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Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health

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IN BRIEF

Clinical integration of physical and behavioral health services may improve health outcomes and reduce costs for individuals with behavioral health conditions, but separate Medicaid financing for physical and behavioral health care can create barriers to coordinated care delivery. In recent years, several states have begun contracting with comprehensive managed care plans to integrate behavioral health services and reduce the fragmentation of care for Medicaid enrollees. This brief, produced with support from Blue Shield of California Foundation and the California Health Care Foundation, describes how integrated financing influences the coordination of physical and behavioral health services at the care delivery or practice level. It distills insights from providers in three states — Arizona, New York, and Washington — that have recently transitioned to integrated managed care. Based on their insights, the brief highlights recommendations for states seeking to improve health outcomes through advancing greater physical-behavioral health integration organized within three key areas: (1) data and quality measures; (2) payment and business practices; and (3) integrated clinical service delivery.

Background

Health Impacts and Costs of Behavioral Health Conditions

People with behavioral health conditions — those with mental health and/or substance use disorders (SUD) — are more likely to experience poor health and social outcomes as well as high costs of care.[1] They have higher rates of chronic physical conditions, as well as increased rates of homelessness, unemployment, poor educational performance, and involvement with the criminal justice system.[2] Strikingly, people with serious mental illness (SMI) die on average 25 years earlier than those without SMI.[3]

Medicaid is the single largest payer for behavioral health services in the United States, with nearly 20 percent of Medicaid enrollees having a behavioral health diagnosis.[4] Medicaid spending for enrollees with behavioral health conditions is more than four times higher than those without these conditions, largely as the result of increased *physical* health care spending.[5] One study found that over 80 percent of the increased costs for people with comorbid mental and physical health conditions were associated with physical health expenditures.[6]

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Despite the connections between behavioral and physical health conditions, many Medicaid enrollees experience gaps in care due to the lack of coordination and information sharing between medical and behavioral health providers, which can result in adverse outcomes for patients with comorbid conditions. People with behavioral health conditions also tend to receive less preventive care and lower-quality physical health care, a disparity that may be affected by the stigma associated with behavioral health conditions.[7]

Physical-Behavioral Health Integration

Many physical and behavioral health providers say that integrated care better meets the needs of patients with multiple co-occurring conditions. **Integrated behavioral health care (integrated care)** is defined by the Agency for Healthcare Research and Quality as: "the care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."[8]

Clinical integration references processes to advance integrated care at the point of service delivery, and is often represented as a continuum beginning with coordinated care and then co-located care, with the highest level defined as full collaboration in a transformed/merged integrated practice.[9] While clinical integration can be implemented in different settings that serve different populations, integration of behavioral health into primary care settings most frequently targets people with mild to moderate mental health conditions. Integration of primary care into behavioral health settings targets adults with SMI and SUD and children with serious emotional disturbances (SED) who may have high levels of physical health comorbidities. There is growing evidence that clinical integration can improve health outcomes and quality of life as well as reduce health care costs.[10] Many states have initiated efforts to pursue clinical integration, especially for vulnerable populations of high-need Medicaid enrollees.[11]

One barrier states face in advancing clinical integration for Medicaid enrollees is separate financing structures for physical and behavioral health care. For many years, most states with Medicaid managed care programs have "carved-out" behavioral health benefits from physical health benefits. While the majority of states organize and finance physical health benefits through comprehensive managed care organizations (MCOs), mental health and SUD services have been administered by separate managed behavioral health organizations (which are often public entities) or on a fee-for-service basis. Under such systems with a person's care managed by multiple entities, consumer access to care and care coordination can be diminished, resulting in worse health outcomes.[12]

In recent years, several states have transitioned to **integrated financing** models by contracting with integrated managed care plans that manage all physical and behavioral health services for Medicaid enrollees, to decrease fragmentation of care, improve health outcomes, and reduce costs. A primary goal of these programs is to enhance providers' access to data, incentives, and tools to deliver integrated services and coordinate care across settings. The potential of integrated physical-behavioral health *financing* to improve *care and outcomes* hinges on whether the integration of

financing supports integration at the clinical level, and whether consumers — particularly those with complex health and social needs — receive care that is better coordinated.

To examine whether integrated financing is delivering on the promise of improved clinical integration and coordination at the practice level, the Center for Health Care Strategies (CHCS), with support from Blue Shield of California Foundation and the California Health Care Foundation, conducted interviews with leaders of nine provider organizations in three states — Arizona, New York, and Washington — that have implemented integrated Medicaid managed care programs.

Most interviewees reported that their state's movement toward plan-level financial integration has accelerated their organization's clinical integration progress. Providers identified three key levers for successfully advancing integrated care that are described in this brief:

1. **Integrated data-sharing and quality measures** to use with plans and providers;
2. **Payment and business practices** that align financial incentives for providers to deliver integrated care, including adoption of value-based payment arrangements; and
3. **Integration in clinical service delivery**, including adoption of clinical practices that foster integrated care delivery, such as service redesign, assessments, staffing, and care planning.

Whereas the overall feedback from interviewees highlights the promise of financial integration, many providers also identified challenges and unintended consequences resulting from the design and implementation of state transitions to integrated financing. This brief shares insights from both positive and negative experiences that can inform future state efforts to advance clinical integration.

Recommendations for other states seeking to advance integration follow each of the three thematic sections. These recommendations identify critical decisions for states related to both the design of integration policies and the transitions to and ongoing monitoring of integrated managed care programs.

Profiled States and Providers

This brief draws on interviews with providers in Arizona, New York, and Washington. These states were selected based on their recent and diverse approaches, as summarized below, to implementing integrated managed care. (See **Appendix 1** for additional details about each state's transition, including a timeline and description of how providers were paid during each phase.)

