

Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working With Managed Care Delivery Systems

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SUMMARY: A growing number of states are integrating physical and behavioral health services for beneficiaries dually eligible for Medicare and Medicaid. These beneficiaries not only have complex needs, but must also navigate between separate programs (Medicare and Medicaid) and care delivery systems (physical and behavioral health) for their services. This brief explores the experience of six states that have achieved varying levels of behavioral health and physical health integration or collaboration for dually eligible beneficiaries within a managed care environment. States are implementing their models of integration (e.g., comprehensive carve-in models, specialty plans for beneficiaries with serious mental illness, hybrid models, and coordinated carve-out models) through contracts with Medicare-Medicaid Plans or Medicaid managed care plans that are aligned with Medicare Advantage Dual Eligible Special Needs Plans.

Regardless of the model chosen, the essential components of integration or coordination are the same, including combining the cultures of behavioral and physical health, information sharing, designing care management and coordination, provider training, and program monitoring and quality improvement. States can encourage the development of these components irrespective of the integration model. Lessons from state experiences include:

- **States can drive integration by combining operational and oversight functions.** States can integrate at the state administrative level, blend payment at the health plan level, and set contract requirements that enhance connections between entities needed for care coordination.
- **State leadership is crucial to improve information sharing.** States can require information sharing agreements, build the “backbone” for information sharing through Health Information Exchanges, and fill information gaps.
- **State guidance on federal and state laws protecting behavioral health information can assist with information sharing.** State guidance would limit misinterpretation of laws, which impedes information sharing for care management.
- **States should seek to balance prescriptiveness with flexibility, particularly in the area of care management and coordination, when setting plan contract requirements.** States can provide guidance to health plans on developing essential elements of integration but give them the flexibility to innovate and build on existing relationships and infrastructure.
- **Misalignment of the recovery model of care in behavioral health systems and the medical model of care in physical health systems can be the most difficult challenge to overcome during integration at the state, health plan, and provider levels.** Strategies to address misalignment include: bringing in behavioral health leaders; consistently affirming an understanding that helping people with behavioral health conditions requires an emphasis on recovery in addition to treatment; training leadership and staff; allowing staff opportunities to learn from each other; developing shared vocabulary, aligning priorities, and identifying complementary strengths; and setting realistic timeframes for selected strategies.
- **States and health plans are building accountability for integrated care at the health plan and provider levels.** The full benefit of integration can only be achieved when health plans and providers are aware of both behavioral and physical health conditions and able to consider their interplay to provide care. The brief provides examples of incentive and value-based purchasing designs for building accountability.
- **The lack of performance measures for behavioral health is a significant limitation to program monitoring and quality improvement.** While federal and state policymakers, measure developers, and endorsers of measures continue to broaden the suite of behavioral health measures, states and plans could benefit by selecting measures that align with national efforts and by using national standards for measure development.
- **Realistic expectations can help state and health plans with self-evaluations.** The benefits of integration will take time to emerge. Health plan representatives recommended giving it a year, with early benefits showing up primarily in the form of process changes that reflect a greater focus on whole-person care, and anticipating initial increases in behavioral health expenditures while looking for decreases in overall health care spending over time.

I. Introduction

A growing number of states have sought to integrate physical and behavioral health services as a way to address the fragmented care historically received by Medicaid beneficiaries with behavioral health conditions.¹ In recent years, some states have extended integration efforts to beneficiaries dually eligible for Medicare and Medicaid, who not only have complex needs but must also navigate between separate programs (Medicare and Medicaid) and care delivery systems (physical and behavioral health) for their services. Dually eligible beneficiaries have high rates of behavioral health disorders and are more likely than other Medicare beneficiaries to have three or more chronic conditions (19 percent compared to 9 percent).² These comorbidities have a negative bi-directional effect on mental health and physical health. Untreated mental health conditions like depression can negatively affect health outcomes and increase costs of treating physical health conditions, and vice versa.³ The confluence of complex conditions, low levels of education, and lack of financial and social supports reported for dually eligible beneficiaries also magnify the challenge they experience navigating separate programs and delivery systems.^{4,5} The movement toward integration recognizes that coordination between the physical health and behavioral health delivery systems can improve quality and lower the cost of care for this population.

Multiple models of physical and behavioral health integration exist, including those within managed care and those built on health homes.⁶ Furthermore, integration occurs at multiple levels—at the state, plan, and provider levels. In this brief, we explore six states – Arizona, Massachusetts, Michigan, Pennsylvania, Tennessee, and Texas – that have achieved varying levels of behavioral and physical health integration and coordination for dually eligible beneficiaries within a managed care environment.⁷ We chose these states because they illustrate: (1) how managed care models can be adapted to a variety of state Medicaid physical and behavioral health delivery systems; and (2) how these models and systems can evolve over time to better meet state goals and beneficiary needs. Using information gathered through document reviews and interviews with state, health plan, and behavioral health organization (BHO)⁸ representatives, we provide an overview of their integration models as well as lessons learned on: (1) levers that states can use to drive integration at the state level; and (2) strategies states can use to encourage integrated care at the health plan and provider levels while providing flexibility for innovation (See Appendix A.1 *Methodology*). Throughout the brief, we define behavioral health to include both mental health conditions and substance use disorders.

II. Overview of State Models

The managed care models the six states are using all seek to coordinate physical and behavioral health services for dually eligible beneficiaries as fully as possible, given the history and delivery system context of each state.⁹ For beneficiaries who receive all their services from Medicaid, states can make a single Medicaid managed care organization (MCO) responsible for both physical and behavioral health services. For dually eligible beneficiaries with these comorbidities, some crucial services are provided by Medicare (e.g., inpatient psychiatric hospital, emergency room, physician, and prescription drug services), others by Medicaid (e.g., intensive case management, addiction treatment, crisis intervention, residential care), and others by state funds or federal block grants (e.g., crisis hotlines, prevention and recovery support services).^{10,11} This makes it more challenging to identify one entity that could be responsible for all necessary services. As a solution, a number of states have contracted with Medicare-Medicaid Plans (MMPs) through the Centers for Medicare & Medicaid Services' (CMS) Financial Alignment Initiative demonstrations or Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) that are aligned with Medicaid MCOs.¹²

Within the context of using managed care to integrate services, levels and models of integration vary as states work within the constraints of existing administrative and service structures and other historical and environmental factors. The table in Appendix A.2 describes the models used by the six states examined in this brief, the managed care plans that support the models, and examples of contract requirements that encourage integration and collaboration. In summary, the state models include the following:¹³

- **Comprehensive carve-in models** – as seen in Massachusetts, Tennessee, and Texas – incorporate all physical and behavioral health services, including those for mild-to-moderate and serious behavioral health conditions, under the management of one MCO. While the health plan bears the responsibility for

managing all services, it may rely on a subcontracted BHO to manage all or a subset of behavioral health services.

- **Specialty plans for beneficiaries with serious mental illness (SMI)** integrate physical and behavioral health services under one plan, but for a very specific high-need population that is carved out of general Medicaid. Arizona’s three Regional Behavioral Health Authorities (RBHAs), which provide all physical and behavioral health services for Medicaid beneficiaries diagnosed with SMI, are examples of this model.¹⁴
- **Hybrid models** carve in to the managed care benefit package mild-to-moderate behavioral health services for beneficiaries but carve out services for people with SMI to be separately managed by a BHO. Arizona’s Medicaid MCOs, in conjunction with a D-SNP, manage mild-to-moderate behavioral health services for dually eligible beneficiaries, and the state’s RBHAs manage behavioral health services for people with SMI. Hybrid models, such as Arizona’s, could rely on a specialty plan for people with SMI.
- **Coordinated carve-out models**, such as those in Michigan and Pennsylvania, retain separate plan management of physical and behavioral health services but rely on contract partnerships and incentives to encourage collaboration between plans and systems. For example, some of Michigan’s MMPs subcontract with BHOs to provide Medicare behavioral health services.

III. State Lessons on Integration

In integrating physical and behavioral health services for dually eligible beneficiaries, a state must consider the model of integration that is right for its circumstances, which are affected by environmental and historical factors as well as existing infrastructure. For example, while a comprehensive carve-in model may be desirable for simplicity, it may not be attainable in every state. This model is feasible for a state like Tennessee, where providers have a long history of Medicaid managed care in both physical and behavioral health systems. In contrast, states such as Michigan and Pennsylvania, which have strong county-based governance structures for behavioral health services in some counties, may choose to proceed more slowly and begin with a coordinated care model. Finally, states like Arizona that have already invested in products and infrastructure such as the RBHAs to integrate services may choose hybrid models in order to build off of existing systems.

Regardless of the model a state chooses, the essential components of integration or coordination are the same from the state perspective, including a blending of behavioral and physical health care delivery practices and perceptions (i.e., “cultures” of care delivery) to incorporate strategies that draw from a recovery model of care;¹⁵ information sharing; designated care management and coordination; provider training; and program monitoring and quality improvement. For example, whether in the context of a comprehensive carve-in or a coordinated carve-out arrangement, plans, subcontracted and partner organizations, and providers must share both physical and behavioral health information in a way that supports and encourages “whole-person” care. As expected, a fully carved-in model under one MCO can more readily develop foundational components of integration. Although possible, the same task will take longer for a coordinated carve-out model and require more effort because change must occur within multiple systems and entities.

