physical health, behavioral health, long-term services and supports, and ancillary services can lead to both improved health outcomes and reduced expenses over time for a high-cost, high-needs population (Hirth et al. 2009).

One noticeable weakness of the PACE program is its limited flexibility and scalability: there are only 116 PACE programs in 32 states (National PACE Association 2015). Legislation enacted in late 2015 (P.L. 114-85) extended the authority of the Secretary of the U.S. Department of Health and Human Services to change program features to try to improve the program. Permissible changes include altering payment rates and benefits and expanding eligibility to those under the age of 55, possibly providing new opportunities to integrate physical and behavioral health for dually eligible beneficiaries.

## Barriers to Behavioral and Physical Health Integration in Medicaid

There is evidence to suggest that programs to integrate behavioral and physical health can be effective in improving care and controlling costs, both in general and within Medicaid, and an increasing number of Medicaid agencies are initiating such programs. However, implementation is far from universal. Legal, administrative, and cultural barriers discourage integration efforts; some of these are described below.

## Billing policies and restrictions

Being able to provide physical and behavioral health services on the same day encourages providers to colocate and implement integration efforts. However, some state Medicaid programs prohibit a provider from billing for both a behavioral health and physical health visit on the same day or to bill for more than one medical, behavioral health, or dental encounter per day.<sup>10</sup> These billing restrictions are designed to reduce inappropriate billing (such as sending a patient for unnecessary referrals or tests while they are at the provider location), but they have unintended consequences that can limit access to care. These policies are of particular concern to colocated providers who provide both medical and behavioral health services at the same site. Some states have addressed this issue through state policy (Houy and Bailit 2015, NACHC 2012, SAMHSA 2010).

## Coverage of behavioral health services

Medicaid coverage of behavioral health services varies considerably across states and may not include all the services needed by individuals with behavioral health conditions. To the extent that services are not covered, integration of those services with others cannot be accomplished. For example, state coverage of substance use services can be limited or dependent upon the authority a state uses to provide services, the beneficiary's eligibility pathway, or financial support from other funders, such as SAMHSA or state mental health agencies. These variables also affect the coverage of services that facilitate behavioral and physical health integration, such as SBIRT and telehealth (Houy and Bailit 2015).

## Institutions for mental diseases (IMD) exclusion

The Medicaid IMD exclusion is a statutory provision that prohibits federal Medicaid reimbursement for inpatient care provided to individuals over age 21 and under age 65 who are patients in an IMD, as well as other benefits

provided to IMD residents whether these are furnished inside or outside the IMD. IMDs can include psychiatric hospitals, nursing facilities and chemical dependency treatment facilities. This means states will not use Medicaid dollars for beneficiaries who are over age 21 and under age 65 who are patients of an IMD for these services (Box 4-4) (Rosenbaum et al. 2002).

The IMD exclusion serves as a barrier to integration in several ways. First, it creates a disincentive for physical health providers to provide care in IMDs and accept patient referrals of individuals who are residents of IMDs because Medicaid will not pay for the provision of these services. Second, it discourages certain residential facilities, such as long-term care facilities, from treating and accepting Medicaid patients with behavioral health diagnoses because they run the risk of being classified as an IMD and losing federal financial participation for their Medicaid patients (McMahon 2015, Edwards 1997, Office of Technology Assessment 1987).

## Provider ability to bill Medicaid

Behavioral health integration often relies on many types of providers, including physicians, psychologists, social workers, and peer counselors. States often limit the types of practitioners who can bill Medicaid for behavioral health services. For example, psychologists are often restricted in the types of services they can provide and might be required to have a relationship with the ordering physician, and psychologists in training (i.e., supervised interns, residents, and postdoctoral trainees) might not be able to bill Medicaid. Such policies limit the ability of medical facilities to integrate these professionals into their care teams (Houy and Bailit 2015, APA 2012).