Arizona

In 2013, Arizona's state Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), began integrating the financing of physical and behavioral health services for certain populations. Before 2013, MCOs were primarily responsible for physical health services, while most Medicaid behavioral health services were carved out of AHCCCS Medicaid MCO contracts, and separately managed by Regional Behavioral Health Authorities (RBHAs). Through a geographically phased rollout that launched in 2014, newly integrated RBHAs began managing physical and behavioral health services for adult Medicaid enrollees with SMI. In 2018, integrated AHCCCS Complete Care (ACC) plans began managing both physical and behavioral health services for enrollee populations that previously enrolled in separate plans, including: (1) children with SED; (2) adults

with SUD; and (3) adults and children with mild-to-moderate behavioral health needs. An evaluation of 2013-2014 integration initiatives found improvement in all measures of patient experience, ambulatory care, preventive care, and chronic disease management. Hospital-related measure results were mixed, however. While the majority of these measures, such as 30-day post-hospitalization for mental illness follow up rate, showed improvement, some measures such as inpatient utilization rate showed a performance decline.[13]

New York

Prior to 2015, most specialty behavioral health services in New York were carved out of managed care plans and provided via fee-for-service. In 2015, New York began transitioning all adults eligible for Medicaid managed care to receive physical and behavioral health benefits from an integrated managed care plan, and created a new type of health plan, called a Health and Recovery Plan (HARP). HARPs are separate products within existing MCOs for adults with SMI and serious SUD diagnoses, and have additional requirements for care management and newly added home- and community-based services benefits. New York is phasing in integrated managed care plans and HARPs for children in 2019, along with expanding covered mental health and SUD services for children and their families. New York issued a request for proposals in January 2019 to evaluate this behavioral health demonstration, including improvements in health and behavioral health outcomes for enrollees in integrated MCOs.[14]

Washington

Before 2016, three separate entities managed physical and behavioral health care in Washington: (1) all physical health as well as behavioral health services for individuals with mild to moderate needs were managed by MCOs; (2) specialty mental health services for enrollees with SMI were managed by Regional Support Networks (RSNs) that subcontracted with community mental health agencies to deliver care; and (3) SUD services were administered through multiple regional and state contracting mechanisms. In 2016, the Washington Health Care Authority (HCA) began implementing fully integrated managed care, phased in by region. Under the fully integrated managed care model, MCOs provide physical and behavioral health services to adults and children, while the state contracts with administrative service organizations in every region to deliver crisis services to Medicaid and non-Medicaid enrollees. An evaluation of integration efforts for adult populations in an early adopting region found statistically significant improvement in 10 out of 19 enrollee outcomes in 2016 and 11 out of 19 enrollee outcomes in 2017, including access to preventive/ ambulatory health services, SUD treatment penetration, and mental health treatment penetration.[15] Most other outcomes did not show significant relative change, though two outcomes (comprehensive diabetes care — hemoglobin A1C testing and emergency department (ED) utilization per 1,000 coverage months) showed statistically significant unfavorable changes. Notably, the unfavorable change in ED utilization in the early adopting region was measured in comparison with the rate of decreased utilization in other regions, which had higher historical rates of utilization.

Interviewed Providers

In each state, senior Medicaid and behavioral health officials identified and assisted in recruiting interviewees from among provider organizations who collectively have sought to advance clinical integration across various settings and an array of subpopulations. The profiled organizations, as a

result, include many leading-edge providers with valuable insights on the lessons, challenges, and benefits of clinical integration, though this group is not representative of the full range of provider experiences related to transitioning to integrated financing models.

As summarized in **Table 1,** the interviewed providers had different lengths of experience working with integrated managed care plans ranging from six weeks to six years, and included providers serving adults and children and delivering an array of primary care, mental health, and SUD services.

Table 1. Interviewed Providers

Provider	Population Served	Services Provided	Transition(s) to Integrated Managed Care
ARIZONA			
Children's Clinics	More than 5,000 children with complex chronic diagnoses, primarily children with Children's Rehabilitative Services (CRS) conditions [16]	Primary and mental health care for families, rehabilitative therapies, pediatric specialty care, and multidisciplinary clinics	2013. CRS members began receiving services managed by one statewide integrated CRS plan; as of 2018, services for CRS members are managed by integrated ACC plans
Partners in Recovery	More than 8,000 adults with SMI	Mental health services including assertive community treatment (ACT), psychosocial rehabilitation/peer services, primary care, and health and wellness services	2014. Members with SMI began receiving services managed by integrated RBHA
Bayless Integrated Healthcare	More than 20,000 adults and children for primary care including children with mild to severe behavioral health needs and adults with mild to moderate behavioral health needs	Behavioral health services including substance use, primary care, and school-based physical and behavioral services	2018. Adults and children received services from integrated ACC plans; previously, adults and children received behavioral health services through a RBHA while and physical health services through another MCO
Happy Kids Pediatrics	More than 40,000 children	Primary care	2018. Most children began receiving services managed by integrated ACC plans
NEW YORK			
Institute for Community Living (ICL)	More than 10,000 adults and children, including individuals with mental illness and intellectual and developmental disabilities	Mental health, supportive services, and service-enriched housing*	2015. New York City region transitioned to integrated MCOs and HARPs
Access: Supports for Living	More than 8,000 children and families with mental illness, substance use disorders, and/or intellectual or developmental disabilities	Behavioral health services (including all Certified Community Behavioral Health Clinics services), care management, supportive services, and service-enriched housing*	2016. New York State (non-New York City) transitioned to integrated MCOs and HARPs
WASHINGTON			
Clark County Community Services	As a county government agency, serve the more than 465,000 residents of Clark County	Funder of non-Medicaid mental health and SUD services, housing and homeless services, permanent supportive housing, and other services; directly manage crisis responder services	April 2016. Region transitioned to fully integrated managed care
Catholic Charities of Central Washington	More than 3,000 children and adults	Counseling and behavioral health services, family support services, early learning and child services, and affordable housing*	January 2018. The North Central region transitioned to fully integrated managed care
Mid-Valley Clinic	Children and adults	Multispecialty clinic certified as rural health clinic delivering primary, specialty, and surgical care as well as behavioral health services	January 2019. County transitioned to fully integrated managed care