States have various levers to encourage integration within Medicaid managed care, including setting plan contract expectations and requirements for developing the core components of integration. States must often consider how prescriptive and flexible the health plan contracts must be to maximize integration. On one hand, prescriptiveness can lead to unified standards and processes that may increase consumer protections for beneficiaries and decrease administrative burdens on providers and downstream BHO subcontractors. For example, state requirements for information sharing between Medicare and Medicaid health plans covering the same beneficiaries improves care coordination. On the other hand, too much prescriptiveness may hinder flexibility of health plans and BHOs to innovate and set up systems and structures that best align with beneficiary needs. For example, strict state requirements on the make-up of care management teams and the interactions of team members may not give health plans and providers the discretion to do what is best for the beneficiary. We describe below: (1) opportunities for explicit state action and requirements to push development of integration components; and (2) opportunities for states to signal the importance of integration elements while providing flexibility to allow plans to innovate.

A. Opportunities and Strategies for States to Drive Integration

States can actively drive integration of historically siloed cultures and systems of behavioral and physical health for dually eligible beneficiaries by: (1) integrating at the state level through administrative and payment changes; (2) developing the “backbone” for information sharing; (3) setting contract requirements that simplify and enhance connections between entities needed for care coordination for dually eligible beneficiaries; and (4) developing strategies for program monitoring and quality improvement.

1. Integrate at State Level through Administrative and Payment Changes

The push to integrate behavioral and physical health can begin at the state administrative and regulatory level. Many states are challenged in integration efforts because behavioral health is the responsibility of a state mental health and substance use agency (or agencies) or unit separate from the Medicaid agency. This can create misalignments in provider policies, administrative processes, and incentives for behavioral and physical health services.¹⁶ Some states, like Arizona, have chosen to consolidate the administration of behavioral health services under the Medicaid agency. Prior to the consolidation, as required in statute, the Arizona Health Care Cost Containment System (AHCCCS) contracted with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS). ADHS administered contracts with RBHAs, which provided all behavioral and physical health services for people with SMI as well as carved-out behavioral health services for most other acute populations. The 2016 consolidation of AHCCCS and ADHS brought together the contract oversight and the regulatory levers needed to encourage change at the plan level.¹⁷ However, administrative integration should be done in a way that recognizes the unique differences in the provision of behavioral and physical health care and uses strategies to blend them (see box *Arizona: Blending Cultures of Behavioral and Physical Health*).

Arizona: Blending Cultures of Behavioral and Physical Health

Misalignment of the recovery model of care in behavioral health systems and the medical model of care in physical health systems can be the most difficult challenge in integrating care at the state, health plan, and provider levels. The recovery model considers the totality of a person’s environment (e.g., whether they are involved with the corrections system or require housing assistance) and views care through the lens of recovery rather than treatment. The recovery model also emphasizes an individual’s role in care. Historically, the medical model of care views this same person as a recipient of covered services and does not consider how environmental factors affect their health and engagement in care. This model tends to be driven by treatment protocols and providers. Blending these two cultures so that the behavioral health and physical health staff at all levels can work in concert requires time and effort.

Arizona’s experience in incorporating the Division of Behavioral Health Services into AHCCCS offers strategies for other states in facilitating such cultural integration:

- **Bring into the organization behavioral health leaders** who understand the behavioral health community and are considered trusted advocates by that community. For example, AHCCCS hired a staff member from the Division of Behavioral Health Services who had lived experience and understood the importance of recovery to lead the Office of Individual and Family Affairs (OIFA). OIFA reaches out to community organizations and individuals with behavioral health needs and their families to incorporate their input in shaping future behavioral health service delivery systems.
- **Consistently and strongly communicate that “recovery matters” in discussions with the community and providers.** In Arizona, having that message come from AHCCCS leaders allayed early concerns from the behavioral health community about the administrative merger.
- **Train leaders and staff** on behavioral health core competencies and provide strategies for reducing stigma. All members of the executive team received awareness training, which AHCCCS continues to offer staff.
- **Allow staff opportunities to learn from each other** through co-locating behavioral and physical health staff and providing opportunities for staff to formally and informally interact. AHCCCS held “lunch and learn” meetings to provide opportunities for team members to talk about each other’s experiences.
- **Develop shared vocabulary, align priorities, and identify complementary strengths** for behavioral and physical health staff. In addition, explain the challenges of integration and offer resources to staff.
- **Set realistic timeframes** to account for various strategies because culture change takes time and requires continuous effort.

States can also drive integration through payment changes by putting the responsibility for both physical and behavioral health in the same Medicaid MCO (e.g., comprehensive carve-in) or adding contract incentives for greater collaboration between Medicaid MCOs and BHOs when historical or environmental factors make integration challenging (e.g., coordinated carve-out). As noted earlier, integrating physical and behavioral health services for dually eligible beneficiaries requires Medicaid linkages with Medicare services through aligned Medicare Advantage D-SNPs or in MMPs.

- **Comprehensive carve-in.** Tennessee and Texas incorporated behavioral health into their Medicaid managed care contracts for dually eligible beneficiaries and Medicaid-only beneficiaries. In Tennessee, Medicaid MCOs that are aligned with D-SNPs have responsibility for all behavioral health services for both populations. According to a Tennessee health plan representative, the state’s action “created a culture of integration.” In Texas, the state contracts with MMPs to manage both physical and behavioral health services for dually eligible beneficiaries. In addition, Texas requires all Medicaid managed care plans to incorporate behavioral health services into their benefit package for Medicaid-only beneficiaries.
- **Coordinated carve-out.** In Pennsylvania and Michigan, state Medicaid contract requirements drove BHOs and Medicaid health plans to improve coordination. Pennsylvania’s 2016 Medicaid contracts require MCOs and BHOs to create shared care plans and set up a pay-for-performance structure to incentivize sharing information on admissions and joint care planning for high-need beneficiaries (see Appendix A.3 *Pennsylvania: Pay-for-Performance in Medicaid MCO contracts*). According to a BHO representative, this led to participation of all Medicaid plans in coordinated care and a significant increase in their level of engagement with the BHO about shared beneficiaries.¹⁸ In Michigan, the state required that MMPs subcontract with the BHOs in their region to manage Medicare behavioral health services for dually eligible beneficiaries and assist with overall care coordination.

2. Develop “Backbone” for Information Sharing

The exchange of participant-level data is the foundation of any effort to integrate or coordinate care. The more entities that are involved in an integrated or coordinated model, the more complicated sharing necessary information becomes. For dually eligible beneficiaries who receive both Medicare and Medicaid services for behavioral and physical health conditions, multiple areas of potential misalignment (behavioral health and physical health misalignment, Medicare and Medicaid misalignment) become barriers to information exchange. States can help facilitate information sharing by:

- **Urging greater information sharing between the organizations managing services for dually eligible beneficiaries.** Health plan representatives said that state leadership is crucial to movement in information sharing. To address the data exchange challenges arising when the D-SNPs and Medicaid MCOs serving the same dually eligible beneficiaries were not within the same parent company, Tennessee strengthened requirements for coordination under the state’s Medicare Improvements for Patients and Providers Act (MIPPA) contracts with D-SNPs. All D-SNPs are required to send daily Medicare hospital admissions data and discharge reports, including observation stays, to Medicaid MCOs that cover outpatient follow-up services for the same beneficiaries but are under different parent companies.¹⁹ Similarly, in Michigan, data sharing between behavioral health and physical health plans was limited until the state required it in its contracts with MMPs operating in Michigan’s Financial Alignment Initiative demonstration.
- **Increasing their understanding of privacy protections for behavioral health information and providing guidance to health plans.** State staff can increase their understanding of and provide more guidance on federal and state laws protecting behavioral health information to promote information sharing. Plans noted that behavioral health providers may be reluctant to share any information with health plans for care management because they mistakenly believed it to be prohibited under the Health Insurance Portability and Accountability Act (HIPAA). In addition, health plan and state representatives noted that substance use information that is protected under federal confidentiality rules (42 C.F.R Part 2) requires additional processes, such as obtaining consent to share. Furthermore, state restrictions and protections on behavioral health information vary and may be more strict and complex than federal protections.²⁰ Thus, state understanding of federal and state regulations and development of clearer guidance to health plans on

the data that can be shared and the types of service providers that can receive information would help support greater information sharing.²¹

Massachusetts formed a workgroup that included MMPs, representatives of the advocacy community, and state representatives to develop resource materials that provided principles and best practices for sharing behavioral health information (see Appendix A.4 *Massachusetts: Principles and Best Practices for Sharing Behavioral Health Information*). The development process, which took over a year, required considerable compromise to balance the community's concern that too much information leads to stigma and can hinder care with the health plans' position that more information would improve care coordination. As one Arizona health plan noted, "fallacies are developed through not having direct policies," and state guidance would limit misinterpretations that occur from people devising their own interpretations of laws. A recent Anthem Public Policy Institute paper on strategies to promote effective information sharing outlines some common misconceptions about protections for behavioral health data.^{22,23} Finally, state agencies that administer physical and behavioral health programs should be sure they have a clear understanding of the state's privacy laws so they can avoid inadvertently impeding changes made at the federal level to assist with sharing behavioral health information.²⁴ Publicizing an examination of the state's privacy laws that are relevant to the exchange of behavioral health information, such as the 2016 report completed on Massachusetts' laws, would provide clarity.²⁵

