An Overview of Physical and Behavioral Health Integration

I. Introduction and Models

Behavioral health integration refers to the incorporation of mental health care and substance use disorder services with physical health, often in primary care settings. The California Health Care Foundation (CHCF) defines integrated care as: "the delivery, coordination, and payment for care related to the full continuum of an individual's physical and behavioral health needs, as managed by a single accountable entity." The notion of behavioral health integrated into primary care is well researched and supported by various groups, including the American Psychiatric Association (APA) and the Academy of Psychosomatic Medicine. The model known as the "Collaborative Care Model" is one that is recommended by the APA. This model focuses on several elements: team-driven care, population-focused care, measurement-guided care, and evidence-based care with attention to accountability and quality improvement. This system helps to destigmatize treatment for behavioral health issues and helps vulnerable populations overcome barriers to both medical care and preventive care. In addition, those with physical health conditions (like diabetes) who also have mental health conditions (like depression) have a harder time managing their physical health condition compared to someone with diabetes without a co-occurring mental health condition. Research has also found that up to sixty percent of mental health care happens in primary care settings and this does not account for all the mental health conditions that go untreated. It is clear that physical and mental health care are inextricably combined and that a significant portion of mental health care is already occurring in primary care settings. While researchers have found that integrating behavioral health into primary care for adult with depression and anxiety disorders is effective, there is still a need for more research.

II. California's Current System – Needs and Barriers

It is well established that people with behavioral health conditions experience higher rates of major chronic illnesses while also experiencing subpar quality of care for their physical

health needs. People with a diagnosis of serious mental illness or substance use disorder on average die 20 years earlier from preventable physical illnesses. In addition, on average, people with behavioral health conditions incur health care costs at four times the rate of those without such conditions; this spending is largely on physical health care needs. In fact, one study found that five percent of Medi-Cal enrollees account for fifty percent of the spending and that forty-five percent of that five percent are enrollees with a severe mental illness diagnosis. Thus the needs of this population cross both the physical and behavioral health care sectors.

Under the current fragmented Medi-Cal system, many people with behavioral health needs go without adequate services and receive little coordination of their care. People who need behavioral health care must currently navigate a complicated trifold system. They must to access physical health care and non-specialty mental health services from managed care plans, obtain specialty mental health services from the county mental health system, and seek SUD services from county the Drug Medi-Cal programs. As a result, individuals fall through the gaps and go without necessary services. Under the current system, the penetration rate of mental health access is low - around 5-6% of all Medi-Cal enrollees received any mental health service in FY17-18. In addition, according to a 2018 CFCH report, access to SUD services meets only 10% of the expected need statewide. These statistics show we are not currently meeting the need for services.

Despite the many reasons why integration can provide better care - like better coordination between physicians and increased preventive care for vulnerable populations - there are numerous obstacles to achieving complete integration in Medi-Cal. First, fully integrating behavioral health would require changes to California's Medicaid Section 1915(b) waiver. Further, due to historic funding arrangements established in state law - like the 1991 and 2011 Realignment legislation that dedicated mental health care funding to counties outside of the state annual budget, and Proposition 30 that prohibits the state from passing mandates that would increase county costs without additional funding - making any significant changes would require the state legislature to revisit these laws and funding streams. There are also concerns with the capacity of MCPs to treat populations with serious mental illness (SMI) or serious emotional disorders (SED) since counties are currently the most familiar with the needs of these populations. Along with these concerns there is fear that integration will displace the county mental health workforce and contracted providers or that mental health care will be overshadowed by physical care.

Another barrier to integration is the lack of data sharing and information sharing between MCOs and county systems. Providers in both complain that they are not able to access information regarding what services their patient is receiving in other systems, whether their patient has been hospitalized, or what kind of psychiatric prescriptions their patient has. With formal integration this connection can be better managed and supported. While specific outcomes are difficult to measure, Blue Sky Consulting has identified several

valid and reliable measures that plans can use to track data. These measures can be used to ensure that coordination between MCOs and county systems is effective.

III. Other State Approaches

States have taken a variety of approaches to integrating behavioral and physical health care in their Medicaid programs over the last few years. Kaiser Family Foundation reports that: eleven states reported some action that would impact behavioral health services under MCO contracts. Mississippi, New Jersey, New York, South Carolina, Virginia, and West Virginia all reported taking actions to carve in behavioral health. Arizona has reported plans to implement behavioral health care into MCO contracts. Washington reported they are implementing a fully integrated managed care model statewide. Ohio also reported implementing a fully integration of behavioral health services and Arkansas reported plans to implement a new MCO program for those with complex behavioral health needs. Michigan reported pilot programs that would provide physical and behavioral health services. The Institute for Medicaid Innovation compiled a review of behavioral health financing models that highlights the differences between states.. See attachment. This demonstrates that there is a clear shift toward including behavioral health into MCO contracts.