** Also partners with a federally qualified health center to deliver integrated physical and behavioral health care in at least one clinical setting.*

Provider Insights on the Impact of Integrated Managed Care on Clinical Integration

All nine interviewed providers have embraced new opportunities to better integrate care in their clinical settings to more effectively serve patients with physical and behavioral health needs. Many interviewees said their state's transition to integrated financing facilitated provider-level data-sharing, quality measures, and aligned financial incentives. Those improvements accelerated clinical integration and care coordination; however, the extent of this acceleration depended on a wide range of factors, including the state's approach to integration, the underlying managed care and policy environments, and characteristics of the local delivery system.

Following is a discussion of three levers that are critical for driving clinical integration in new financially integrated programs: (1) integrated data-sharing and quality measures; (2) payment and business practices, and (3) integrated clinical service delivery. Each section includes examples of strategies that promote integration; as well as challenges that need to be addressed to fully embrace these changes in new integrated models. Finally, each section concludes with several policy recommendations for states to consider as they design and implement integrated programs.

1. Integrated Data-Sharing and Quality Measures

Financial integration creates a lever for plans and providers to share more comprehensive data about patients' physical and behavioral health diagnoses, utilization, referrals, and treatment plans, because health plans now have access to data across a broader continuum of services. Providers can use integrated data to better understand the array of patient needs; assess the gaps in care; coordinate treatment plans; identify high-cost, high-need patients; and develop targeted quality improvement activities. Plans can use comprehensive data from providers to support providers' activities to better coordinate and close gaps in care as well as to develop and refine performance measures and financial incentives. However, while all providers interviewed spoke about the importance of bidirectional exchange of data to better manage consumer needs, the extent to which providers' access to data increased after a transition to integrated managed care varied. Factors that improved providers' access to and use of data include: (1) partnerships and infrastructure that enable information-sharing with managed care plans; (2) investments in health information exchanges; and (3) plan-provider collaboration on developing integrated quality measures to enable greater accountability for performance.

Data-Sharing with Integrated Managed Care Plans

Some behavioral health providers said that the transition to integrated financing had a rapid and game-changing impact on data-sharing, noting that they began receiving data from plans and thus could more effectively identify and engage high-need patients. In Arizona, leadership at Partners in Recovery said that in the previous system of carved-out behavioral health services, providers had limited access to physical health data, and thus, "we were blind to half of the conditions that our patients have." Following the transition to integrated RBHA plans for adults with SMI, Partners in Recovery immediately began receiving primary and acute care utilization data. These data uncovered, for example, that one Partners in Recovery patient had visited the ED 96 times in the past year, with 24 inpatient admissions — and that Partners in Recovery providers had never known

about these visits. Now, Partners in Recovery can identify and engage patients at high risk for acute care utilization to find alternatives to visiting the ED. Similarly, Catholic Charities in Washington began receiving extensive encounter data following the transition to fully integrated managed care, including from local jails that shared data with integrated MCOs. Catholic Charities can now proactively engage patients with behavioral health conditions such as SUDs immediately after law enforcement encounters.

The experience of real-time data-sharing was not universal, however. Some providers in states that had transitioned to integrated care within the last six months observed that newly integrated plans may require additional time to understand behavioral health services before they can more effectively organize and analyze data for bidirectional data-sharing with providers. There may be system incompatibilities too. Behavioral health providers are generally less likely than physical health providers to have or use health information technology. Among those who do use this technology, managed care plan data systems may not be compatible with behavioral health providers' electronic health records (EHRs). Additionally, physical and behavioral health providers may need to redesign their EHR not only to incorporate new data inputs across multiple provider types, but also to highlight the specific elements most relevant for different provider types and protect sensitive data in accordance with federal and state confidentiality regulations. Providers agreed that investments from plans and providers will be critical to future improve data-sharing capabilities.

Most interviewed behavioral health providers experienced an increase in the number of entities that pay for services as a result of the transition to integrated managed care, which has consequences for data-sharing. Working with a single or small number of integrated plans, as opposed to a large number, may offer opportunities to improve data-sharing through closer plan-provider collaboration. In Arizona, Partners in Recovery works primarily with one integrated RBHA. These two organizations partnered to develop a population health platform using comprehensive clinical and claims data, allowing Partners in Recovery to "accelerate the use of data for care management in ways that were unimaginable before an integrated RBHA." On the other end of the continuum, a provider working with more than 10 different MCOs in another state described significant challenges in receiving and working with data across all entities, especially when consumers frequently change plans. As a result, this provider is reliant on older claims data, limiting effectiveness to inform interventions.