## Privacy and data sharing

The ability to share data among providers and between providers and patients is a fundamental component of behavioral health integration. However, rules preventing the exchange of health

### **BOX 4-4. Opportunities and Challenges for Medicaid Coverage of Services to Adults over Age 21 and under Age 65 Residing in Institutions for Mental Diseases**

Through Section 1115 waivers, Medicaid managed care, and the Medicaid Emergency Psychiatric Demonstration states can cover services for a Medicaid beneficiary who is over the age of 21 and under the age 65 who is an IMD resident (Maryland Department of Health and Mental Hygiene 2015; CMS 2015e, 2015f). However, the pathways to cover IMD services are often limited:

- CMS approved IMD exclusion Section 1115 waivers in 10 states, which allowed these states to cover services for IMD residents, but in fiscal year 2006 CMS began to phase out these waivers. Maryland is currently seeking an amendment to its HealthChoice Section 1115 demonstration that would allow Medicaid to pay for services in IMDs (Maryland Department of Health and Mental Hygiene 2015).
- On June 1, 2015, CMS published a notice of proposed rulemaking to modernize Medicaid managed care regulations. This proposed rule allows managed care organizations and prepaid inpatient health plans to receive full federal match on a monthly capitation payment for an enrollee over age 21 and under age 65 who spends less than 15 days in an IMD during that month. Although this allows Medicaid managed care plans to pay for and receive full federal match for services provided to individuals in an IMD, it is limited to only 15 days during a month, which may not be sufficient to meet all patient needs (CMS 2015f).
- The Medicaid Emergency Psychiatric Demonstration, established in Section 2707 of the ACA, permits Medicaid payment to participating private psychiatric facilities for treatment of Medicaid beneficiaries, over age 21 and under age 65. This demonstration is limited to 27 private psychiatric facilities across 11 states and the District of Columbia. This three-year demonstration program ended six months early but was allowed to be extended through 2019 under the Improving Access to Emergency Psychiatric Care Act (P.L. 114-97) (CMS 2015e).

data create barriers to integrating care. At the federal level, privacy rules established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) often prevent parents, family members, and caregivers from receiving health information about family members with serious mental illness, particularly those over the age of 18 (English and Ford 2004). Federal rules authorized by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act (P.L. 114-38) and the Drug Abuse Prevention, Treatment, and Rehabilitation Act of 1972 (P.L. 96-181) limit, with few exceptions, the disclosure of identifiable information by a federally assisted substance abuse

treatment program to any entity, even for treatment, without signed consent from the patient to authorize the disclosure to specific data recipients (42 CFR 2.1–2.67). Federal and state privacy requirements can lead to the exclusion of behavioral health data from health information exchange regulations (Truven Health Analytics 2014). States often impose additional limitations on sharing behavioral health information across providers and between providers and insurers (Jost 2006). Although these restrictions were put in place to protect the privacy of individuals with behavioral health disorders, they also impede the sharing of information among providers—sharing that could benefit patients.

## Adoption of health information technology

The ability to share data and fully integrate care delivery is dependent on provider ability to adopt electronic health records. Behavioral health providers often have limited working capital to invest in technology, and some behavioral health facilities and providers are ineligible to receive incentive payments to adopt electronic health records. For example, behavioral health facilities are not eligible for Medicaid meaningful use incentive facility payments because only hospitals are eligible for these payments. Furthermore, only certain providers working in behavioral health—physicians, nurse practitioners and certain physician assistants—are eligible for the Medicaid incentive payments. Of behavioral health providers who are eligible, few have been able to meet meaningful use standards (CMS 2015g, Bachrach et al. 2014, National Council 2012).

## Temporary funding

As noted throughout the chapter, many of the opportunities states and providers have to integrate behavioral and physical health care are only made possible by temporary funding streams. For example, the Medicaid Emergency Psychiatric Demonstration is a time-limited demonstration program, the health homes program has a temporary 90 percent federal match for the first two years, and the CMS Medicaid Innovation Accelerator Program focusing on behavioral and physical integration will offer states time-limited technical assistance and support to expand existing integration efforts. Without sustained funding, states and providers might have to end current behavioral and physical health integration efforts. Some may choose not to pursue integration efforts knowing that funding will be terminated or decreased over time.