- **Promoting use of standard forms and processes to simplify data sharing.** Michigan developed a template for a universal consent form and encouraged its use by all MMPs.²⁶ The intention was to simplify the process for providers and care managers to acquire consent from beneficiaries. Michigan also created a template data transfer packet to share information between MMPs and BHOs.²⁷ Similarly, in partnership with stakeholders, Arizona created a standard data transfer packet to facilitate sharing of information during beneficiary transitions from Medicaid MCOs to RBHAs after SMI diagnosis.²⁸
- **Supporting and supplementing data sharing through statewide health information exchange (HIE) efforts and "gap filling" strategies.** Both Michigan and Arizona are developing statewide HIEs as the foundation for multi-payer and multi-provider information sharing. Arizona merged two initially separate efforts underway for behavioral health and physical health HIEs to develop a single statewide resource that has common goals and uses one platform.²⁹ The state requires participation of all Medicaid MCOs in the HIE, and participation includes an increasing number of behavioral health providers.³⁰ In addition to developing the HIE, Arizona provides Medicare claims information to Medicaid MCOs for dually eligible members whose Medicare and Medicaid plans are not aligned or who receive Medicare through fee-for-service. The state receives Medicare information from CMS and requires D-SNPs to submit all encounter data, which it then shares with health plans. This "gap filling data," which includes Part D pharmacy data, allows plans to see the services their members are receiving from other health plans or from fee-for-service Medicare providers. In Michigan, MMPs will, in theory, share Part D prescription data with partnering BHOs through an Integrated Care Bridge record that is built on the state HIE. The infrastructure and process of data sharing is still under development, so while the state has made progress in sharing historical Part D data, it is still working toward the goal of sharing current encounter data. In addition, the extent to which this process works in practice varies by BHO and their information technology capabilities (e.g., capacity to receive and analyze Medicare data).

3. Use Contract Requirements to Encourage and Enhance Connections Needed for Care Coordination

Whole person care for dually eligible beneficiaries with behavioral health conditions involves a complex mix of medical, behavioral health, and non-medical supportive services (e.g., housing assistance and transportation) covered across Medicare and Medicaid. To encourage coordination across this continuum of care, states can use contract requirements for:

- **Pushing alignment between Medicaid and Medicare plans.** Some states mandate that Medicaid MCOs offer D-SNPs in the same regions in which they operate to encourage alignment of Medicare and Medicaid plans that cover dually eligible beneficiaries. In Tennessee and Arizona, this alignment supports better coordination of services during critical transitions from Medicare-covered inpatient hospitalizations for

behavioral health conditions to Medicaid-covered outpatient care following hospitalization. Because dually eligible beneficiaries must be given a choice for Medicare services but can be assigned to a Medicaid plan, Arizona also performs a periodic realignment for beneficiaries. The state considers the Medicare plan to be the primary plan and shifts beneficiaries to an aligned Medicaid plan while allowing the member to opt out of this reassignment.³¹

- **Requiring that plans subcontract with community BHOs or include specific public behavioral health providers in their networks.** States seeking to build explicit connections between Medicaid health plans and the local behavioral health system (using comprehensive carve-in models, or coordinated carve-out models) have required plan subcontracts with BHOs to manage services or contracts with community behavioral health centers to provide services such as targeted case management and mental health rehabilitation services. According to BHOs and some state representatives, local organizations understand the behavioral health needs of the community and have existing relationships with public behavioral health systems and services that are critical to supporting people with behavioral health conditions. Michigan’s contracts with MMPs require plans to subcontract with county BHOs that function as Medicaid prepaid inpatient health plans (PIHPs) in the state to manage Medicare behavioral health services. Texas mandated that its Medicaid MCOs maintain a qualified network of entities, including BHOs such as Local Mental Health Authorities (LMHAs) and others. According to a Texas state representative, the contracts were critical because “[these entities] had so much historical use of these services and they developed the model with our sister agency, the Department of Mental Health. They have economies of scale, and the models are set up to include other services, like crisis intervention.”
- **Creating bridges between health coverage and the social service and corrections systems.** The recovery model of care that underpins behavioral health care recognizes that a person’s environment affects health. States can actively develop connections that incorporate information on social determinants of health into information used to coordinate care. Arizona Medicaid recently implemented a program in partnership with the Arizona Department of Corrections that suspends, rather than terminates, Medicaid coverage upon incarceration. Previously, beneficiaries lost coverage during incarceration and needed to reapply upon discharge, which created gaps in coverage and breaks in continuity of care. With the new program, the corrections system electronically notifies Medicaid MCOs and RBHAs of coverage suspension as well as discharge dates. MCOs are required to work with RBHAs to provide “reach-in” care coordination to connect incarcerated beneficiaries with case managers and schedule primary care and behavioral health care appointments as needed upon discharge.³²

4. Develop Strategies for Program Monitoring and Quality Improvement

The field of behavioral health quality measurement is young and still evolving.³³ States monitoring and assessing integration efforts have a limited number of performance measures for behavioral health at their disposal and “fewer proven strategies for implementing the measures that do exist to improve quality and outcomes.”³⁴ As a result, many states and plans rely on measures from the Healthcare Effectiveness Data and Information Set (HEDIS) (e.g., follow-up within 7 or 30 days after hospitalization for mental illness, follow-up after emergency department visit for substance use disorders, screening for diabetes for people with schizophrenia or bipolar disorder who are using antipsychotic medications) to monitor and assess their programs. However, HEDIS measures do not always work well for high-need, high-cost beneficiaries with complex clinical profiles and underlying social needs. Current HEDIS measures, which are essentially traditional clinical outcomes, assess performance by “the extent to which providers comply with recommended guidelines.”³⁵ This may not adequately incorporate the concept of recovery, which emphasizes the role of the individual in improving health and wellness. States also have few non-medical measures of social determinants of health (e.g., increase in stable housing status from date of first service to date of last service), which are important for managing health care for complex beneficiaries.³⁶

Federal and state policymakers, measure developers, and endorsers of measures continue to broaden the suite of behavioral health outcome measures, as well as add structural and process measures of integration (e.g., measures of an individual’s access to effective mental health care in primary care settings and access to preventive and primary care services in behavioral health settings). In the meantime, states and plans could benefit from aligning their work with national efforts on behavioral health measurement and using data to inform integration in the following ways:

- **Select measures that align with larger, national efforts** to develop and test measures for behavioral health.³⁷ For example, some measures vetted for specific care settings may need to be tested in other care settings, or new measures may need to be developed to fill measurement gaps (e.g., for social determinants of health). Resources that can inform measure selection and are linked to national efforts include: (1) quality measures used by the newly authorized Certified Community Behavioral Health Clinics, which have the aim of integrating physical and behavioral health; (2) the National Behavioral Health Quality Framework; (3) the CMS inventory of measures that includes those for behavioral health and substance use; and (4) Medicaid and CHIPRA adult and child core sets, which include behavioral health.³⁸
- **Use national standards for measure development** as they develop their own measures. States and plans may want to assess and adopt the National Quality Forum’s five criteria for measure development: (1) Importance to Measure and Report; (2) Scientific Acceptability of Measure Properties; (3) Feasibility; (4) Usability and Use; and (5) Related and Competing Measures.³⁹ Using national standards for measure development will help states and plans follow a system for developing high-quality measures and increase the likelihood that the measures they choose will facilitate cross-state and national comparisons.
- **Stratify data gathered from existing measures (e.g., for general medical conditions) by high-need populations** (e.g., individuals with comorbid conditions such as SMI and diabetes) that would benefit from integrated care. This would allow states to identify disparities among subpopulations and assess changes related to integration activities. In addition, using existing data would reduce burden on providers to report on additional measures.

Once performance measures are selected, states need to ensure that operational processes are in place and that staff members have the capacity to support data collection on performance, service utilization, cost, and quality from health plans, as well as auditing and review of the collected data. Finally, states need to ensure that there is ongoing communication between the state and health plan staff. States like Arizona and Tennessee have found that program monitoring and improvement are best done through ongoing communication and collaboration, based on regular reports from health plans to the state.⁴⁰

B. Opportunities for States to Allow Health Plan Flexibility for Innovation

Integrating behavioral and physical health requires work at the health plan level as well as at the provider level. Within the context of established requirements that are fundamental to an integrated system, states may provide health plans with the flexibility to innovate and build on existing infrastructure. For example, states could require plans to describe their approach to addressing integration issues in their responses to state requests for proposals (RFPs), rather than detailing those approaches in advance in state RFPs or contracts. Additionally, states could work with plans over time to jointly develop effective integration practices and provide opportunities for health plans to learn from each other (e.g., using learning collaboratives). Flexibility may be warranted in terms of how health plans: (1) operationalize integration; (2) share information; (3) form and operate care management teams; (4) train and work with behavioral health providers who may not be familiar with Medicare billing or managed care processes; (5) integrate care at the provider level; and (6) monitor the program and ensure continuous quality improvement.