Leveraging Health Information Exchanges

Providers reported multiple benefits of participating in information-sharing through a state electronic health information exchange (HIE), and highlighted the importance of real-time hospital data alerts to better identify and engage high-risk patients. In 2016, all three of Arizona's integrated RBHAs invested in a statewide plan to integrate physical and behavioral health data in the HIE, which also exempts behavioral health providers from participation fees.[17] The state has reported significant increases in behavioral health provider participation in this HIE.[18] In Arizona, when Partners in Recovery providers receive an HIE alert that a patient has visited a hospital, they immediately communicate with that hospital to understand the underlying reasons for the visit and intervene, if necessary, to help the patient access care in the most appropriate setting. In New York, the statewide HIE connects regional health information organizations to store and share electronic health data.[19] Access: Supports for Living (Access) in New York is an early adopter of the regional HIE

and can pull real-time utilization data to target patient outreach. Each morning, Access receives an email listing of all patients who presented at a hospital the previous evening, and clinical leaders then participate in a morning huddle to discuss these patients and develop strategies for follow-up care to prevent readmissions. Additionally, the HIE allows Access to see data on recent inpatient discharges and the New York State Office of Mental Health database provides data on quality measures, so staff can focus on engaging patients at risk for gaps in care. For example, staff now use these systems to proactively engage individuals who are prescribed anti-psychotics and have not received clinical testing for diabetes.

Quality Measures

Increased data-sharing can improve accountability for provider performance. Providers, often in collaboration with integrated plans, are using new approaches to evaluate consumer outcomes across physical and behavioral health domains and across different service lines. For leaders at Access in New York, using Healthcare Effectiveness Data and Information Set (HEDIS) quality measures to understand the impact of the behavioral health services they provide on physical health outcomes served as a "real awakening for us to think about whole health care, and changed how we measured our outcomes." Leadership at Bayless Integrated Healthcare in Arizona described using HEDIS measures to assess the effectiveness of different evidence-based mental health treatment practices for patients with co-occurring conditions.

Using Quality Measures to Drive Integrated Care

For Catholic Charities in Washington State, the transition to fully integrated managed care led to a focus on developing a new "whole person care data set" designed to track outcomes related to integrated health care. This data set includes relevant measures related to physical and behavioral health conditions as well as social determinants of health (SDOH) and patient activation measures (PAM) to assess self-care and advocacy. Catholic Charities plans to work with its integrated MCOs to incorporate HEDIS measures into this data set, and use its performance on these quality measures in negotiating risk contracts.

Increased access to data can also support the design of clinical processes that may improve consumer health and quality of life outcomes. While managed care plans have a long history of using a robust set of physical health data to assess the quality of physical health services and measure outcomes, they may have a steep learning curve in understanding how behavioral health services — and integrated care — can affect both physical and behavioral health outcomes. In newly integrated systems, providers can leverage robust data on physical and behavioral health to build more effective partnerships with plans and capture the interconnectedness of physical and behavioral health in care models.

Data and Quality Measures: Policy Recommendations for States

Access to integrated physical and behavioral health data is critical for providers to effectively meet the needs of patients with co-occurring conditions. Interviewees offered many insights on how to most effectively leverage newly available data from integrated managed care plans as well as from other providers to improve the clinical delivery of care. Additionally, many noted that their abilities as providers to access and analyze integrated data, and to be assessed on specific quality measures, will help integrated plans more effectively understand the impact of behavioral health services on health outcomes and improve value-based payment reforms for behavioral health providers. Following are data and quality measure recommendations for states to consider in designing and implementing integrated managed care:

1. Facilitate the development of robust data-sharing protocols between integrated plans and providers prior to the launch of integrated plans.
2. Invest in behavioral health provider readiness on data-sharing and interoperability, including design and adoption of electronic health record systems for integrated care.
3. Invest in electronic health information exchange across medical, behavioral health, and acute care providers to enable all providers to most effectively coordinate and reduce gaps in care.
4. Consider the impact of the number of integrated plans on provider data-sharing and ability to be held accountable for patient outcomes.
5. Develop a quality measure set, with stakeholder input, including process and outcomes measures that collectively assess accountability for meaningful outcomes for individuals with physical and behavioral health needs. These measures should be included in integrated managed care plan contracts as appropriate.

2. Payment and Business Practices

With the appropriate financial, infrastructure (such as billing, data collection and reporting, and information technology), and human resource supports in place to adopt new payment and business models, payment levers can accelerate providers' capacity to deliver integrated care. While not all state transitions to integrated financing models included changes to provider payment structures at the outset, integrated financing can better align system incentives to deliver integrated care and promote provider accountability for managing a more complete range of services. Interviewees noted that following transitions to integrated care, many pursued different business practices, such as participating in state incentive programs, implementing value-based payment (VBP) arrangements, and developing new business relationships. Finally, many providers identified opportunities for states to mitigate administrative burden related to the transition to integrated managed care, which may be particularly relevant for behavioral health providers that have not previously worked with managed care.

Incentive Programs and Value-Based Payment Arrangements

Interviewees described the transformative potential of new payment models, including state incentive programs and value-based contracts, to support their efforts to improve health outcomes through clinical integration. AHCCCS launched the Targeted Investments Program through a 2017 amendment to Arizona's section 1115 demonstration beginning in 2016, and invested $300 million

to support both physical and behavioral health providers in developing the infrastructure for integrated care.[20] Participating providers receive incentive payments annually, contingent on meeting milestones applicable to their provider type. (See **Appendix 2** for additional information about Targeted Investments provider eligibility requirements, milestones, and payments.) Interviewees said this program effectively incentivizes communication protocols between medical and behavioral health providers and care coordination for high-risk patients. Physical and behavioral health providers work toward different milestones, but also have opportunities to work together to improve care and receive incentive payments. Providers highlighted the importance of collaborating to define high-risk patients and identify areas of clinical overlap where both types of providers could improve care.

