ICRC Presenters

• Lauren Rava, Center for Health Care Strategies
• Danielle Chelminsky, Mathematica Policy Research
• Logan Kelly, Center for Health Care Strategies
• Melanie Au, Mathematica Policy Research
Agenda

• Clinical Profiles and Behavioral Health Expenditures for Dually Eligible Beneficiaries

• Medicare and Medicaid Behavioral Health Benefits

• Behavioral Health Integration Landscape

• State and Plan Solutions to Address Challenges of Integration for Dually Eligible Beneficiaries

• Questions and Discussion
Overview of Major Themes

• Behavioral health (BH) conditions and service needs are very common among dually eligible beneficiaries.
  
  • *Note: We use the term “behavioral health” to cover both mental health and substance use disorders, unless otherwise specified.*

• Medicaid coverage of BH services is generally more comprehensive than Medicare coverage.

• Historical care delivery patterns in both Medicare and Medicaid present obstacles to integration.

• States and health plans are developing and implementing models for better integration of physical and behavioral health and Medicare and Medicaid services, such as including both Medicare and Medicaid BH in capitated managed care programs.
Clinical Profiles and Behavioral Health Expenditures for Dually Eligible Beneficiaries
Behavioral Health Conditions Are Highly Prevalent among Dually Eligible Beneficiaries

Behavioral health conditions are more prevalent among dually eligible beneficiaries under age 65 than among those age 65 and older.

<table>
<thead>
<tr>
<th>Behavioral Health Condition (CY 2013)</th>
<th>% Under 65</th>
<th>% 65 and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>24%</td>
<td>15%</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>15%</td>
<td>3%</td>
</tr>
<tr>
<td>Depressive Disorder</td>
<td>33%</td>
<td>22%</td>
</tr>
<tr>
<td>Schizophrenia and Other Psychotic Disorders</td>
<td>13%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Dually Eligible Beneficiaries with Mental Health Conditions Have High Physical Health Comorbidity Rates

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip/Pelvic Fracture</td>
<td>61%</td>
</tr>
<tr>
<td>Other Metabolic Disorder</td>
<td>55%</td>
</tr>
<tr>
<td>Stroke</td>
<td>54%</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>52%</td>
</tr>
<tr>
<td>Anemia</td>
<td>47%</td>
</tr>
<tr>
<td>Musculoskeletal Disorder</td>
<td>46%</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>45%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>42%</td>
</tr>
<tr>
<td>Heart Condition</td>
<td>42%</td>
</tr>
<tr>
<td>Neoplasm</td>
<td>40%</td>
</tr>
<tr>
<td>Eye Disease</td>
<td>39%</td>
</tr>
</tbody>
</table>

- Physical health comorbidities are prevalent among individuals with mental health conditions
- One or more mental health conditions were found to co-occur in over 50% of those with:
  - Hip or pelvic fracture
  - Metabolic disorder
  - History of stroke and
  - Lung disease

Medicare and Medicaid Expenditures for All Mental Health and Substance Use Disorders, 2018 Projection*

Total Mental Health and Substance Use Disorder Expenditures

- Medicare (Mental Health) 13%
- Medicare (SUD) 1%
- Medicaid (Mental Health) 27%
- Medicaid (SUD) 4%
- Other MH/SUD Spending 61%

* SAMHSA projection based on historical data for 2009.

Medicaid Is Expected to Finance a Large and Growing Share of Mental Health Treatment Spending

Medicaid Is Also Expected to Finance a Larger Share of SUD Spending Over Time

Comparison of Spending for Dually Eligible Beneficiaries with and without Mental Health Disorders

Average Annual Spending on Dually Eligible Beneficiaries, 2006-2009

Spending for dually eligible beneficiaries with mental health disorders is at least twice that of individuals without these conditions.

Characteristics of Dually Eligible Beneficiaries in Each State

- You can use the Medicare-Medicaid Linked Enrollee Analytics Data Source (MMLEADS) file to find detailed state and national level data on the characteristics of dually eligible beneficiaries. Note: Data is from 2012 and is fee-for-service only.