1. Operationalization of Integration within Health Plans

Many of the state-level strategies for operationally integrating behavioral and physical health also apply to integration at the health plan level:

- Ensure internal behavioral health leadership;
- Consistently affirm an understanding that helping people with behavioral health conditions requires an emphasis on recovery in addition to treatment;
- Train leadership and staff;
- Allow staff opportunities to learn from each other;
- Set realistic timeframes to account for selected strategies; and

- Develop shared vocabulary, align priorities, and identify complementary strengths.

States can share these lessons and allow plans the flexibility to apply them within the context of their own infrastructure and history with integration.

For example, Michigan requires MMPs and partnering BHOs to establish care team meetings to discuss shared enrollees, but health plans have the flexibility to structure these meetings as needed. One health plan found that joining existing team meetings at the BHO worked best. The meetings allow staff from both organizations to develop an understanding of the importance of integration and an appreciation of the strengths of the behavioral health recovery model of care. According to a BHO representative, some Medicaid MCOs adapted their care management activities to embrace recovery concepts, such as meeting with beneficiaries in their own homes and sending care team members to locate beneficiaries who might otherwise be lost to care. Learning has occurred in both directions as BHO care management staff have learned about other chronic conditions as well. However, the level of collaboration occurring between health plans and BHOs through team meetings varies across subcontracts and depends on factors such as prior health plan and BHO relationships and readiness of both parties to collaborate (e.g., availability of trained staff, buy-in of leadership).

2. Information Sharing

Effective health information sharing requires an assessment of gaps in information that are important for coordinating care for beneficiaries with behavioral health conditions and an assessment of IT infrastructure. States can encourage, and perhaps consider requiring through contract solicitations, health plans to conduct these assessments early in the planning process, both internally and for subcontracted organizations.

- **Assessment of information gaps for dually eligible beneficiaries.** In situations in which some behavioral health services are carved-out of an MCO (e.g., inpatient services for behavioral health or services for SMI), health plans must assess the critical pieces of information that must be shared and the gaps in this information, and determine ways to fill those gaps. For dually eligible individuals with behavioral health conditions, gaps in information may occur when a beneficiary’s Medicare and Medicaid coverage for services either transitions from one payer to the other or overlaps. For example, information gaps may occur during transitions from hospitalization to outpatient care and with use of psychiatric drugs covered through Medicare Part D that Medicaid behavioral health providers may not be aware of (see state opportunities for addressing this challenge through “gap filling” strategies in Section III.A.2). In Michigan, an MMP and partnering BHO noted that the lack of timely exchange of information on hospital admissions and discharges challenged coordination of follow-up care.
- **Assessment of IT capabilities of subcontracted BHOs.** Health plans that are partnering or subcontracting with BHOs need to assess the IT infrastructure and capabilities of BHOs early in the planning process. Many behavioral health providers were ineligible to participate in the Medicare and Medicaid Electronic Health Record Incentive Programs that funded technology and infrastructure development, and the behavioral health system lags the medical system in IT infrastructure and capabilities.⁴¹ A Michigan health plan representative recommended that readiness assessment of IT capabilities for BHO partners should occur as early in the process as possible before program launch to allow time to build infrastructure and capabilities.
- **Identify and implement principles and best practices for sharing behavioral health information.** Health plans working on integration, particularly those that have not covered behavioral health services in the past, would benefit from having a standard guide on principles and practices for sharing behavioral health information. One Massachusetts MMP implemented the principles and best practices developed by a workgroup of health plans, community advocates, and state representatives by: (1) updating and aligning confidentiality agreements and consent forms so that beneficiaries understood that communication between the health plan and providers would occur; (2) communicating with and reminding providers about confidentiality and the need to get consent to speak with behavioral health providers; and (3) educating and training staff and providers to reduce stigma associated with behavioral health conditions. According to a health plan representative, the balance of protecting confidentiality while sharing the information needed to integrate care delivery is difficult to achieve and remains a work in progress.

3. Care Management Teams and Care Coordination Activities

The care team at the plan level, supported and facilitated by a working process for information sharing, is a critical piece of the “engine” that runs integrated care. According to several BHO representatives, the care management model for people with behavioral health needs must be flexible enough to allow plans and providers to do what is best for beneficiaries and to innovate using existing relationships. Representatives of a national BHO and a national health plan with experience integrating behavioral health said that the complexity of the beneficiary population with behavioral health needs may require a myriad of care team compositions and interactions. States may be inclined toward prescriptiveness to ensure uniformity in models of care management and coordination, verify appropriate competencies and licensing for care team members, and track that beneficiary ratios allow for substantive care coordination to occur. However, health plan representatives said that when states are overly prescriptive about the makeup of the care team (e.g., requirements that the team include a certain number of members with specific expertise), health plans and providers could be pushed to focus more on meeting set requirements than doing what makes the most sense for the beneficiary. The balance between the two needs may be achieved over time if states and health plans continue to communicate and learn from each other.

When given the opportunity to determine the best roles for care team members and to develop appropriate care coordination activities, health plans have found ways to build on the unique strengths of behavioral health staff (i.e., their care management skills, relationships with beneficiaries, and understanding of the social determinants of health) and the recovery model of care to improve care coordination. These strategies include:

- **Conducting joint visits that include both medical and behavioral health professionals for high-risk cases.** Michigan and Texas health plans found joint visits that include both medical and behavioral health professionals to be beneficial for members with behavioral health issues that are beyond the comfort level of the medical case managers. Health plan representatives from both states described these visits occurring in hospitals as part of their process for care transitions.
- **Enlisting behavioral health professionals in obtaining patient consent and locating beneficiaries lost to care.** The relationships behavioral health staff often have with beneficiaries can ease difficult interactions, such as ones that involve requesting consent to share behavioral health information, and can facilitate finding beneficiaries using connection with systems related to social determinants of health (e.g., housing and corrections systems). Both Michigan and Texas health plans used these strategies.
- **Assisting with transitions of care.** Beneficiaries with behavioral health conditions are particularly vulnerable during periods of transition when their care is “handed-off” from one delivery system to another (e.g., health plan changes resulting from changes in SMI designation) or from one delivery setting to another (e.g., transition from hospital setting to outpatient setting). Staff with behavioral health training can be critical during these transitions. A Texas health plan hired licensed professional counselors (LPCs), who are masters-level professionals, to serve as transition-of-care coaches for people transitioning out of a hospital setting. A health plan representative said that the behavioral health training and preparation received by LPCs was more suited to the transition-of-care position, which had in the past been filled by medically trained nurses who at times were not comfortable with managing people with behavioral health conditions. These transition-of-care coaches oversee a four- to six-week transition from hospitalization back into the community. During that period, the coach meets the individual prior to discharge, manages medication adherence, connects hospitalized beneficiaries with community mental health providers, and ensures beneficiaries keep appointments. According to a health plan representative, the switch to hiring LPCs as transition-of-care coaches did not present significant

Flexibility Needed for Care Team Compositions and Interactions

“We are training our staff to understand what are the critical pieces of information at any one time, and...what relationships do we have to have [to get that information]. Often those answers vary within a single population. Some have to do with relationships with caregivers, some have to do with relationships with hospitals, or other level of facilities, or community based workers. We have to use all [available] resources to support patients.”

—Chief Medical Officer of a national health plan with expertise in behavioral health integration

staffing challenges. While it may have taken longer to hire staff fully licensed as LPCs, as opposed to LPC interns that did not yet meet the full state requirement, the health plan was able to fill these positions.

- **Connecting with systems that address social determinants of health.** Understanding the importance of social determinants of health is integral to the behavioral health recovery model of care. That understanding can lead to connections with systems addressing those needs. An Arizona health plan integrated an assessment of social determinants of health into case management software so that case managers can address issues of homelessness and safety. In addition, the plan is working on connecting to a “human services campus” – a campus for the homeless that provides shelter and supportive services such as employment services – to allow the campus to notify them of people coming through the system in order to identify beneficiaries and coordinate their care.⁴² A health plan staff member is also physically located at the campus to help coordinate services for individuals and connect them to the right Medicaid-covered services.

4. Training and Working with Behavioral Health Providers

States looking to advance integration for dually eligible beneficiaries in environments where behavioral health is still largely carved out, and where BHOs and behavioral health providers have mainly operated within state contracts and grants or fee-for-service systems (FFS), should be aware of the time and support needed for BHOs and providers to acquire knowledge of Medicare and Medicaid managed care and to set up needed infrastructure.