In other states, even where state policy has largely maintained existing payment structures, partnerships with integrated managed care plans are allowing some behavioral health providers to begin participating in VBP arrangements that incentivize clinical integration. For example, although the transition to integrated care continued the underlying fee-for-service payment system for behavioral health provider payments, New York concurrently rolled out an extensive VBP initiative that included a number of voluntary opportunities to promote incentives and accountability for integrated care.[21] Access participates in Coordinated Behavioral Health Services, a behavioral health independent practice association (IPA) focused on integrated behavioral and physical health. It also holds a value-based contract with an integrated MCO that will shift later this year to an arrangement with both upside and downside risk. Also in New York, Institute for Community Living has partnered with Healthfirst (an MCO that offers a HARP plan) in a HARP VBP pilot.[22] Representatives of both providers said that they have improved health outcomes and are better-prepared to participate in future VBP arrangements because of their participation in these arrangements.

Other providers have worked closely with their integrated managed care plans, and in some cases with their state Medicaid agency, to develop and refine VBP arrangements that advance integrated physical and behavioral health services. Plans may also be able to make investments in critical capacity areas that allow providers to meet requirements for new payment models, such as information technology, and data collection and reporting capacity. Bayless Integrated Healthcare in Arizona has value-based contracts with most ACC plans, and has worked closely with these plans to educate them about behavioral health care models, payment rates, and coding practices, among other things, to develop financially sustainable contract terms. Similarly, Children's Clinics in Arizona has collaborated with plans and AHCCCS to develop behavioral health quality measures for VBP models. As part of this effort, Children's Clinics negotiated a wraparound rate for key behavioral health services that were not previously reimbursable. Similarly, Partners in Recovery in Arizona receives incentive payments from its partner RBHA based on physical health performance measures such as increasing the number of patients with diabetes who receive an annual retinal eye exam. To achieve this objective, Partners in Recovery now works with a local optometrist and coordinates appointments for their clients within their clinics.

New Business Relationships

Adoption of new integrated financing models can drive physical and behavioral health providers to explore new partnerships. In 2018, Arizona's Happy Kids Pediatrics began working with integrated ACC plans in 2018, and also established a partnership with a behavioral health provider to offer co-located physical and behavioral health services to more effectively meet the behavioral health needs of its patient population. The potential for incentive payments from the Targeted Investments Program strengthened the business case for this new collaboration. For pediatric primary care providers such as Happy Kids Pediatrics, the Targeted Investments Program outlines 20 core components and related milestones tied to provider payments to advance the objective of integrating primary care and behavioral health services for both preventive and chronic illness care.[23] For example, milestones require communications and care management protocols with other providers and with MCOs, and patient attestations that warm hand-offs for newly identified behavioral health needs occurred 85 percent of the time. Other milestones require the development of practice-specific action plans to improve integration, using the Standard Framework for Levels of Integrated Healthcare continuum[24] to track progression between coordinated, co-located, and integrated levels of care. These milestones, among others, incentivize practices such as Happy Kids Pediatrics to enter into these partnerships.

Additionally, multiple providers interviewed across different states have partnered with federally qualified health centers (FQHCs) to create integrated practices. The Institute for Community Living in New York recently partnered with an FQHC to develop an integrated health hub, which includes primary care, mental health, care management, and a family resource center. Still however, in these partnerships, the physical and behavioral health providers may be using different EHRs, and providers are exploring different approaches to addressing this challenge.

Provider Payment and Business Practice Challenges

The experience of behavioral health providers transitioning to integrated managed care is shaped by the previous mechanisms under which they reimbursed for mental health and/or SUD services. (See **Appendix 2** for additional detail on how behavioral health provider payment mechanisms changed related to the transitions for specific populations by state.) In states where providers previously received payment from a single entity for services or via a block grant, transitioning to working with private plans as well as multiple payers can lead to administrative challenges. For example, some behavioral health providers transitioning to integrated managed care experienced revenue issues in the months immediately following the transition. They also described increased rates of claims denials and delayed payments until they became familiar with all of the specific processes and requirements of different integrated MCOs. While many of these issues were resolved in the months immediately following the transition, some providers reported ongoing administrative burden to manage billing with multiple plans, and identified the need to hire additional administrative support staff to process encounters in accordance with the requirements of each integrated plan.

Some providers, especially smaller behavioral health providers, may have limited financial resources, which may impede their ability to meet the data, reporting, and billing requirements of working with managed care plans. Mergers may help providers manage these financial challenges by improving access to supporting infrastructure, creating economies of scale, and increasing negotiating power.

Some interviewees described the financial pressures on smaller behavioral health providers in a changing market with evolving payer and provider relationships, and noted that integrated financing may have the effect of accelerating consolidation of the behavioral health provider market.

Even as Medicaid agencies move toward integrated financing, other state policies and procedures can impede capacity to develop new service lines and business models. Some providers described challenges becoming credentialed with plans to provide both physical and behavioral health services, even though they had integrated licenses. One behavioral health provider struggled to secure primary care credentials from the integrated MCOs, which contributed to the decision to partner with an FQHC to set up an integrated clinic.

Payment and Business Practice Reforms: Policy Recommendations for States

Many providers have pursued new payment and business arrangements that facilitate clinical integration. However, some behavioral health providers described "living in the gap" between focusing on improved outcomes and quality measures and being paid for fee-for-service encounters. Providers identified greater opportunities for integrated managed care plans to pay for value. Following are payment and business practice reform recommendations for states to consider in designing and implementing integrated managed care:

1. Develop methodologies inclusive of behavioral health services in VBP models that incentivize high-value integrated care.
2. Invest in provider readiness and system capacity to participate in VBP arrangements, tailoring this support to the unique considerations of smaller behavioral health providers.
3. Develop state-administered incentive or other investment programs to foster clinical practice changes, build system infrastructure and capacity to enable integrated care delivery, and improve communication between physical and behavioral health providers.
4. Consider the impact of the number of integrated plans on provider contracting and administrative burden.
5. Identify needed reforms to licensing and credentialing to enable providers to deliver and be paid for integrated care.