- Example Variables (see first tab in MMLEADS link for list of all variables):
  - Chronic conditions: Percent with Alzheimer's disease, bipolar disorder, depression, drug use
  - Utilization: Percent with at least one Medicare or Medicaid community or residential mental health service
  - Payment: Medicaid mental health FFS payments

- Why It’s Useful to States:
  - Compare types of beneficiaries by demographics, enrollment categories, chronic conditions, utilization and spending
  - Compare states to other states and to the national average
  - Help develop tailored integrated care programs
  - See the ICRC TA brief: How States Can Better Understand their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources for more information
State vs. National Examples from MMLEADS, 2012

### Percent with Bipolar Disorder

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>National</th>
<th>Maryland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Benefit</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Partial Benefit</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td>Medicare Only</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>Medicaid Only (Disability)</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

### Percent with at Least One Medicare or Medicaid Community Mental Health Service

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>National</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Benefit</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>Partial Benefit</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>Medicare Only</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Medicaid Only (Disability)</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Medicare and Medicaid Behavioral Health Benefits
Medicare Mental Health Services Coverage

• **Medicare Part A** covers mental health care services in inpatient care settings such as general and psychiatric hospitals.

• **Medicare Part B** covers mental health care services in outpatient settings provided by approved health care professionals (psychiatrists and other physicians, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, and physician assistants).
  
  • Part B may cover partial hospitalization, a structured program of psychiatric services provided in community mental health centers or hospital outpatient settings.
  
  • Standard copay amounts apply for both Part A and Part B coverage, which Medicaid covers for dually eligible beneficiaries.

  Covered services may include individual and group psychotherapy, psychiatric diagnostic interviews, medication management, and other services and therapies including Screening, Brief Intervention, and Referral to Treatment (SBIRT).

• **Medicare Part D** covers prescription drugs, including drugs to treat mental health conditions.

Medicare Substance Use Disorder (SUD) Services Coverage

• **Medicare Part A** covers SUD services provided in inpatient care settings.

• **Medicare Part B** covers outpatient SUD services such as counseling when delivered by covered providers, and some partial hospitalization services.
  
  • Standard copay amounts apply for both Part A and Part B coverage, which Medicaid covers for dually eligible beneficiaries.

• **Medicare Part D** covers many medications to treat SUD, including those used in Medicaid-Assisted Treatment (MAT).

• While medications used for MAT must be included in Part D formularies, the delivery of MAT is generally covered in Part A, and many types of MAT are also covered in Part B.

• Recent policy changes to address prescription opioid misuse and opioid use disorder include developing a new framework that allows Part D sponsors, including D-SNPs, to implement drug management programs that limit access to coverage for frequently-abused drugs.

Medicaid Mental Health Services Coverage

- States are required to cover medically necessary mental health services, including services delivered in inpatient hospital, outpatient hospital, rural health clinic, nursing facility, home health, and physician office settings.
- States can elect to cover additional services through state plans or waivers.
- All states cover prescription drugs for Medicaid-only beneficiaries.

<table>
<thead>
<tr>
<th>States Covering Mental Health Services in Medicaid State Plan, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Services</td>
</tr>
<tr>
<td>Crisis Intervention</td>
</tr>
<tr>
<td>Psychotherapy</td>
</tr>
<tr>
<td>Telemedicine</td>
</tr>
<tr>
<td>Case Management/ Care Coordination</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
</tr>
<tr>
<td>Peer Support</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation</td>
</tr>
</tbody>
</table>

Medicaid Substance Use Disorder Services Coverage

- All states cover Buprenorphine for MAT, and most states also cover Naltrexone and Methadone.
- Range of state coverage for continuum of SUD services.
- Many states provide SUD services, such as detoxification, psychotherapy, peer support, and crisis intervention through Medicaid state plans.

<table>
<thead>
<tr>
<th>States Covering Continuum of SUD Services, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention</td>
</tr>
<tr>
<td>Outpatient Services</td>
</tr>
<tr>
<td>Intensive Outpatient (with or without partial hospitalization)</td>
</tr>
<tr>
<td>Medically Managed Intensive Inpatient Services</td>
</tr>
<tr>
<td>Residential Services</td>
</tr>
</tbody>
</table>

- States are pursuing Section 1115 waivers to provide additional community-based services to individuals with SUD needs, and to expand treatment options by providing SUD services in Institutions of Mental Diseases (IMDs).