- **States can encourage Medicare education.** In efforts to integrate physical and behavioral health for dually eligible beneficiaries, health plans have noted the need to provide Medicare training and time for BHOs and providers to learn about Medicare claims, rules, and medical necessity criteria.⁴³ This increased understanding of Medicare billing can lead to cost savings for the state from more effective coordination of benefits between Medicare and Medicaid (see box *Michigan and Arizona: States Benefit as BHOs and Providers Develop an Understanding of Medicare Billing*).
- **States can encourage managed care education and flexibility for providers to adapt to new functions.** Health plans have noted the need to educate behavioral health providers on managed care functions, since some providers may have operated in the past primarily with grant funding and Medicaid FFS payment for a limited set of services. Behavioral health providers may need time and flexibility to become proficient with managed care prior authorization and billing requirements and adjust to capitated payment systems. In an effort to ease the transition for behavioral health providers, Texas health plans waived pre-authorizations for targeted case management and rehabilitation services newly carved into the comprehensive carve-in model. For their first year of integration for dually eligible beneficiaries, some Arizona health plans chose to do something similar for transportation services offered by behavioral health providers. The state of New York (not specifically examined in this brief) developed a training, consultation, and educational resource center to assist all behavioral health providers in the transition to Medicaid managed care.⁴⁴

Arizona and Michigan: States Benefit as BHOs and Providers Develop an Understanding of Medicare Billing

An increased understanding of Medicare billing can lead to cost savings for the state resulting from more effective coordination of benefits between Medicare and Medicaid.

- In Arizona, a state representative noted that improved coordination of benefits for Part D behavioral health prescription medications in one RBHA resulted in a savings of \$5 million in state-only grant funds.
- A Michigan BHO representative noted that the process of learning about Medicare billing helped the behavioral health provider community bill Medicare for appropriate services for which they had not been in the practice of billing before.

5. Integration at the Provider Level

The full benefit of integration can only be realized when it is occurring at the practice level, with providers aware of both behavioral and physical health conditions and able to consider their interplay to appropriately provide care. States can encourage health plans to adopt strategies to drive provider accountability for integrated care.⁴⁵ Several plans noted that asking providers to become knowledgeable in a new area, particularly a complex area like behavioral health, requires incentives. Health plans in Tennessee and Arizona have developed incentive programs and value-based payment models to encourage primary care and behavioral health providers to address both physical and behavioral health needs (see box *Tennessee: Incentive Program to Encourage Provider Accountability for Integrated Care*). An Arizona health plan implemented a value-based contract with organizations providing Assertive Community Treatment⁴⁶ for high-risk beneficiaries with SMI; the contract includes performance measures for medical care (e.g., to track reductions in utilization of emergency department) and social factors (e.g., employment). The health plan is also rolling out contracts with “whole health clinics” that include incentive payments that require meeting minimum requirements for both behavioral and physical health measures to receive bonus payments.

Tennessee: Incentive Program to Encourage Provider Accountability for Integrated Care

One Tennessee health plan has a provider incentive program called a “gap-in-care closure program.” The program pays a bonus to a provider if a member has a gap in care, such as a missing immunization or preventative screening, and the provider is able to close that gap. The provider receives a \$10 to \$15 bonus per patient if they can close the gap. Providers, including community mental health centers, receive a monthly list of their beneficiaries with gaps in care. Specific to behavioral health, a primary care physician may be notified about a gap in regular behavioral health follow-up visits after an admission to an inpatient psychiatric facility or a gap in refills of behavioral health medications.

6. Health Plan Monitoring and Quality Improvement

The task of integrating behavioral health services takes time to accomplish, and many of the programs we examined have not reached a point in their implementation and data analysis to show measured improvements in outcome measures. To track quality improvements, health plans need to build their own internal staff capacity to monitor, report, and evaluate their data to ensure integration efforts are progressing as intended and are operating in cost-effective ways.

Health plan representatives from various states provided lessons from their experience with monitoring and assessing integration efforts:

- **Give it at least a year.** The work needed to accomplish organizational integration, develop or adapt information systems and processes, adapt care management teams and activities, and build and train a behavioral health network takes at least a year, according to some health plan representatives. “It takes about a year to do it well, don’t rush it,” advised an executive from a Tennessee health plan. Conceivably, a model that requires changes to occur across two systems, such as the financial alignment demonstration model that integrates Medicare and Medicaid in Michigan, could take longer.
- **Early benefits will be changes in philosophy, which may be seen in process measures that capture increases in administrative efficiency, use of appropriate care settings and care coordination.** When assessing progress, the early benefits of integration may show up primarily in the form of changes in philosophy – a greater focus on whole-person care – that can reduce the back and forth about who is responsible for different aspects of a person’s care. Thus, increases in administrative efficiency, use of appropriate care settings and care coordination may be early benefits. In return, appropriate primary care and behavioral health services may actually increase, but emergency department visits and hospital admissions and readmissions should decrease over time. But before changes to expenditures occur, a health plan may see some improvements in process measures, such as those for care coordination. For example, a Michigan BHO representative said that before its partnership with Michigan MMPs, about 60 percent of their shared members had not received a health risk assessment because the health plan could not reach them.

Anecdotally, the partnership has improved the MMP’s ability to perform these assessments. An Arizona health plan’s new contract for “whole health clinics” includes an incentive program to encourage clinics to focus on both the physical and behavioral aspects of the beneficiary’s needs. Most of these clinics were behavioral health providers for many years and had not been fully involved in addressing physical health needs. After an inpatient hospitalization, in order for these clinics to receive the incentive payment, follow-up care for both physical and behavioral health conditions must be provided.

- **Look for increases in behavioral health service utilization but potential decreases in overall cost of care.** Several health plan representatives noted that improvements in integration may actually increase behavioral health care utilization and costs as unmet needs are addressed. One Tennessee health plan representative noted that as beneficiaries receive needed services in more appropriate settings (e.g., shifting from inpatient to outpatient care settings), measures such as hospital admissions per 1000 people and length of stay for inpatient admissions should decrease. “Don’t create the illusion that behavioral health spend is going to go down because it probably needs to go up; look at it within the context of the overall spend... which I would like to see go down [as unnecessary medical expenses decrease],” he said. One Arizona plan, which had switched from a carve-out to a carve-in model for behavioral health services for non-SMI dually eligible beneficiaries, noted no initial change in utilization of behavioral health services (e.g., medications) after integration into the Medicaid MCO benefit. This indicated that access to needed services, previously carved-out and provided by a RBHA, did not diminish. The health plan expects to see an increase in services for unmet need next and then hopefully decreases in overall spending as unnecessary medical services decrease.⁴⁷

IV. Conclusion

States have developed different approaches to using managed care to integrate physical and behavioral health services for dually eligible beneficiaries. Models range from comprehensively carving all behavioral health services into one managed care contract to using contract requirements and incentives to encourage coordination between separately held physical and behavioral health contracts. This variation reflects the constraints under which states operate, including existing administrative and service structures and other historical and environmental factors. While a comprehensive carve-in model may be desirable for simplicity, it may not be feasible given pre-existing state circumstances.

Regardless of the model a state chooses, the following are essential components of integration or coordination: (1) a combined culture of behavioral and physical health that focuses on whole-person care; (2) information sharing; (3) designated care management and coordination processes; (4) provider capacity building and training; (5) provider- level integration; and (6) program monitoring and quality improvement. States can drive and encourage the development of these components irrespective of the model of integration. The strategies highlighted in this brief provide options for states, at varying levels of readiness, that are considering ways to integrate physical and behavioral health for dually eligible beneficiaries.

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ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the ***Integrated Care Resource Center*** are coordinated by [Mathematica Policy Research](#) and the [Center for Health Care Strategies](#). For more information, visit www.integratedcareresourcecenter.com.

Appendix A1. Methods

From April through December 2016, ICRC conducted 15 semi-structured phone interviews with representatives from health plans, behavioral health organizations, and state Medicaid agencies. Notes from each call were recorded and coded for themes. ICRC interviewed local representatives from health plans in each of the six study states, as well as one corporate representative of a national health plan. The team also interviewed local representatives from three behavioral health organizations in three study states and one corporate representative of a national behavioral health organization. Finally, ICRC conducted four interviews with representatives from three state Medicaid agencies. In addition to information gathered through semi-structured interviews, ICRC also reviewed managed care contracts and Financial Alignment Initiative demonstration three-way contracts (where relevant) from the six study states for information on requirements for physical and behavioral health integration.