## Licensing requirements

Health care facilities are required to adhere to state licensing requirements that are meant

to protect patients and ensure the appropriate delivery of services. However, the involvement of multiple state agencies can result in conflicting, overlapping, or duplicate licensing requirements that impede the delivery of integrated care. Typically, facility and staffing requirements assume that physical and behavioral health services are provided in separate settings with different providers. For example, if a mental health organization provides basic physical health services (e.g., blood pressure monitoring, checking vital signs), the facility may be required to meet the standards of the physical health provider (e.g., regarding exam rooms, bathrooms, drug storage, or lab services) even if the mental health provider does not plan to offer extensive physical health services. Similarly, a physical health provider organization seeking to include behavioral health providers on site could be required to meet all the staffing requirements for a mental health clinic, such as the presence of a psychiatrist, certain education levels for all behavioral health providers, or a multidisciplinary care team (Houy and Bailit 2015, Bachrach et al. 2014).

## Behavioral health workforce

Physical and behavioral health integration is dependent on the availability and patient capacity of behavioral health professionals (Burke et al. 2013). The general shortage and geographic maldistribution of behavioral health providers coupled with the unwillingness of some to serve the Medicaid population limits access for Medicaid beneficiaries (Hyde 2013, Decker 2012). The Health Resources and Services Administration (HRSA) reports that in 2015 there were over 4,200 areas in the United States with a shortage of mental health professionals (HRSA 2015a).<sup>11</sup> HRSA and SAMHSA have worked together to increase the number of primary care and behavioral health providers of all levels who are committed to serving an underserved population through the National Health Service Corps program, the Graduate Psychology Education program, and the Behavioral Health Workforce Education and Training for Professionals and Paraprofessionals

program (HRSA 2015b, 2015c). State Medicaid programs can also support behavioral health provider and integration training by leveraging their use of Medicaid graduate medical education funding.<sup>12</sup> States can use this funding to support residency training in community health centers, to require that training programs include a module on behavioral health integration, and to support the training of behavioral health specialists and providers willing to serve Medicaid beneficiaries (IOM 2014, Spero et al. 2013).

### Infrastructure capacity

Behavioral health and physical health providers that seek to integrate care may need to add staff, conduct training, and build infrastructure (e.g., billing, clinical workflows, and human resource management) to serve patients with complex needs. However, the ability of providers to scale up is often limited by financial constraints and the availability of trained providers. Federal and state agencies have recognized that integration is not a simple task, and some have offered financial support to providers to expand their service lines (Colorado Department of Health Care Policy and Financing 2015, HRSA 2015d).

### Professional cultural and training barriers

Physical health and behavioral health providers typically train and practice separately. This leads to differences in treatment philosophies, working styles, and patient-communication practices. Lack of knowledge regarding the different fields and different workforce cultures can impede the delivery of integrated care. Training the future physical and behavioral health workforce to practice collaboratively and in team settings with multiple levels of providers can foster integration while also making the core components (e.g., care coordination, colocation, screening and referral to treatment) the new norm for care delivery (Lewin Group and Institute for Healthcare Improvement 2012, Leigh et al. 2008).

## Conclusion

The integration of physical and behavioral health systems, services, and providers can play a role in improving health outcomes and reducing costs for a high-cost, high-need population. In addition, Medicaid enrollees with behavioral health conditions almost always have problems with their physical health. The behavioral and physical conditions can interact with and exacerbate each other, and they often lead to worse outcomes if not treated in a coordinated manner (MACPAC 2015a).

The increasing number of behavioral health integration efforts reflects movement in understanding how best to treat behavioral health conditions and prevent them from getting worse or contributing to a decline in physical health. Behavioral health integration within the Medicaid program is not defined by one model and can encompass clinical, financial, and administrative domains. However, the spectrum of integration models—plus research gaps, policy and practice barriers, and limited quality measures for behavioral health outcomes—makes it difficult for policymakers and program administrators to determine which model or hybrid would work best to improve health outcomes and reduce costs in a given setting.

The Commission plans to continue working in this area; for instance, exploring the integration of additional types of services like pharmacy, long-term services and supports, and services that affect the social determinants of health such as housing. Additionally, we intend to examine the Medicaid IMD exclusion and Medicaid's interaction with other systems that provide behavioral health services to the Medicaid population such as the criminal justice system. In doing so, we will continue to highlight the needs of individuals with behavioral health disorders and consider whether recommendations for Medicaid policy changes are warranted.