Medicaid Institutions for Mental Diseases (IMD) Exclusion

- IMDs are inpatient facilities of more than 16 beds in which 51 percent or more of patients are being treated for mental diseases.
- Historically, federal Medicaid matching payments have been prohibited for IMD services provided to Medicaid beneficiaries between the ages of 22 and 64.*
- CMS finalized rule in April 2016 to partially lift IMD exclusion in capitated managed care settings.**
  - Rule allows states to include short-term IMD stays (15 days or less) in capitated payments to MCOs or Pre-paid Inpatient Health Plans (PIHPs)
- Legislation just approved by Congress and sent to President would give states the option of covering IMD services for adults with SUD for up to 30 days in a year.***

* 42 U.S.C. §1396d(i)
** Federal Register, May 6, 2016. Section 438.6(e), discussed on pp. 27555-27563.
Behavioral Health Integration Landscape
Multiple Layers of Fragmentation for Dually Eligible Beneficiaries

- Dually eligible beneficiaries with behavioral health issues often must navigate across several delivery systems:
  - Physical health and behavioral health services/related support
  - Medicare and Medicaid covered services and program rules
  - Mental health and SUD services
Implications of Medicare and Medicaid Behavioral Health Coverage Differences and Payer Disconnects

- **Challenges in coordinating prescription drug utilization**
  - Major form of treatment for behavioral health conditions
  - Primarily covered by Medicare for dually eligible beneficiaries
  - Significant coordination/clinical issues in Medicaid nursing facilities and in HCBS waiver programs

- **Coverage limitations in each program; gap-filling coverage from each program is often not coordinated**
  - Medicare: limited SUD services and limited longer-term and/or rehabilitative mental health service coverage
  - Medicare: few “step-down” options in lieu of costly inpatient psychiatric services
  - Medicaid: IMD exclusion

- **Limits on certain types of behavioral health providers under Medicare**

- **Administrative and operational challenges due to gaps in data (e.g., for care coordination)**
Medicaid System-Level Landscape

- General trend away from fee-for-service toward managed systems for behavioral health care, but purchasing models in many states still separate behavioral health services from other Medicaid-covered health services.

- Often administered and regulated by multiple state agencies and levels of government, even if a single health plan is responsible for both physical and behavioral health.

- Growing movement towards physical and behavioral health integration in managed care models.

### State Approaches to Integrating/Coordinating Physical and Behavioral Health Services for Medicaid Beneficiaries*

<table>
<thead>
<tr>
<th>Description</th>
<th>State Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carve-in:</strong> BH services are carved in to managed care benefit package</td>
<td><strong>Tennessee:</strong> In TennCare, managed care organizations are responsible for covering all physical and behavioral health services, as well as LTSS.</td>
</tr>
<tr>
<td><strong>Carve-out:</strong> BH services are managed by separate behavioral health organization</td>
<td><strong>Pennsylvania:</strong> Behavioral health services are separately managed by counties, in collaboration with behavioral health managed care organizations (BH-MCOs); state requires some level of collaboration between BH-MCOs and physical health managed care organizations.</td>
</tr>
<tr>
<td><strong>Hybrid Approach:</strong> Specialty plans deliver all services to people with SMI, BH services carved in for other populations</td>
<td><strong>Arizona:</strong> Integrated regional behavioral health authorities manage physical and behavioral health services for beneficiaries with SMI. As of October 1, 2018, AHCCCS Complete Care includes integrated physical and behavioral health for non-SMI populations. <strong>New York:</strong> Carves all state plan behavioral health services into mainstream managed care plan and designates a subset of these as health and recovery plans (HARPs), which offer a separate product line and additional specialized services for people with SMI.</td>
</tr>
</tbody>
</table>

*See appendix for other states and program details.
## State Approaches to Integrating/Coordinating Physical and Behavioral Health Services for Dually Eligible Beneficiaries*

<table>
<thead>
<tr>
<th>Description</th>
<th>State Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carve-in:</strong> BH services are carved in to managed care benefit package</td>
<td><strong>Massachusetts:</strong> One Care Medicare-Medicaid Plans, under the financial alignment demonstration, manage both physical and BH services for dually eligible beneficiaries under age 65.</td>
</tr>
<tr>
<td><strong>Partial carve-in:</strong> Some BH services are carved-in but subcontracted to behavioral health organizations (BHOs) to manage</td>
<td><strong>Michigan:</strong> Medicare BH services are carved-in to MMP contracts, but MMPs subcontract/partner with BHOs to manage the Medicare BH services; Medicaid BH services remain carved out and managed by BHOs.</td>
</tr>
<tr>
<td><strong>Hybrid Approach:</strong> Specialty plans deliver all services to people with SMI, BH services carved in for other populations</td>
<td><strong>Arizona:</strong> Dual Eligible Special Needs Plans (D-SNPs), aligned with Medicaid managed care plans, cover general mental health services along with physical health benefits; regional behavioral health authorities, aligned with a D-SNP, cover these services for beneficiaries with SMI.</td>
</tr>
</tbody>
</table>