3. Integration in Clinical Service Delivery

Across care settings and patient populations, integrated financing has created new opportunities and energy for interviewed providers to move toward clinical integration of physical and behavioral health services to more effectively meet the needs of their patients. The focus of clinical changes varied among providers interviewed, and included service and staffing redesign, screening and assessment practices, care coordination, and interventions to address SDOH. Providers are leveraging new data-sharing opportunities, payment incentives, and partnerships with managed care plans and other providers to accelerate their ability to deliver integrated care that encompasses physical and behavioral health as well as social needs. States can create policies to further drive these activities, including streamlining oversight activities at the state level, making investments or using plan requirements that encourage investments in provider training and capacity building, or developing incentives to drive integration at the service delivery level.

Service and Staffing Redesign

After transitioning to working with integrated plans, many providers have increased their capacity to deliver integrated care by redesigning the services delivered and staffing arrangements. When Partners in Recovery in Arizona began working with an integrated RBHA, it introduced primary care into its behavioral health settings, and focused on increasing member engagement around physical health and wellness. Partners in Recovery used newly available data on its patient population from the RBHA to identify opportunities to impact modifiable health behaviors, and subsequently established a teaching kitchen and fitness center where newly hired staff lead cooking and exercise classes. As a result of the transition to fully integrated managed care, Catholic Charities in Washington State redesigned services around the holistic needs of the communities it serves to improve the quality of care, including using patient surveys to inform quality improvement and hiring a client services manager. This initiative has increased its ability to deliver earlier interventions for populations with rising risk.

Some providers have focused on expanding integrated care delivery to new settings. Several providers have pursued partnerships to allow them to open clinics with co-located physical and behavioral health services. For example, since opening the East New York Health Hub in partnership with the Community Healthcare Network, an FQHC, Institute for Community Living reported that many of its patients who were previously disconnected from primary care providers can now have same-day visits, resulting in improved access to preventive care. Also in New York, Access partners with an FQHC on an integrated clinic for individuals with serious behavioral health needs, and has recently expanded its offerings to include SUD services, including medication-assisted treatment. Access is in the process of opening two behavioral health urgent care centers to help individuals with acute needs access high-quality care outside of an ED and then engage in ongoing treatment. In Arizona, the transition of children's behavioral health to integrated ACC plans led Bayless Integrated Healthcare to partner with plans on developing integrated school-based clinics. Services delivered at these clinics include primary care, psychiatry, therapy, and wellness coaching with a focus on destigmatizing children and families with mental health needs. Developing these clinics to provide comprehensive care for the whole family only became financially viable when they could reimburse to the same MCO for an entire family's physical and behavioral health services. Before, the siloed funding streams for children and adults limited its ability to serve children.

Bridging Differences Across Providers

Providers need to bridge cultural as well as clinical differences to integrate physical and behavioral health models of care.

At Children's Clinics in Arizona, leadership observed that behavioral health providers often contributed expertise in holistic assessments of individual and family situations, while physical health providers were more experienced with tracking data and outcomes. Creating integrated teams requires leadership to merge these different strengths and perspectives and foster open and productive communication and education. These integrated provider teams — particularly care coordination staff — benefit from training on these varying approaches to care and the continuum of physical and behavioral health needs.

Screening and Referrals

While most physical and behavioral health providers have historically only screened their patients for the needs that they themselves treat, many providers reported that they now use more expansive screenings that are required by the state as part of their contracts with MCOs. For example, Catholic Charities in Washington State includes questions about physical and behavioral health as well as family situations and SDOH. In Arizona, Children's Clinics leadership said that they introduce these conversations to patients by saying, "We're going to ask you questions that you've never been asked before, and you will see providers you never thought you would see all at the same time. Your appointment has to be a little longer now, but we're doing this because we think it's going to give you a better life." One provider, however, cautioned that lengthy intake appointments could deter consumers from accessing care. Interviewees said that intakes may require two hours to complete, and that they are looking for opportunities to increase efficiency while also capturing vital information.

Beyond initial assessments, many providers are incentivized under integrated managed care to conduct periodic screenings. In particular, behavioral health providers have an increased focus on screening patients for chronic physical health conditions. When an assessment identifies an unmet need, providers strive for warm handoffs to the appropriate staff or external providers with referrals and patient follow-ups as needed. Arizona has developed guidance and specific targets for assessments and management of identified high-risk populations for participating providers in the Targeted Investments Program. One participating provider, Happy Kids Pediatrics, used to refer patients with behavioral health needs to external providers, but would not receive any follow-up information afterward. Now, in response to Targeted Investments measures, they conduct a warm hand-off to their co-located behavioral health partner and ensure that a patient is seen within five days to receive the full intake and develop a treatment plan.

Integrated Care Plans and Care Coordination

When held accountable for quality measures and closing gaps in care across all health needs, some providers have invested in integrated care planning and coordination within their clinical practices. Many of the interviewed providers produce a single integrated care plan across all health needs and conduct weekly care coordination meetings with both physical and behavioral health staff to discuss the highest-risk patients. Integrated service plans, created by physical and behavioral health providers as well as patients and family members, have "transformed the quality of care that a family receives," said a Children's Clinics interviewee. These plans equip all providers with the necessary understanding of patient goals and treatment plans across different clinical practices. At Partners in Recovery, clinicians collaborate on patient-centered integrated care plans for high-need patients. These plans draw on the organization's innovative approach of using functional behavioral assessments to review high-utilizers' ED records, and incorporate input from patients, family members, and other providers to better understand the root causes for preventable ED visits.