CHCF has identified models in three other states that have promoted integrated health care:

- *Washington* has taken an approach of fully integrated managed care. The behavioral health services are included in comprehensive Managed Care Organizations (MCOs) contracts. The MCO may subcontract with other behavioral health organizations to administer these services. Their prior system had behavioral health care carved out of MCOs, with Behavioral Health Organizations (BHOs) contracting with Regional Support Networks to deliver mental health care and SUD services with a fee-for-service model. Washington approached integration by fully integrating for all populations into managed care through a regional rollout. Washington is in the final phase of transitioning to integrated care. They began transitioning in 2016 and expect to be fully integrated by 2020.
- *New York* has undertaken an overall hybrid approach that combines comprehensive managed care carve-in and specialty plan. In New York, the integrated MCOs provide care for the general population while specialty plans manage mental health care for those with SMI or SUD needs. These specialty plans, called Health and Recovery Plans (HARPs), were created within existing MCOs and are available to people with SMI or SUD diagnoses. Because they are developed with existing MCOs they both integrate physical and behavioral health care. HARPs are designed to help enrollees meet recovery and wellness goals using person-centered care plans, community based services, and others. People

with SMI and SUD diagnoses can also choose to enroll in a MCO instead of a HARP. The prior system provided behavioral health care through a fee-for-service system and was carved out from MCOs. New York's timeline of implementation started in 2015 and continued into 2019. The implementation occurred by both geographical region and by population with later phasing in planned for children. Like Washington, New York also used multiple integrated plans per region and did not procure new plans for integration.

- *Arizona* has taken a different approach, contracting with specialty plans to manage all the physical and behavioral health services for enrollees with SMI. Arizona differs from Washington by their approach to integrate SMI populations first and then moved to a hybrid approach to maintain specialty plans while integrating general populations. Arizona's prior system had specialty behavioral health care carved out from MCOs and was managed by the Regional Behavioral Health Authorities. For most of Arizona's populations, the transition to integrated care began in 2014 and completed in 2018. Arizona also phased their implementation by population and geographic region. Arizona also differed from both Washington and New York by undergoing procurement for new integrated plans while the other two states contracted with their existing MCOs.

In some other states there has been push back against efforts to integrate behavioral and physical health. In Maryland, for example, there has been organized resistance to behavioral health integration. A professional association of Maryland's public community health behavioral providers (Community Behavioral Health Association of Maryland) developed talking points against two integration bills (SB 482 and HB 846). These bills sought to move the current system of Medicaid behavioral health care out through the separate Administrative Services Organization's (ASOs) into the MCOs. This would have been a significant change in the management of public funding and management for behavioral health services. The most prominent arguments against integration in Maryland concerned care coordination and MCO efficiency and effectiveness. with respect to care coordination, they argue that an integrated system would jeopardize populations most at risk like severe SUD and SMI populations by limiting the state's ability to collect data, coordinate care, and align eligibility, especially for those not eligible for Medicaid. They also raised the concerns that in an integrated system, providers would have to communicate with nine different entities and processes for credentialing, authorization, and payment because of the nine MCOs in the state. They argued this would increase administrative costs and errors. Finally, the Association argued there are advantages to carved out system, including: better management of SMI and SUD populations because of focus on behavioral health, targeted care management and care coordination from those experienced in the population, development of contractual performance standards that ensure high quality care, and provider access standards that ensure that members received timely care.

IV. Conclusion

Integration can be complicated and largely depends on factors such as political will and the existing delivery-system structure in place that predates it. Integration is also not a "one size fits all" proposition, as states have adopted numerous different models of integration, from fully integrated managed care to hybrid integration models. Whichever model is adopted, it can take years to fully implement such changes statewide and the road to integration along the way can be bumpy.

Behavioral Health Financing Models by State, 2019

States	Primary Carve-Out To CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing In Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Alabama				X	
Alaska				X	
Arizona- Acute Care			X		
Arizona- SMI Population					X
Arkansas- FFS/PCCM				X	
Arkansas- PASSE					X
Arkansas- AR WORKS			X		
California	X				
Colorado- RAEs			X		
Connecticut				X	
Delaware		X			
District of Columbia		X			
Florida			X		
Florida- SMI Population					X
Georgia			X		
Hawaii			X		
Hawaii- SMI Population	X				
Idaho	X				
Idaho- Duals Population			X		
Illinois			X		

States	Primary Carve-Out To CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing In Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Indiana		X			
Iowa			X		
Kansas			X		
Kentucky			X		
Louisiana			X		
Maine				X	
Maryland		X			
Massachusetts-MCO Delivery System			X		
Massachusetts-PCCM/ACO Delivery System	X				
Michigan	X				
Minnesota			X		
Mississippi			X		
Missouri		X			
Montana				X	
Nebraska			X		
Nevada			X		
New Hampshire			X		
New Jersey		X			
New Mexico			X		
New York			X		
New York- SMI Population					X
New York-Long-Term Care		X			
North Carolina	X				
North Dakota				X	
North Dakota-Medicaid Ex-pansion			X		
Ohio			X		
Oklahoma				X	
Oregon			X		
Pennsylvania	X				
Rhode Island			X		
South Carolina			X		
South Dakota				X	

States	Primary Carve-Out To CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing In Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Tennessee			X		
Texas			X		
Utah	X				
Vermont				X	
Virginia			X		
Washington-Integrated Managed Care Counties			X		
Washington-Transitional Counties[7]	X				
West Virginia			X		
Wisconsin		X			
Wisconsin-Family Care Program			X		
Wyoming				X	

Notes: The financing model presented in this table derived based on *OPEN MINDS*'s assessment of each state's Medicaid behavioral health financing system. Each state was assessed using the information contained in the OPEN MINDS Behavioral Health System State Profile Series.

Source: Open Minds. (2019). State Medicaid behavioral health carve-outs: The Open Minds 2019 annual update. https://www.open-minds.com/intelligence-report/state-medicaid-behavioral-health-carve-outs-the-open-minds-2019-annual-update/