*See appendix for other states and program details.*
Challenges to Physical and Behavioral Health Integration

- Data sharing challenges
  - Privacy considerations, such as federal regulations around sharing substance-use data
  - Limited financial and staff resources for enhancing the capacity to share information
- Need for quality measures and payment incentives to promote provider accountability
- Administrative barriers to program monitoring and quality improvement
- Different cultures of care delivery, such as the medical model vs. recovery-focused model
- Separate professional training of physical and behavioral health providers
State Strategies for Addressing Integration Challenges for Dually Eligible Beneficiaries
ICRC Technical Assistance Tool


• Interviewed state administrators and health plans in six states (AZ, MA, MI, PA, TN, TX) in 2016 about their experiences with behavioral health integration
Data Sharing Infrastructure

State strategies to assist with data sharing, from August 2017 ICRC brief on integration:

**BH and PH Data Sharing**
- Health information exchange (AZ)
- State guidance on BH data security concerns (CA)
- Best practices for sharing BH information (MA)
- Standard forms and tools (AZ, CA)

**Medicare and Medicaid Data Sharing**
- MIPPA contract requirements on data sharing (TN)
- State-initiated data gap-filling (AZ)
- Requirements in health plan contracts (MI)

Managed Care Program Design Considerations: Dually Eligible Beneficiaries

States have used managed care program design strategies to address integration challenges:

1. Requirement to integrate BH and PH services

2. Alignment of Medicare Advantage D-SNPs and Medicaid plans
   - **Arizona, Pennsylvania, Tennessee:** Required health plans with Medicaid MCOs to offer D-SNPs in same regions in which they operate

3. Provider network requirements
   - **Texas:** Required Medicaid MCOs and Medicare-Medicaid Plans to subcontract with BHOs for targeted case management and rehabilitation services
   - **Michigan:** Required Medicare-Medicaid Plans to subcontract with BHOs in their region

Managed Care Program Design Considerations: Dually Eligible Beneficiaries

4. Integrated care teams and care coordination
   • Formal and informal integrated care team meetings used to coordinate between health plan, BHO, and medical and BH providers
   • BH care managers can facilitate obtaining patient consent, locating beneficiaries lost to care, connecting with community-based support services (e.g., housing assistance, employment assistance)
   • Joint care coordination visits that include both medical and behavioral health staff for high-risk cases

Considerations for integration:
   • Clear definitions of coordination roles and responsibilities
   • Clear distinction of health plan and BHO responsibilities for BH services
   • Integrating medical and recovery focused models of care

Managed Care Program Design Considerations: Dually Eligible Beneficiaries

5. Promoting shared accountability through measurement and payment

- **Tennessee**: “Gap-in-care-closure” program pays bonuses to both BH and PH providers that can close a gap in care (e.g., missing immunization, missing refills on behavioral health medications)

- **California**: Requires joint Cal MediConnect performance measures to test MMP-county collaboration for specialty mental health services
  - Both MMPs and county Mental Health Plans can earn incentive payments if they meet quality metrics that advance care coordination across the systems, such as decreased rates or emergency department utilization for individuals with SMI

- **Arizona**: Contracts with “whole health clinics” that require meeting minimum requirements for both behavioral and physical health measures to receive bonus payments

Managed Care Program Design Considerations: Dually Eligible and Medicaid Beneficiaries

6. States and health plans can develop and expand services to fill BH and SUD gaps

- **Tennessee**: D-SNP (BlueCare) in carve-in state expanding medication-assisted treatment (MAT) services

- **Massachusetts**: Medicare-Medicaid Plan (Commonwealth Care Alliance) in carve-in state developed enhanced community-based crisis stabilization units as a less intensive alternative to Medicare inpatient psychiatric facility services for under-65 dually eligible beneficiaries

States Expanding SUD Services through Section 1115 Waivers

• **California** 1115 SUD demonstration: County authorities that function as managed care plans (i.e., prepaid inpatient health plans) expanded recovery services, multiple levels of residential SUD treatment (no IMD exclusion), and MAT

• **Massachusetts** 1115 SUD demonstration: Managed care plans will expand diversionary behavioral health services (e.g., community crisis stabilization, clinical support services for substance abuse, intensive outpatient program) and other SUD services such as low-intensity residential services