Providers pursuing integrated care also more actively engage other treating providers or other partners to ensure that patients experience well-coordinated care. Partners in Recovery promotes coordination between physical and behavioral health providers through daily integrated care touchpoints to discuss all patients coming in that day. Access in New York now provides care

management services in EDs and focuses on care transitions when patients leave acute care settings, including by coordinating care with peer service organizations when a patient leaves a psychiatric hospitalization. As discussed in the earlier section on integrated data-sharing and quality measures, Access conducts daily huddles to discuss patients admitted the previous night, as well as weekly huddles with partner organizations to coordinate care for individuals with complex needs or with a gap in their physical health quality indicators, such as a missing screening. New partners include child welfare services staff who join huddles for high-risk children. Finally, when working across multiple provider types and equipped with comprehensive data, providers can conduct real-time medication reconciliation for prescribed medical and psychotropic medications.

Additionally, many states pursuing integrated managed care require newly integrated MCOs to conduct more robust coordination of care management at the plan level, especially for high-need populations. Liaisons from MCOs worked on-site at the Arizona-based Children's Clinics to meet with patients and coordinate care, and other interviewed providers described closely collaborating with MCO care management staff. Providers cited the value of MCO care management in identifying gaps in care, coordinating patient outreach, and addressing patient questions related to plan coverage or communications.

Expanding the Focus on Social Determinants of Health

Leadership at Clark County Community Services (Clark County) in Washington State bring a unique perspective on how the transition to integrated managed care can affect the resources allocated to address social determinants of health. As the social service agency in county government, Clark County previously managed multiple funding sources for behavioral health services. When many of these funding sources were moved to integrated MCOs or the regional Behavioral Health Administrative Service Organization, the county experienced greater flexibility to target their local behavioral health funding to initiatives that address social determinants of health. This new organizational flexibility mirrored a broader commitment, across plans and providers, to ensure that the care delivered extends beyond the clinic walls. County leadership noted that "care integration is bigger than just physical health and behavioral health; it is about whole person care," as one of the most significant impacts of the transition to fully integrated managed care.

Social Determinants of Health

For many providers, transitioning to integrated physical and behavioral health has also led to greater organizational focus on SDOH. In addition to incorporating questions related to SDOH on screenings and assessments, providers frequently identified new service delivery initiatives to address SDOH. While some providers, such as the Institute for Community Living in New York, have long offered supportive housing services, others are expanding their work in this area. In Washington State, the Medicaid agency created Accountable Communities of Health (ACH) within each region to better align health resources to improve health and address all medical, behavioral, and social needs. ACHs engage a broad group of stakeholders from different sectors and communities and offer training to providers.[25] Providers there said ACHs centralize resources to address SDOH in clinical work, as well as in aggregate data and inform regional planning on issues related to SDOH. The Mid-Valley Clinic, a North Central Washington rural health clinic in early stages of integrating behavioral health services, described

these ACH trainings as very valuable. The trainings and resources also equip organizations with practical skills such as motivational interviewing for integrated care coordination.

Integrated Clinical Service Delivery: Policy Recommendations for States

Interviewees say delivering integrated care has led to service delivery transformations to address physical and behavioral health needs as well as SDOH. Many providers noted opportunities for states to more effectively support these efforts in the transition and implementation of integrated managed care. They also underscored the foundational importance of data-sharing and payment reforms to help them transform clinical care delivery. Following are recommendations related to clinical service delivery for states to consider in designing and implementing integrated managed care:

1. Invest in provider training and capacity-building for clinical integration to foster adoption of evidence-based and promising practices. Consider assigning responsibility for clinical integration to a single statewide agency to ensure that providers can access available resources.
2. Collaborate with providers and managed care plans to develop guidance on integrated screenings and other assessments that align with quality measures. Develop infrastructure for providers to share assessment information to avoid duplication of efforts.
3. Ensure that consumers with co-occurring physical health, mental health, and SUD needs can receive same-day services and coordination for multiple conditions. States might consider requirements that managed care plans facilitate integrated care management.
4. Incentivize the development of integrated service plans across physical and behavioral health needs, with requirements to engage patients and families.
5. Provide comprehensive monitoring and oversight of access to integrated care as well as all quality measures to identify any disparities in the care delivered.
6. Identify opportunities for providers to incorporate assessments and interventions related to SDOH into their service delivery, and, where applicable, consider the unique role for county-based entities in coordinating planning and service delivery related to SDOH and social needs.

Looking Ahead

States interested in developing or refining integrated managed care models can glean valuable lessons both from the emerging evidence in formal evaluations of patient outcomes in integrated systems, and from the on-the-ground experiences of providers in these systems. Providers have identified important elements in the design and implementation of effective integrated programs, from data-sharing to payment mechanisms to specific interventions to foster integrated clinical delivery. These broad considerations reflect the importance of thoughtful design of physical-behavioral health integration initiatives, including managed care plan requirements and state policies that will shape providers' ability to integrate care at the clinical level.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center committed to improving health care quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit **www.chcs.org**.