## Endnotes

<sup>1</sup> It is worth noting that the definition of included costs affects results. Most studies consider the costs of administering an integration initiative, such as provider and case manager salaries and benefits, overhead, record keeping, and program materials, in their calculations. However, it is often unclear if and how these studies incorporate start-up costs, such as program planning, recruitment, and training. Additionally, it is not clear if programs that receive start-up funds or a temporary enhanced federal match can sustain their efforts after that initial funding period is over.

<sup>2</sup> The state of Kansas did not report its Medicaid payment approaches for mental health services in the cited SAMHSA report. However, Kansas has since reported that it covers all behavioral health services through managed care (NRI et al. 2015, CMS 2014b).

<sup>3</sup> For purposes of this project, behavioral health disorders encompassed all mental health conditions. Programs in the planning and development stages or programs that had expired as of March 1, 2015, were excluded.

<sup>4</sup> For an overview of behavioral health and physical health integration efforts that are occurring at the clinical level across the country, see AHRQ's interactive integration map at [http://integrationacademy.ahrq.gov/ahrq\\_map](http://integrationacademy.ahrq.gov/ahrq_map) (AHRQ 2015).

<sup>5</sup> States receive eight fiscal quarters of 90 percent federal match for specific health home services. These services include: comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, linkage and referral to community and social support services, and use of health information technology (Spillman et al. 2014).

<sup>6</sup> Missouri has another health home, the Primary Care Health Home. This health home targets individuals with chronic conditions, and as a result was not included in the catalog.

<sup>7</sup> For dually eligible beneficiaries, Medicaid covers services that are not covered under Medicare, such as long-term services and supports. Certain dually eligible beneficiaries might also have their Medicare premiums and cost-sharing paid for by Medicaid (MACPAC 2015c).

<sup>8</sup> Diversionary behavioral health services can include, but are not limited to, community crisis stabilization, community support programs, transitional care units, structured outpatient addiction programs, and psychiatric day treatment (Massachusetts Executive Office of Health and Human Services 2016).

<sup>9</sup> Specialty mental health services not covered by Medicare include intensive day treatment, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, targeted case management, portions of inpatient psychiatric hospital services, and medication support services. Certain Medi-Cal drug benefits include levoalphacetylmethadol (LAAM) and methadone maintenance therapy, day care rehabilitation, outpatient individual and group counseling, perinatal residential services, and naltrexone treatment for narcotic dependence (MACPAC 2015b).

<sup>10</sup> In 2010, SAMHSA identified 30 states that paid for both a behavioral health visit and medical visit on the same day, 14 states that prohibited same-day billing for behavioral health and medical visits, and 3 states that allowed for same-day billing in fee for service, but not for federally qualified health centers. SAMHSA was unable to determine same-day billing policies for the remaining three states (SAMHSA 2010).

<sup>11</sup> HRSA developed the health professional shortage areas criteria to define and designate areas characterized by a shortage of primary medical, dental, or mental health providers (HRSA 2015b).

<sup>12</sup> Graduate medical education is the period of medical education that occurs after physicians graduate from medical or dental school.

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# APPENDIX 4A: Summary of Selected Medicaid Behavioral Health Integration Programs

TABLE 4A-1. Key Attributes and Target Populations for Selected Medicaid Behavioral Health Integration Programs

State	Program name	Start year	Area	Pilot?	Medicaid target population	Includes dually eligible beneficiaries?	Other groups included in target population?
<b>Managed care</b>							
AZ	Mercy Maricopa Integrated Care	2014	Select region	No	Adults with SMI only <sup>1</sup>	Yes	Medicaid only <sup>2</sup>
FL	Magellan Complete Care Serious Mental Illness Specialty Plan	2014	Selected regions	No	Children with SED only <sup>3</sup> Adults with SMI only	Yes	Medicaid only
MA	Massachusetts Behavioral Health Partnership	2012	Statewide	No	All children <sup>4</sup> All adults <sup>4</sup>	Yes	Medicaid only
MN	Preferred Integrated Network Program	2009	Selected regions	No	Children with SED only Adults with SMI only	Yes	Medicaid only
<b>Primary care case management/patient-centered medical home</b>							
NC	Community Care of North Carolina	2010 <sup>5</sup>	Statewide	No	All adults	Yes	Medicaid only
VT	Blueprint for Health	2006	Statewide	No	All children All adults	Yes	Private coverage <sup>6</sup> Medicare
<b>Health home program</b>							
IA	Integrated Health Homes	2013	Statewide	No	Children with SED only Adults with SMI only	Yes	Medicaid only
KS	KanCare Health Homes	2014	Statewide	No	Children with SED only Adults with SMI only	Yes	Medicaid only
ME	MaineCare Behavioral Health Homes Program	2014	Statewide	No	Children with SED only Adults with SMI only	Yes	Medicaid only
MD	Maryland Health Home Program	2013	Statewide	No	Children with SED only Adults with SMI <sup>7</sup>	Yes	Medicaid only
MO	Missouri Community Mental Health Center Healthcare Homes	2012	Statewide	No	Children with SED <sup>8</sup> Adults with SMI <sup>8</sup>	Yes	Medicaid only
NJ	New Jersey Behavioral Health Homes	2014	Select region	No	Children with SED only Adults with SMI only	Yes	Medicaid only
OH	Ohio Health Homes	2014	Selected regions	No	Children with SED only Adults with SMI only	Yes	Medicaid only

