services. The table compares the experiences of states that have achieved varying levels of behavioral health and physical health integration or collaboration for dually eligible beneficiaries in a managed care environment. States are implementing their models of integration (e.g., comprehensive care-management models, specialty plans for beneficiaries with serious mental illness, hybrid models, and coordinated care-carve-out models) through contracts with Medicare-Medicaid Plans or Medicaid managed care plans that are aligned with Medicare Advantage Dual Eligible Special Needs Plans.

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

- **States can drive integration by combining operational and oversight functions.** States can integrate at the state administrative level, blend payment at the health plan level, and set contract requirements that enhance connections between entities needed for care coordination.
- **State leadership is crucial to improve information sharing.** States can require information sharing agreements, build the "backbone" for information sharing through Health Information Exchanges, and fill information gaps.
- **State guidance on federal and state laws protecting behavioral health information can assist with information sharing.** State guidance would limit misinterpretation of laws, which impedes information sharing for care management.
- **States should seek to balance prescriptiveness with flexibility, particularly in the area of care management and coordination, when setting plan contract requirements.** States can provide guidance to health plans on developing essential elements of integration but give them the flexibility to innovate and build on existing relationships and infrastructure.
- **Misalignment of the recovery model of care in behavioral health systems and the medical model of care in physical health systems can be the most difficult challenge to overcome during integration at the state, health plan, and provider levels.** Strategies to address misalignment include: bringing in behavioral health leaders; consistently affirming an understanding that helping people with behavioral health conditions requires an emph637xm The lack of performance measures for behavioral health is a significant limitation to program monitoring and quality improvement. While federal and state policymakers, measure developers, and endorsers of measures continue to broaden the suite of behavioral health measures, states and plans could benefit by selecting measures that align with national efforts and by using national standards for measure development.
- **Realistic expectations can help state and health plans with self-evaluations.** The benefits of integration will take time to emerge. Health plan representatives recommended giving it a year, with early benefits showing up primarily in the form of process changes that reflect a greater focus on whole-person care, and anticipating initial increases in behavioral health expenditures while looking for decreases in overall health care spending over time.

I. Introduction

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

Multiple models of physical and behavioral health integration exist, including those within managed care and those built on health homes.

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

- Select measures that align with larger, national efforts to develop and test measures for behavioral health.[37] For example, some measures vetted for specific care settings may need to be tested in other care settings, or new measures may need to be developed to fill measurement gaps (e.g.,

- Develop shared vo

3. Care Management Teams and Care Coordination Activities

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

When given the opportunity to determine the best rolan

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

- Connecting with systems that address social determinants of health. Understanding the importance of social determinants of health is integral to the behavioral health recovery model of care. That understanding can lead to connections with systems addressing those needs. An Arizona health plan integrated an assessment of social determinants of health into case management software so that case managers can address issues of homelessness and safety. In addition, the plan is working on connecting to a "human services campus" – a campus for the homeless that provides shelter and supportive services such as employment services.

5. Integration at the Provider Level

The full benefit of integration can only be realized when it is occurring at the practice level, with providers aware of both behavioral and physical health conditions and to consider their interplay to appropriately provide care. States can encourage health plans to adopt strategies to drive provider accountability for integrated care.[45] Several plans noted that asking providers to become knowledgeable in a new area, particularly a complex area like

Appendix A1. Methods

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

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

State	Target Population	Responsible Health Plan	Medicaid Plan Contractors Required to Offer D-SNPs[a]	Medicaid Plan Contractors Required to Subcontract/Partner with BHO or Contract with Specific BH Providers	Physical and Behavioral Health Services Provided by Responsible Health Plans on a Capitated Basis
Texas	Dually eligible beneficiaries	MMPs	N/A		

[c] Texas requires STAR+PLUS Medicaid managed LTSS (MLTSS) plans to offer a D-S

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

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

- Perform baseline stratification that categorizes beneficiaries by level of physical and behavioral health needs (for example, level 1 = low physical health/low behavioral health needs and level 4 = high physical health/high behavioral health needs)
- Develop and use an integrated care plan in care management for at least 500 members with the partnering BHO or MCO
- Attest that for 90 percent of hospital admissions, the BHO or MCO is notified within one business day of admission

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

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

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

Best practices to support these principles include:

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

[a] Slides on promoting behavioral health privacy principles within One Care available at: https://onecarelearning.ehs.state.ma.us/

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[39] The National Quality Forum provides an explanation of criteria in the August 2016 document "Measure Evaluation Criteria and Guidance for Evaluating Measures for Endorsement" available at: http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx.

[40] The 2016 quality assessment and performance improvement strategy for the Tennessee Bureau of TennCare is available at: https://www.tn.gov/assets/entities/tenncare/attachments/qualitystrategy.pdf. The AHCCCS quality assessment and performance improvement strategy, which was revised October 2012, is available at: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/quality.html.

[41] Ragone 2016, et al.

[42] Additional information on the Medicaid MCO's supportive housing program is available at: http://files.kff.org/attachment/Issue-Brief-Linking-Medicaid-and-Supportive-Housing-Opportunities-and-On-the-Ground-Examples.

[43] The Medicare Benefit Policy Manual is available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf.

[44] Managed care trainings and tools developed by the Managed Care Technical Assistance Center (MCTAC) are available at http://ctacny.org/about-us.

[45] The Health Care Payment Learning and Action Network (HCP-LAN), a network of health care stakeholders, developed an alternative payment model (APM) framework to align multipayer efforts to advance APMs and to track progress nationally. The framework describes payment models by degree of provider risk and advancement. HCP-LAN was convened by the CMS Alliance to Modernize Healthcare, a federally funded research and development center. The APM framework is available at: https://hcp-lan.org/workproducts/apm-whitepaper.pdf.

[46] Assertive Community Treatment is an evidenced-based practice for "delivering a full range of services to people who have been diagnosed with a serious mental illness" (SAMHSA website).

[47] While a growing evidence base suggests that integration leads to improved care and reduced costs, the evidence has been focused on specific populations (e.g., adults with depression and anxiety disorders). A 2016 MACPAC report on integration noted that most studies have focused on integration at the practice level, "leaving many questions unanswered about the effects of financial and administrative integration efforts that are underway in Medicaid programs." The report is available at: https://www.macpac.gov/wp-content/uploads/2016/03/Integration-of-Behavioral-and-Physical-Health-Services-in-Medicaid.pdf.