Appendix A2. State Programs and Models of Integrated Physical and Behavioral Health Care

State	Target Population	Responsible Health Plan	Medicaid Plan Contractors Required to Offer D-SNPs ^a	Medicaid Plan Contractors Required to Subcontract/Partner with BHO or Contract with Specific BH Providers	Physical and Behavioral Health Services Provided by Responsible Health Plans on a Capitated Basis
Comprehensive Carve-In Model					
Massachusetts	Dually eligible beneficiaries under 65	Medicare-Medicaid plans (MMPs)	N/A	No	<ul style="list-style-type: none"> All Medicare and Medicaid physical health services. Medicare and Medicaid behavioral health services, including addiction and substance use services. Targeted case management (TCM) and rehabilitation option services provided by the Department of Mental Health and the Department of Developmental Services are excluded from capitation but coordinated with MMPs.
	<p>Example requirements for BH coordination:</p> <ul style="list-style-type: none"> Integrated Care Team (ICT) for each enrollee includes primary care physician (PCP), BH clinician if indicated, care coordinator, long-term services and supports (LTSS) coordinator if indicated (can also include others). Inpatient and 24-hour diversionary behavioral health providers provide a discharge plan to ICT members following any behavioral health admission. <p>Example requirements for information sharing:</p> <ul style="list-style-type: none"> Health plan must leverage the statewide Health Information Exchange (HIE) where applicable to ensure effective linkages of clinical and management information among all providers. To the extent permitted by law, the health plan shall require all substance use disorder treatment providers to submit to the Department of Public Health (DPH), Bureau of Substance Abuse Services the data required by DPH. <p>Example requirements for staff or provider training:</p> <ul style="list-style-type: none"> Health plan shall provide education and training at least annually for all PCPs to familiarize PCPs with the use of mental health and substance use disorder screening tools, instruments, and procedures. Health plans shall educate members on their rights related to information sharing. 				
Tennessee	All Medicaid beneficiaries (including dually eligible beneficiaries)	Medicaid managed care plans (MCOs)	Yes	No	<ul style="list-style-type: none"> All Medicaid physical health services. All Medicaid behavioral health services, including addiction and substance use services. All services coordinated with Medicare coverage for dually eligible beneficiaries.
	<p>Example requirements for BH coordination:</p> <ul style="list-style-type: none"> MLTSS members, TennCare members who meet eligibility or medical necessity criteria for Tennessee Health Link, or TennCare members who meets medical necessity criteria for Systems of Support are assigned a care coordinator or support coordinator who has primary responsibility for coordination of all of the member's physical health, behavioral health, and long-term services and support needs. Resources and staff with specialized expertise, such as behavioral health, can supplement but not supplant the role of the care coordinator or support coordinator. Members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities will be provided with appropriate follow-up behavioral health services. <p>Example requirements for information sharing:</p> <ul style="list-style-type: none"> MCOs receive and are required to process standardized electronic information on daily inpatient admissions and census and discharge reports from each D-SNP operating in the regions served by the MCOs. If MCO uses different systems for physical health services, behavioral health, and/or long-term care services, the MCO will have the capability to integrate data from the different systems. <p>Example requirements for staff or provider training:</p> <ul style="list-style-type: none"> For MCO staff, training will be provided on coordination of physical and behavioral health needs that includes an introduction to the unique behavioral health challenges individuals with intellectual and developmental disabilities may face; understanding of behavior as communication; potential causes of behavior, including physiological or environmental factors; person-centered assessment and support planning for individuals with challenging behaviors, including positive behavior supports (e.g., supported employment); and behavioral health crisis prevention, intervention and stabilization services; and the role of the support coordinator. 				

State	Target Population	Responsible Health Plan	Medicaid Plan Contractors Required to Offer D-SNPs ^a	Medicaid Plan Contractors Required to Subcontract/Partner with BHO or Contract with Specific BH Providers	Physical and Behavioral Health Services Provided by Responsible Health Plans on a Capitated Basis
Texas	Dually eligible beneficiaries	MMPs	N/A	Yes, contract with local mental health authorities for targeted case management and rehabilitation services	<ul style="list-style-type: none"> All Medicare and Medicaid physical health services. All Medicare and Medicaid behavioral health services, including substance use services.
	<p>Example requirements for BH coordination:</p> <ul style="list-style-type: none"> MMPs will support a service coordination team for each member, led by a service coordinator, to ensure integration of medical, behavioral health, substance use treatment, LTSS, and social needs. <p>Example requirements for information sharing:</p> <ul style="list-style-type: none"> MMP's behavioral health service provider contracts must require the provider to make available behavioral health clinical assessment and outcomes data for quality management and network management purposes. <p>Example requirements for staff or provider training:</p> <ul style="list-style-type: none"> MMPs must establish ongoing PCP training on identification of and coordination of LTSS and behavioral health services 				
Texas ^b	All Medicaid managed care beneficiaries	Medicaid MCOs	Yes ^c	Yes, contract with Local Mental Health Authorities for targeted case management and rehabilitation services	<ul style="list-style-type: none"> All Medicaid physical health services. All Medicaid behavioral health services, including substance use services.
	<p>Example requirements for BH coordination:</p> <ul style="list-style-type: none"> Before discharge, network providers who provide inpatient psychiatric services must schedule outpatient follow-up or continuing treatment for the member. The outpatient treatment must occur within seven days from the date of discharge. Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments. 				
Specialty Plans for SMI Model					
Arizona ^d	Medicaid beneficiaries with SMI	Regional Behavioral Health Authorities (RBHAs)	Yes ^e	No	<ul style="list-style-type: none"> All Medicaid physical health services. All Medicaid behavioral health services, including substance use services. All services are coordinated with Medicare coverage for dually eligible beneficiaries.
	<p>Example requirements for BH coordination:</p> <ul style="list-style-type: none"> For individuals with SMI who are transitioning from a health plan to a RBHA, there shall be a 14-day transition period in order to ensure effective coordination of care. The health plan must provide relevant information regarding transitioning members to the receiving contractor using an Enrollment Transition Information form. This information must be shared no later than 10 business days after AHCCCS notification of transition. The RBHA must maintain protocols for members with chronic special health needs during the transition period to maintain continuity of care (for example, for timely transition of the member from the relinquishing PCP to the receiving PCP). To facilitate the transition of members transitioning out of jails and prisons into communities, AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration, rather than terminate coverage. Upon the member's release, the member's AHCCCS eligibility is un-suspended allowing for immediate care coordination activities. To support this initiative the RBHA is required to participate in criminal justice system "reach-in" care coordination efforts. <p>Example requirements for information sharing:</p> <ul style="list-style-type: none"> RBHA will partner with the justice system to communicate timely data necessary for coordination of care in conformance with all applicable administrative orders and HIPAA requirements that permit the sharing of written, verbal, and electronic information. On a recurring basis (no less than quarterly based on adjudication date) and for purposes of member care coordination, AHCCCS shall provide the RBHA an electronic file of claims and encounter data for members enrolled with the RBHA who, during the member's enrollment period, have received services from another contractor or through AHCCCS' fee for service system. 				

State	Target Population	Responsible Health Plan	Medicaid Plan Contractors Required to Offer D-SNPs ^a	Medicaid Plan Contractors Required to Subcontract/Partner with BHO or Contract with Specific BH Providers	Physical and Behavioral Health Services Provided by Responsible Health Plans on a Capitated Basis
Hybrid Model					
Arizona	Dually eligible beneficiaries without SMI who are 18 years of age and older	Medicaid MCOs	Yes	No	<ul style="list-style-type: none"> All Medicaid physical health services. All behavioral health services for people with mild to moderate disorders, including substance use services. All services coordinated with Medicare coverage for dually eligible beneficiaries.
	<p>Example requirements for BH coordination:</p> <ul style="list-style-type: none"> Same requirement regarding 14-day transition period to ensure effective coordination of care as for beneficiaries with SMI (see above). Same requirements as above regarding "reach-in" care coordination efforts for members transitioning out of jails and prisons into communities. <p>Example requirements for information sharing:</p> <ul style="list-style-type: none"> Health plans are expected to collaborate with AHCCCS and Arizona Health-e Connection and the state HIE to target efforts to specific areas in which HIT and HIE can bring significant change and progress, including those focused on behavioral health, partnerships for integrated care, justice system transitions, and care coordination. 				
Coordinated Carve-Out Model					
Michigan	Dually eligible beneficiaries 21 years and older	MMPs	N/A	Yes, contract or partner with county BHOs that function as prepaid inpatient health plans (PIHPs) for Medicaid behavioral health services	<ul style="list-style-type: none"> All Medicare and Medicaid physical health services. Only Medicare behavioral health services, but subcontract with BHOs that function as PIHPs to manage these services. All Medicaid BH services are managed by PIHPs in a separate capitated contract. MMPs and PIHPs coordinate services.
	<p>Example requirements for BH coordination:</p> <ul style="list-style-type: none"> Every beneficiary has an ICT to ensure the integration of the medical, behavioral health, psychosocial care, and LTSS. The ICT includes the enrollee, the MMP's care coordinator, the PIHPs' supports coordinators, and additional providers as needed. <p>Example requirements for information sharing:</p> <ul style="list-style-type: none"> Health plan is required to employ a care coordination platform, supported by web-based technology, that allows secure access to information and enables all enrollees and members of the ICT to use and (where appropriate) update information. The MMP will be required to share information across providers, and between MMPs through its care coordination platform. Care coordination platform includes an integrated care bridge record for each beneficiary, which includes current conditions, medications, and historical and current utilization information, among other things. The approved electronic care coordination platform will be compliant with HIPAA, and provide for the exchange of data in a standard format. <p>Example requirements for staff or provider training:</p> <ul style="list-style-type: none"> Health plan will provide PCP training on identification of the need for and coordination of LTSS and behavioral health services. 				
Pennsylvania	All Medicaid managed care beneficiaries	Medicaid MCOs	Yes, beginning in 2018 ^f	Yes, partner with BHOs	<ul style="list-style-type: none"> All Medicaid physical health services.⁹ No behavioral health services. All Medicaid BH services managed by BHOs.
	<p>Example requirements for BH coordination:</p> <ul style="list-style-type: none"> Medicaid MCOs and BHOs are required to develop and implement written agreements regarding interaction and coordination of services provided by beneficiaries. They are encouraged to develop uniform coordination agreements to promote consistency in the delivery and administration of services. Establishes Integrated Care Plan Program wherein MCOs and BHOs can receive payment for improvements in shared physical health and behavioral health measures (see Appendix A.3 <i>Pennsylvania: Pay-For-Performance in Medicaid MCO Contracts</i>). 				