**TABLE 4A-1. (continued)**

State	Program name	Start year	Area	Pilot?	Medicaid target population	Includes dually eligible beneficiaries?	Other groups included in target population?
OK	Oklahoma Health Homes	2015	Statewide	No	Children with SED only Adults with SMI only	Yes	Medicaid only
RI	Community Mental Health Organization Health Homes <sup>9</sup>	2011	Statewide	No	Adults with SMI only	Yes	Medicaid only
WV	West Virginia Health Homes	2014	Selected regions	No	Other children <sup>10</sup> Other adults <sup>10</sup>	Yes	Medicaid only
<b>Accountable care organization</b>							
CO	Accountable Care Collaborative	2011	Statewide	No	All children All adults	Yes	Medicaid only
MN	Hennepin Health	2012	Select region	No	Other adults <sup>11</sup>	Yes	Medicaid only
MN	Integrated Health Partnerships Demonstration: Southern Prairie Community Care	2014	Selected regions	No	All children All adults	No	Medicaid only

**Notes:** SMI is serious mental illness (adults only). SED is serious emotional disturbance (children only).

<sup>1</sup> Medicaid-enrolled adults with SMI (including dually eligible beneficiaries) are the only individuals who receive integrated physical health and behavioral health benefits. Other Medicaid-covered adults and children with general behavioral health needs receive behavioral health services only.

<sup>2</sup> Mercy Maricopa provides limited behavioral health services for persons diagnosed with a serious mental illness who do not qualify for Arizona’s Medicaid program.

<sup>3</sup> Florida’s Magellan Complete Care Serious Mental Illness Specialty Plan covers children age six and older.

<sup>4</sup> Massachusetts’s Behavioral Health Partnership covers only individuals who are enrolled in the MassHealth Primary Care Clinician Plan.

<sup>5</sup> Community Care of North Carolina officially launched statewide in 2001, but behavioral health integration efforts began in 2010. However, the state has moved to end this program and plans to transition Medicaid beneficiaries into Medicaid managed care.

<sup>6</sup> Private coverage includes self-insured employer plans.

<sup>7</sup> Maryland’s Health Home program also includes adults with an opioid substance use disorder and those who are at risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use.

<sup>8</sup> Beneficiaries who are eligible for Missouri’s Community Mental Health Center Healthcare Homes must have SMI or SED, or another behavioral health problem combined with another chronic condition. Missouri has another health home program, Primary Care Health Home Initiative, which targets individuals with chronic conditions.

<sup>9</sup> Rhode Island has three approved health home programs. This table includes only the Community Mental Health Organization Health Home, which focuses on individuals with SMI. The other health home programs include: (1) the CEDARR Family Centers Health Home program, which focuses on children with SED who also have two chronic conditions, and (2) the Opioid Treatment Programs Health Home program, which focuses on opioid-dependent Medicaid beneficiaries.

<sup>10</sup> West Virginia’s Health Home program is open to Medicaid beneficiaries of any age with bipolar disorder who are at risk for or infected with hepatitis type B or C.

<sup>11</sup> Minnesota’s Hennepin Health covers Medicaid-eligible childless adults with incomes under 133 percent of the federal poverty level.