Considerations for integration:

• Stigma
• Criminal justice interactions
• Administrative infrastructure

Appendix:
State Examples of Medicare-Medicaid Behavioral Health Integration
# Medicaid Carve-in and Partial Carve-in Models for Medicaid-only and D-SNP Enrollees

<table>
<thead>
<tr>
<th>State</th>
<th>Approach</th>
</tr>
</thead>
</table>
| Arizona   | • Specialized, integrated behavioral health plan (Regional Behavioral Health Authority, or RBHA) in Maricopa County for Medicaid beneficiaries with SMI  
  • Coordinates all BH and physical health, including Medicare services for dually eligible beneficiaries (as a D-SNP)  
  • As of October 1, 2018, AHCCCS Complete Care includes integrated physical and behavioral health for non-SMI populations |
| Tennessee | • Regional MCOs integrate all PH, BH and LTSS benefits  
  • TennCare CHOICES MCOs must have companion D-SNP to coordinate all services (including BH) for enrolled dually eligible beneficiaries  
  • Use of BH performance measures for pay for performance |
## Capitated Financial Alignment Demonstration Carve-in Model

<table>
<thead>
<tr>
<th>State</th>
<th>Approach</th>
</tr>
</thead>
</table>
| Massachusetts | • “One Care” covers dually eligible beneficiaries ages 21-64; previously <65 dually eligible beneficiaries were excluded from managed care and received BH services via FFS  
• Supplemental diversionary and community alternative BH services |
| New York      | • “FIDA” MMPs cover all Medicare and Medicaid BH services  
• **Note:** Medicaid-only: BH services integrated into mainstream MCOs in New York City region; MCOs may partner with a BHO to offer BH state plan services and/or may further qualify as specialized Health & Recovery Plans (HARPs) that offer community-based services for individuals with SMI; Expanded statewide in 2016 |
# Financial Alignment Demonstration Partial Carve-in and Contracted Models

<table>
<thead>
<tr>
<th>State</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>• “Cal MediConnect” MMPs cover Medicare BH services; Medicaid services for individuals with “mild-to-moderate” mental health disorders</td>
</tr>
<tr>
<td></td>
<td>• County mental health plans (MHPs) cover specialty MH services</td>
</tr>
<tr>
<td></td>
<td>• MMPs and MHPs required to sign an MOU, outlining coordination standards across care planning, data sharing, administrative and network functions</td>
</tr>
<tr>
<td>Michigan</td>
<td>• Under “MI Health Link” demonstration, previously existing Medicaid regional behavioral health Prepaid Inpatient Health Plans (PIHPs) are first-tier, down-stream contractors of the MMPs for Medicare BH services</td>
</tr>
<tr>
<td></td>
<td>• State continues to contract directly with PIHPs for Medicaid BH services</td>
</tr>
<tr>
<td></td>
<td>• MI Health Link includes a “Care Bridge,” an MMP-PIHP electronic care coordination platform for enrollees with BH, substance use disorder, and I/DD needs</td>
</tr>
</tbody>
</table>
Questions and Discussion
Additional Resources

- Alternatives to Inpatient Psychiatric Services for Medicare-Medicaid Enrollees: A Case Study of Commonwealth Care Alliance (Integrated Care Resource Center/May 2016)
- Integrating Behavioral Health into Medicaid Managed Care: Lessons from State Innovators (Center for Health Care Strategies/April 2016)
- Integration of Behavioral and Physical Health Services in Medicaid (MACPAC Report to Congress/March 2016)
- Beneficiaries Dually Eligible for Medicare and Medicaid (MedPAC-MACPAC Data Book/ January 2018)
- Physical and Mental Health Condition Prevalence and Comorbidity among Fee-for-Service Medicare-Medicaid Enrollees (Centers for Medicare & Medicaid Services/September 2014)
- State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment (The Commonwealth Fund/August 2014)
- State Approaches to Integrating Physical and Behavioral Health Services for Medicare-Medicaid Beneficiaries: Early Insights (Center for Health Care Strategies/February 2014)
- State Options for Integrating Physical and Behavioral Health Care (Centers for Medicare & Medicaid Services/October 2011)
About ICRC

• Established by CMS to advance integrated care models for dually eligible beneficiaries

• ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies

• Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges

• Send additional questions to: ICRC@chcs.org