^a D-SNPs would cover Medicare services for dually eligible beneficiaries. For MMP participating in the financial alignment demonstration, D-SNPs are not involved because the MMP has taken on responsibility for both Medicare and Medicaid services.

^b Texas operated one pilot program in North Texas that carved out behavioral health services to be managed by a BHO, NorthSTAR. The pilot ended in December 2016, with all Medicaid beneficiaries in that region now receiving behavioral health services through Medicaid MCOs. The move was intended to align that region with movement in the rest of the state to carve-in behavioral health services in MCOs.

- ^c Texas requires STAR+PLUS Medicaid managed LTSS (MLTSS) plans to offer a D-SNP in the counties in which they serve that are most populous. State options for combining contracts with D-SNPs and Medicaid managed care organizations are described in a November 2016 ICRC technical assistance tool at this link: http://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues__Options.pdf.
- ^d The table does not cover the Children’s Rehabilitative Services program in Arizona, which also integrates physical and behavioral health for enrollees.
- ^e When the first RBHA, Mercy Maricopa Integrated Care (MMIC), integrated physical and behavioral health services for people with SMI in 2014, AHCCCS required it to offer a D-SNP specifically for those enrollees. However, when the RBHA model expanded statewide in 2015, AHCCCS changed the requirement to allow RBHAs to use a companion D-SNP product that also served other members (i.e., general Medicaid enrollees).
- ^f Beginning in 2018, Pennsylvania’s new Medicaid MLTSS program, Community Health Choices (CHC), will require CHC MCOs to have companion D-SNPs in the regions and service areas they serve (Pennsylvania HealthChoices Agreement, 2016).
- ^g Medicaid long-term supports and services (LTSS) are currently not included in health plan capitated benefits, but will be included in the new Community Health Choices managed care program that is scheduled to begin in 2018.

SOURCES:

- AHCCCS Medical Policy Manual: Chapter 500. Effective July 7, 2016. Available at: <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/520.pdf>
- Arizona Acute Care Contract. Effective October 1, 2016. Available at: <https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/AcuteCare/AcuteCareAmendmentFinal100116.pdf>
- Arizona Regional Behavioral Health Authority Contract – Maricopa County. Effective October 1, 2016. Available at: <https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/TitleXIX2016MaricopaCountyAmendment2.pdf>
- Massachusetts Three-Way Contract for Capitated Model, Issued December 28, 2015. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MassachusettsContract.pdf>
- Michigan Three-Way Contract. Effective November 1, 2016. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MichiganThreeWayContractUpdate112016.pdf>
- Open Minds. “State Medicaid Behavioral Health Carve-Outs: The OPEN MINDS 2017 Annual Update.” Open Minds, January 2017.
- Pennsylvania HealthChoices Agreement, Effective January 1, 2016. Available at: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_040149.pdf
- Tennessee MCO Statewide Contract, January 1, 2017. Available at: <https://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf>
- Texas Uniform Managed Care Manual. Effective November 15, 2015. Available at: <https://hhs.texas.gov/services/health/medicaid-chip/provider-information/contracts-manuals/texas-medicaid-chip-uniform-managed-care-manual>
- Texas Three-Way Contract. Issued December 15, 2015. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TexasContract.pdf>

Appendix A3. Pennsylvania: Pay-for-Performance in Medicaid MCO Contracts

Pennsylvania's 2016 Medicaid MCO contracts provides financial incentives to MCOs and BHOs that meet the following requirements for beneficiaries with serious and persistent mental illness (SPMI):

- Perform baseline stratification that categorizes beneficiaries by level of physical and behavioral health needs (for example, level 1 = low physical health/low behavioral health needs and level 4 = high physical health/high behavioral health needs)
- Develop and use an integrated care plan in care management for at least 500 members with the partnering BHO or MCO
- Attest that for 90 percent of hospital admissions, the BHO or MCO is notified within one business day of admission
- MCOs will receive payment based on incremental improvement on five quality measures:
 - Initiation and engagement of alcohol and other drug dependence treatment;
 - Adherence to antipsychotic medications for individuals with schizophrenia;
 - Combined physical health/behavioral health inpatient 30 day readmission rate for individuals with SPMI;
 - Emergency department utilization for individuals with SPMI; and
 - Combined physical health/behavioral health inpatient admission utilization for individuals with SPMI (Exhibit B2 in contract).

Appendix A4. Massachusetts: Principles and Best Practices for Sharing Behavioral Health Information^a

One Care, the state's financial alignment demonstration, developed resource materials for Medicaid-Medicare plans that presented five principles to follow regarding sharing of behavioral health information:

- Honor beneficiary choice regarding sharing psychiatric information;
- Commit to protecting beneficiary privacy;
- Communicate privacy policies and procedures to beneficiaries;
- Promote transparent provider-beneficiary communication, notes, and documentation; and
- Provide education and training to staff and providers to reduce stigma and increase understanding of privacy policies.

Best practices to support these principles include:

- Giving beneficiaries access to medical records;
- Training providers in maintenance of behavioral health information;
- Encouraging providers to obtain signed releases of behavioral health information;
- Explaining how behavioral health information will be shared;
- Respecting the central role of beneficiary in care planning; and
- Sharing all information with providers for whom the beneficiary provides consent.

^a Slides on promoting behavioral health privacy principles within One Care are available at: <https://onecarelearning.ehs.state.ma.us/>

ENDNOTES

- ¹ Medicaid and CHIP Payment and Access Commission (MACPAC). “Integration of Behavioral and Physical Health Services in Medicaid.” In *Report to Congress on Medicaid and CHIP*. March 2016. Available at: <https://www.macpac.gov/wp-content/uploads/2016/03/Integration-of-Behavioral-and-Physical-Health-Services-in-Medicaid.pdf>.
- ² Medicare Payment Advisory Commission (MedPAC). “Report to the Congress: Medicare and the Health Care Delivery System.” June 2016. Available at: <http://www.medpac.gov/docs/default-source/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0>.
- ³ MACPAC. “Behavioral Health in the Medicaid Program—People, Use, and Expenditures.” In *Report to Congress on Medicaid and CHIP*. June 2015. Available at: <https://www.macpac.gov/publication/behavioral-health-in-the-medicare-program%E2%80%95people-use-and-expenditures/>.
- ⁴ MACPAC 2016, op cit.
- ⁵ MedPAC and MACPAC. “Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid.” January 2017. Available at: <https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicare-3/>.
- ⁶ The Medicaid state plan option under Section 2703 of the Affordable Care Act allows states to establish health homes, a comprehensive system of care coordination for Medicaid beneficiaries with chronic conditions. To provide “whole-person” care, health home providers integrate and coordinate all primary, acute, behavioral health and long-term services and supports. Additional information is available at: <https://www.medicare.gov/medicaid/ltss/health-homes/index.html>.
- ⁷ Texas also has integration models for Medicaid-only beneficiaries. At times, state representatives drew lessons from their models of integration for Medicaid-only beneficiaries that were also applicable to efforts for dually eligible beneficiaries. This brief includes those lessons as well.
- ⁸ In this brief, we define “behavioral health organization” to include managed behavioral health care organizations, regional behavioral health authorities, local mental health authorities, and pre-paid inpatient health plans.
- ⁹ A 2011 ICRC technical assistance brief provides an overview of other managed care models that states were using at that time to integrate physical and behavioral health services. See A. Hamblin, J. Verdier, and M. Au. “State Options for Integrating Physical and Behavioral Health Care.” Centers for Medicare & Medicaid Services, October 2011. Available at: <https://www.medicare.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/BH-Briefing-document-1006.pdf>.
- ¹⁰ Centers for Medicare & Medicaid Services. Medical Learning Network. “Mental Health Services.” January 2015. Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mental-Health-Services-Booklet-ICN903195.pdf>.
- ¹¹ Integrated Care Resource Center. “Coordination of Medicare and Medicaid Behavioral Health Benefits.” August 2016. Slides and recording. Available at: <http://www.integratedcareresourcecenter.com/technicalAssistance/workingWMedicare.aspx>.
- ¹² Under the Financial Alignment Initiative’s capitated model demonstrations, the Centers for Medicare & Medicaid Services entered into three-way contracts with participating states and health plans to develop and test delivery system models that better align the financing of Medicare and Medicaid programs and integrate primary, acute, behavioral health and long-term services and supports for dually eligible beneficiaries. State options for combining contracts with D-SNPs and Medicaid managed care organizations are described in a November 2016 ICRC technical assistance tool available at: http://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues_Options.pdf.
- ¹³ The framework for integration models was drawn from a Center for Health Care Strategies issue brief “Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators.” The brief also provides lessons on planning for integration, including stakeholder engagement strategies. Available at: http://www.chcs.org/media/BH-Integration-Brief_041316.pdf.
- ¹⁴ Arizona contracts with three regional behavioral health authorities (RBHAs) to manage both physical and behavioral health services for people with SMI. However, beneficiaries with SMI and long-term supports and service needs are managed through MCOs in the Arizona long term care system (ALTCS).
- ¹⁵ The Substance Abuse and Mental Health Services Administration (SAMHSA) defines “recovery” as “a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential....The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one’s health and wellness that may involve setbacks.” This approach to care may be unfamiliar to providers who have primarily worked within a treatment model of care. Additional information is available on the SAMHSA website at: <https://www.samhsa.gov/recovery>.
- ¹⁶ MACPAC 2016, op cit.
- ¹⁷ A recent report by The Commonwealth Fund details Arizona’s consolidation of its physical and behavioral health services agencies and offers information on the benefits of the consolidation and additional lessons from the state’s experience. See D. Bachrach, P. Boozang, and H. Davis. “How Arizona Medicaid Accelerated the Integration of Physical and Behavioral Health Services.” The Commonwealth Fund, May 2017. Available at: http://www.commonwealthfund.org/~media/files/publications/issue-brief/2017/may/bachrach_arizona_medicare_integrated_behavioral_hlt_ib.pdf.
- ¹⁸ Pennsylvania’s requirements grew out of a state pilot project, the SMI Innovations Project, which was supported and evaluated by the Center for Health Care Strategies and Mathematica Policy Research. The evaluation of the pilot project is available at: <http://www.chcs.org/resource/smi-innovations-project-in-pennsylvania-final-evaluation-report/>.