**Sources:** Bonner 2015, SHADAC 2015.

**TABLE 4A-2. Key Organizations, Payment Models, and Integration Components Involved in Selected Medicaid Behavioral Health Integration Programs**

State	Program name	Key organizations	Payment model	Direction of integration			Independent evaluation?
				PH into BH	BH into PH	Two-way integration	
<b>Comprehensive managed care</b>							
AZ	Mercy Maricopa Integrated Care	MCO	Shared risk	Yes	No	No	Yes
FL	Magellan Complete Care Serious Mental Illness Specialty Plan	BHO	Shared risk	No	No	Yes	Yes
MA	Massachusetts Behavioral Health Partnership	BHO	Shared risk	No	No	Yes	No
MN	Preferred Integrated Network Program	MCO County	Shared risk	Yes	No	No	Yes
<b>Primary care case management/patient-centered medical homes</b>							
NC	Community Care of North Carolina	Other lead entity PCPs	Enhanced payments	No	Yes	No	Yes
VT	Blueprint for Health	Other lead entity PCPs	Enhanced payments	No	Yes	No	No
<b>Health home programs</b>							
IA	Integrated Health Homes	BHO CMHCs FQHCs	Enhanced payments Incentives	Yes	No	No	Yes <sup>2</sup>
KS	KanCare Health Homes	MCOs CMHCs Counties FQHCs Other	Enhanced payments Incentives	No	No	Yes	Yes <sup>2</sup>
ME	MaineCare Behavioral Health Homes Program	CMHCs PCPs	Enhanced payments	Yes	No	No	Yes <sup>2</sup>
MD	Maryland Health Home Program	CBHCs	Enhanced payments	Yes	No	No	Yes <sup>2,3</sup>
MO	Missouri Community Mental Health Center Healthcare Homes	CMHCs	Enhanced payments	Yes	No	No	Yes <sup>2</sup>
NJ	New Jersey Behavioral Health Homes	CMHCs	Enhanced payments	Yes	No	No	Yes <sup>2</sup>
OH	Ohio Health Homes	CBHCs	Enhanced payments Incentives	Yes	No	No	Yes <sup>2</sup>
OK	Oklahoma Health Homes	CMHCs Other lead entity	Enhanced payments	Yes	No	No	Yes <sup>2</sup>

**TABLE 4A-2. (continued)**

State	Program name	Key organizations	Payment model	Direction of integration			Independent evaluation?
				PH into BH	BH into PH	Two-way integration	
RI	Community Mental Health Organization Health Homes	CMHCs	Enhanced payments	Yes	No	No	Yes <sup>2</sup>
WV	West Virginia Health Homes	CMHCs FQHCs Other lead entity	Enhanced payments	No	Yes	No	Yes <sup>2</sup>
<b>Accountable care organizations</b>							
CO	Accountable Care Collaborative	Other lead entity PCPs BHOs	Enhanced payments	No	Yes	No	No
MN	Hennepin Health	Hospital/provider system County FQHC	Shared risk	No	Yes	No	Yes
MN	Integrated Health Partnerships Demonstration: Southern Prairie Community Care	Other lead entity Hospital/provider system FQHCs PCPs CMHCs Counties	Shared savings	No	No	Yes	No

**Notes:** PH is physical health. BH is behavioral health. MCO is managed care organization. BHO is behavioral health organization. PCP is primary care practice. CMHC is community mental health center. FQHC is federally qualified health center. CBHC is community behavioral health center.

- <sup>1</sup> Based on publicly available resources, it is unclear whether Iowa Integrated Health Homes have physical health provider satellite offices within behavioral health homes.
- <sup>2</sup> The Urban Institute is under contract with the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, to conduct a five-year, independent evaluation of all Medicaid health home initiatives.
- <sup>3</sup> The State of Maryland is also conducting an evaluation of its health home program.
- <sup>4</sup> All New Jersey Behavioral Health Homes must be fully or partially colocated within three years of certification.
- <sup>5</sup> Colocation of physical and behavioral health providers varies by health home in Rhode Island. However, some health homes have noted colocated providers.
- <sup>6</sup> Colocation of physical and behavioral health providers participating in Colorado's Accountable Care Collaborative may exist in some cases, but colocation can be dependent on the five regional care collaborative organizations.

**Source:** SHADAC 2015.