Appendix 1. Summary of Transition to Integrated Managed Care in Profiled States

Year	Population	Overview of State Approach	Primary behavioral health provider payment mechanisms before transition	Primary behavioral health provider payment mechanisms after transition
ARIZONA*				
2013	Children's Rehabilitative Services (CRS) Enrollees	Integrated all physical, behavioral, and CRS specialty services to be managed by a single statewide MCO.	Providers received payments from a statewide CRS plan for specialty CRS services, and single regional RBHAs for behavioral health services.	Providers receive payments from a single statewide MCO for primary, specialty, and behavioral health services.
2014 - 2015	Enrollees with SMI	Integrated all physical and behavioral health services to be managed by an integrated RBHA, with one integrated RBHA available in each region.	Providers received payments from single regional RBHAs for specialty behavioral health services.	Providers receive payments from single regional integrated RBHAs for primary and all behavioral health services.
2018	General Adult (non-SMI) and Children **	Integrated all physical and behavioral health services to be managed by an integrated ACC plan, including adults with mild to moderate mental health or substance use needs.	Providers received payments from single regional RBHAs for behavioral health services for adults with general mental health and substance use needs and children.	Providers receive payments from between two and seven integrated ACC plans for all primary and behavioral health services for this population.
NEW YORK				
2015 - 2016	Adults	Integrated all physical and behavioral health services for adults to be managed by an integrated MCO, which could be either a mainstream Medicaid managed care plan or a HARP.*** The number of available plans varies by region, with up to 11 plans in the New York City region.	Providers received payments from mainstream MCOs for mild to moderate behavioral health services, and from the state Medicaid agency for specialty behavioral health services.	Providers receive payments from integrated MCOs (mainstream MCOs or HARPs) for all physical and behavioral health services.
2019	Children	Began transition of children into integrated mainstream MCOs and HARPs in 2019, which requires transitioning six 1915(c) waivers to an integrated Section 1915(c) waiver and then a Section 1115 waiver authority. HARPs will be required to contract with health homes for children, which began operating in 2016.	Providers received payments from mainstream MCOs for mild to moderate behavioral health services, and from the state Medicaid agency for specialty behavioral health services.	Providers receive payments from integrated MCOs (mainstream MCOs or HARPs) for all physical and behavioral health services.
WASHINGTON				
2016 - 2020	Adults	Integrated all physical and behavioral health services for adults and children to be managed by one of up to three integrated MCOs, with integration phased by region.	Providers received payments from mainstream MCOs for mild to moderate behavioral health services, from the Regional Service Network (RSN) for mental health services, and from county governments for SUD Services.****	Providers receive payments from between three and five integrated MCOs for all physical and behavioral health services.

***Other Arizona Medicaid enrollees either have transitioned to integrated managed care at other times (including enrollees eligible for Arizona Long-Term Care Services, and those dually eligible for Medicare and Medicaid) or are planned to transition by 2020 (including children in foster care).*

*** CRS enrollees transitioned at this time from receiving coverage from a single statewide integrated CRS plan to selecting one of several available ACC plans.*

**** HIV Special Needs Plans may also be integrated MCOs.*

*****For regions that transitioned after 2016, RSNs transitioned to become managed behavioral health organizations responsible for both mental health and SUD services.*

Appendix 2. Arizona Targeted Investments Program[26]

Arizona's Targeted Investments (TI) Program is designed to incentivize behavioral health integration in the state's Medicaid program. Three types of Medicaid providers are eligible to participate: primary care, behavioral health, and hospitals, each with its own eligibility requirements as outlined below. The TI program is authorized under AHCCCS' Section 1115 Waiver for five years beginning in 2016. Under the program, managed care plans provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for Medicaid beneficiaries.

Provider Eligibility Requirements		
Primary Care Provider	**Behavioral Health Provider**	**Hospital**
■ Providers must have a minimum assigned AHCCCS members across all health plans with which they are contracted. ■ Providers must attest to having: ○ An electronic health record (EHR) that can exchange and use electronic health information from other systems without special effort on part of the user, and; ○ Completed a behavioral health integration assessment using one of the AHCCCS-specified tools.	■ Providers must have delivered an AHCCCS-defined minimum number of qualifying outpatient services to members during a recent 12-month period. ■ Providers must attest to having: ○ An EHR that can exchange and use electronic health information from other systems without special effort on part of the user, and; ○ Completed a behavioral health integration assessment using one of the AHCCCS-specified tools.	■ Hospitals must have had an AHCCCS-defined minimum number of qualifying member discharges across all health plans during a recent 12-month period. ■ Hospitals must attest to having an EHR that can exchange and use electronic health information from other systems without special effort on part of the user.

TI Payments. Financial incentives are paid on an annual basis to participating eligible providers. The table below describes how providers can qualify to receive incentive payments for each year of the program.

TI Program Incentive Payments Timeline	
Year	**Payment Contingencies**
Year 1 (10/16-9/17)	Contingent on acceptance into program.
Year 2 (10/17-9/18) **Year 3** (10/18-9/19)	Contingent on completing core component milestones, which vary by provider type and concentration. Below are examples of milestones for primary care providers focused on adults with behavioral health needs.[27] For a list of milestones for behavioral health providers and hospitals working with adult and pediatric populations, refer to the TI years 2 and 3 core components and milestones on the TI program overview website.[28] 1. Utilize a behavioral health integration toolkit and practice-specific action plan to improve integration and identify level of integrated healthcare 2. Identify members who are high-risk and develop electronic registry; Demonstrate use of identification criteria and document members in registry 3. Utilize care managers for members in high-risk registry; Demonstrate that care manager(s) are trained in integrated care 4. Implement integrated care plan 5. Screen all members to assess SDOH 6. Develop communication protocols with physical health and behavioral health providers for referring members 7. Screen all members for behavioral health disorders 8. Utilize the Arizona Opioid Prescribing Guidelines for acute and chronic pain 9. Participate in the health information exchange with Health Current 10. Identify community-based resources 11. Prioritize access to appointments for all individuals listed in high-risk registry 12. Participate in any TI program-offered training
Year 4 (10/19-9/20) **Year 5** (10/20-9/21)	Contingent on meeting or exceeding performance targets. Performance targets to be determined.

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