- ¹⁹ National Academy for State Health Policy. “Improving Care for Dual Eligibles: How States are Innovating through Medicare Advantage D-SNP Plans.” Presented January 9, 2017. Slides available at: <http://www.nashp.org/webinar-improving-care-for-dual-eligibles-how-states-are-innovating-through-medicare-advantage-d-snp-plans/>.
- ²⁰ R. Belfort, and A. Dworkowitz. “Sharing Behavioral Health Information in Massachusetts: Obstacles and Potential Solutions.” Blue Cross Blue Shield of Massachusetts Foundation and Manatt, Phelps, and Phillips, LLP. March 2016. Available at: http://bluecrossfoundation.org/sites/default/files/download/publication/Behavioral_Health_Data_Sharing_FINAL.pdf.
- ²¹ T. Adams Ragone. “Integrating Behavioral and Physical Health Care in New Jersey: Legal Requirements for the Sharing of Patient Health Information among Treatment Providers.” Seton Hall Law School Center for Health & Pharmaceutical Law & Policy, June 2016. Available at: <http://www.cshp.rutgers.edu/Downloads/10980.pdf>.
- ²² Anthem Public Policy Institute. “Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders: Strategies Used by Medicaid Managed Care Organizations to Promote Effective Information Sharing.” December 2016. Available at: <http://www.thinkanthem.com/report/anthem-public-policy-institute-releases-white-paper-series-mental-health-and-substance-use>.
- ²³ Examples of misconceptions provided in the paper include: HIPAA requires patient authorization for disclosures for treatment purposes, Part 2 regulations restrict the disclosure of all substance abuse treatment information, and consent for release of Part 2 protected information must be a separate document and cannot be combined with any other type of patient consent.
- ²⁴ In January 2016, SAMHSA finalized changes to 42 C.F.R. Part 2 regulations that would allow use of a general consent form that names a broad entity (e.g., a health information exchange organization) or designates a general panel of providers as authorized recipients of protected health information. However, if a state’s own privacy laws require stricter requirements, then the state would not be able to take advantage of federal modifications to Part 2 regulations. For more information see: Belfort and Dworkowitz, 2016, op cit.
- ²⁵ Belfort and Dworkowitz 2016, op cit.
- ²⁶ Michigan’s universal consent form is available at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_58005-343686--,00.html.
- ²⁷ Michigan’s packet includes patient demographics, history, utilization, and both physical and biopsychosocial assessments. However, the completeness and timeliness of the information shared varies for every Medicare-Medicaid Plan and BHO partnership. BHO information technology capabilities and buy-in to the concept of coordination can factor into this variation.
- ²⁸ Arizona’s Enrollment Transition Information (ETI) Form is available at: <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/520a.docx>.
- ²⁹ Additional information on Arizona’s HIE efforts, including a brief history and the state’s current efforts to expand connectivity and functionality for behavioral health is available in a 2016 Arizona Health-E Connection (AzHeC) presentation. See D. Spitzer, “Expanding Statewide HIE Connectivity & Functionality for Physical and Behavioral Health: A Network Update.” Presented June 20, 2016. Slides available at: https://azhima.org/annualmeeting/wp-content/uploads/2016/04/AzHeC-Spitzer-Presentation-FINAL_6-16-16_v2.pdf. Additional information on how Arizona financed the HIE and incentivized provider participation is provided in an AHCCCS Prospective Offerors’ Conference presentation, November 8, 2016 (slide 31). Slides available at: https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH18/ReqForProp/POCATIF_ConferencePresentation.pdf.
- ³⁰ V. Rountree and B. Kohler. “AHCCCS Prospective Offerors’ Conference.” Presented at the AHCCCS Prospective Offeror’s Conference, Phoenix, AZ, November 8, 2016. Slides available at: https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH18/ReqForProp/POCATIF_ConferencePresentation.pdf.
- ³¹ States cannot enroll a beneficiary into a Medicare plan aligned with a companion Medicaid plan in which a beneficiary is enrolled except through seamless conversion, which is limited to circumstances when a beneficiary ages into Medicare or becomes eligible based on disability after a two-year waiting period. The process requires approval by CMS of a request from a Medicare plan, and the agency announced in 2016 that it is suspending acceptance of new seamless conversion proposals while it reviews its policies.
- ³² AHCCCS. “Transitions out of the Criminal Justice System.” Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html>.
- ³³ H. Pincus, et al. “Quality Measures for Mental Health and Substance Use: Gaps, Opportunities, and Challenges.” *Health Affairs*, 35, no. 6, 2016, pp. 1000-1008. doi: 10.1377/hlthaff.2016.0027.
- ³⁴ MACPAC 2016, op cit.
- ³⁵ Pincus et al. 2016, op cit.
- ³⁶ K. Purington, and R. Yalowich. “Measuring Physical and Behavioral Health Integration: A Look at State Approaches in the Context of Value-Based Purchasing.” National Academy for State Health Policy, January 2017. Available at: <http://www.nashp.org/wp-content/uploads/2017/01/Measuring-Integration-Brief.pdf>.
- ³⁷ Pincus et al. 2016, op cit.
- ³⁸ Technical specifications for quality measures used by Certified Community Behavioral Health Care Clinics are available at: <https://www.samhsa.gov/section-223/quality-measures>. The National Behavioral Health Quality Framework, which incorporates specific National Outcome Measures that measure social determinants of health, is available at: <https://www.samhsa.gov/data/national-behavioral-health-quality-framework>. The CMS measures inventory can be filtered by behavioral health and/or substance use and is available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html>. The Medicaid and CHIPRA adult and child core sets are available at: <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html>.

- ³⁹ The National Quality Forum provides an explanation of criteria in the August 2016 document “Measure Evaluation Criteria and Guidance for Evaluating Measures for Endorsement” available at: http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx.
- ⁴⁰ The 2016 quality assessment and performance improvement strategy for the Tennessee Bureau of TennCare is available at: <https://www.tn.gov/assets/entities/tenncare/attachments/qualitystrategy.pdf>. The AHCCCS quality assessment and performance improvement strategy, which was revised October 2012, is available at: <https://www.azahcccs.gov/Resources/OversightOfHealthPlans/quality.html>.
- ⁴¹ Ragone 2016, et al.
- ⁴² Additional information on the Medicaid MCO’s supportive housing program is available at: <http://files.kff.org/attachment/Issue-Brief-Linking-Medicaid-and-Supportive-Housing-Opportunities-and-On-the-Ground-Examples>.
- ⁴³ The Medicare Benefit Policy Manual is available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf>.
- ⁴⁴ Managed care trainings and tools developed by the Managed Care Technical Assistance Center (MCTAC) are available at <http://ctacny.org/about-us>.
- ⁴⁵ The Health Care Payment Learning and Action Network (HCP-LAN), a network of health care stakeholders, developed an alternative payment model (APM) framework to align multipayer efforts to advance APMs and to track progress nationally. The framework describes payment models by degree of provider risk and advancement. HCP-LAN was convened by the CMS Alliance to Modernize Healthcare, a federally funded research and development center. The APM framework is available at: <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>.
- ⁴⁶ Assertive Community Treatment is an evidenced-based practice for “delivering a full range of services to people who have been diagnosed with a serious mental illness” (SAMHSA website).
- ⁴⁷ While a growing evidence base suggests that integration leads to improved care and reduced costs, the evidence has been focused on specific populations (e.g., adults with depression and anxiety disorders). A 2016 MACPAC report on integration noted that most studies have focused on integration at the practice level, “leaving many questions unanswered about the effects of financial and administrative integration efforts that are underway in Medicaid programs.” The report is available at: <https://www.macpac.gov/wp-content/uploads/2016/03/Integration-of-Behavioral-and-Physical-Health-Services-in-Medicaid.pdf>.