Managing Managed Care Plans to Promote Physical-Behavioral Health Integration in States

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Abstract of Dissertation

Managing Managed Care Plan to Promote Physical-Behavioral Health Integration in States

One option that state Medicaid programs interested in better integration of physical and behavioral health services have is to align payment of these services by using one Medicaid managed care contract. This option is consistent with a national trend toward moving more services and populations into Medicaid managed care in order to achieve better quality of care at a lower cost, and is therefore attractive to states. However, the success of that approach in driving better integration of physical and behavioral health services at other levels of the system depends on how the new Medicaid managed care contract is implemented.

The states of Kansas and Texas both carved new behavioral health services into their Medicaid managed care contracts in 2013 or 2014 in an effort to promote better integration of physical and behavioral health services. This dissertation builds case studies using document review and interviews with state personnel, managed care plans, and providers/ advocates in order to understand how these two states employed their authority, policy incentives, and ideas to advance the goal of integrated care beyond the payment level. The goals of this research were to understand how these strategies were used to promote additional levels of integration in the state, including at the administrative level, the managed care plan level, and the clinician level (through enhanced coordination, collaboration, and/ or collocation of care), while continuing to advance the goal of maintaining beneficiary access to high quality behavioral health care through the managed care plans. Contextual barriers that existed in each state to make integration efforts more difficult were also examined.

At the administrative level, Kansas was unable to integrate, due to implementation issues and the different goals held by the behavioral health and Medicaid agencies. Texas had a more successful approach, streamlining administration through their Medicaid agency but bringing key stakeholders in to advise the agency.

At the managed care plan level, both states struggled with improving integration. Managed care plans did not fully utilize their position as a central hub for information about each beneficiary's health care by providing needed information to the providers who were caring for them. They also did not clearly delineate care management responsibilities between themselves and providers.

At the clinical level, successful efforts at clinical integration at the community mental health center (CMHC) level were spawned in both states by alternative payment strategies put in place by the managed care plans. Only one of the two states (Texas) contractually required this of their managed care plans, but efforts proliferated in both states.

In Texas, the involvement of key stakeholders in the design and implementation of integration efforts was key to ensuring that all stakeholders were working toward common goals and was critical to the overall success of the state. A legislatively-appointed stakeholder body that issued recommendations regarding how oversight of the program should proceed was particularly effective because the recommendations were vetted by people at many different levels of the system.

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Chapter 1: Introduction and Purpose

Current efforts to expand the coordination of mental health and substance abuse (hereafter referred to collectively as "behavioral health") services with physical health services for Medicaid beneficiaries proliferate at both the state and national levels, due in part to the implementation of the Affordable Care Act (as described in detail later in this paper). One way that states are supporting better integration of these services and improved care coordination, while also managing health care costs, is by carving Medicaid specialty behavioral health services into comprehensive managed care contracts that also cover physical health services. In 2013 and 2014, four states (Arizona, Florida, Kansas, and Texas) achieved this level of integration (McGinnis & Houston, 2016). States could choose to oversee the implementation and administration of these newly aligned Medicaid programs using a variety of mechanisms. For example, they could use their authority, policy incentives, or a culture of ideas to generate ground-level innovation. The aim of this research was to understand how two of these four states (Kansas and Texas) leveraged these different mechanisms to incentivize managed care plans to provide and promote integration of physical and behavioral health services and understand how these mechanisms promoted care delivery and care integration at the provider level.

This study focused on Kansas and Texas in order to learn more about states' early experiences and strategies to oversee behavioral health benefits and promote care integration. Weiss' theory of policy intervention was used to identify the levers that states can use to ensure that managed care plans implement new benefits to advance integration. Strategies included ideas (such as research, technical assistance, training, or

demonstration projects) and inducements (such as contractual requirements, policy/ regulatory authority, coordinated efforts with other agencies, financial incentives or reporting requirements) to oversee the integration of new behavioral health benefits with physical health benefits.

Chapter 2: Background

Explanation of Behavioral Health Services

The term "behavioral health" refers to both mental health and substance use disorder (SUD) services, which have a long history of being offered through systems separate from Medicaid. While state Medicaid programs typically offer a comprehensive array of physical health services, mental health and SUD have historically been offered through less well-developed systems that are staffed and financed separately. For example, each state has a Single State Agency, which is responsible for obtaining and administering federal SUD funds such as the substance abuse prevention and treatment block grant, as well as developing and regulating services. States may also have a separate state mental health authority, which obtains and administers mental health funding such as the mental health services block grant, defines covered services, and sets payment rates for those services. However, today there is renewed focus on offering behavioral health services (mental health and SUD) in a more integrated way, as well as better integrating behavioral health services with physical health services so that patients can receive more holistic care.

One reason that policymakers are focused on better integration of mental health and substance abuse services is because these disorders often co-occur. Research investigating the relationship between these two types of diseases dates back to the 1970s. Early studies found that a wide range of mental health disorders were affiliated with SUD (Sciacca, 1991; DeLeon, 1998). Studies found that those seeking treatment for SUD had rates of co-occurring mental health disorder between 50 and 75 percent, and

between 20 and 50 percent of those seeking treatment for mental health disorder had co-occurring SUDs (Sacks, Sacks, DeLeon, Bernhardt & Staines, 1997). Because rates of co-occurrence of these two types of disorders are high, the federal government has begun to promote integrated care, by offering grants to states to improve treatment, as well as by conducting research and providing technical assistance (SAMHSA, 2016).

State Medicaid policymakers have begun to focus on improving services for those suffering from a behavioral health disorder in part due to incentives in the Affordable Care Act (discussed later in this paper). States are also focusing on these disorders because they tend to be chronic in nature, need better integration, and can also co-occur with chronic physical health conditions, which make them costly. The Robert Wood Johnson Foundation sponsored a synthesis of the evidence on physical and mental health co-morbidities and found that at least 68% of adults with a mental health disorder had a co-morbid physical disorder (Goodell, Druss, Reisinger & Walker, 2011). These factors result in behavioral health patients having high expenditure diseases with rapidly escalating costs (Dickey & Hocine, 1996). The National Institute of Mental Health reported that total expenditures for mental health conditions went up from $35.2 billion in 1996 to $57.5 billion in 2006 (National Institute of Mental Health, 2015).

People with mental health and substance abuse conditions seek care for these respective conditions in different types of settings, as seen in Figure 1. The settings of care currently being used by patients are important to understand, because these providers need to be involved in efforts to coordinate care. Mental health and substance abuse services are undergoing a transformation as care shifts from inpatient hospital settings and becomes more outpatient-based (explained in further detail in the following section).

However, the hospital remains a common place for patients with severe disorders to receive care for both types of conditions. Patients seeking SUD treatment are more likely than those seeking mental health treatment to be seen in a specialty facility, whereas those seeking mental health treatment are more likely to be seen by an office based professional such as a psychiatrist. Both types of patients are increasingly turning to pharmaceuticals, and drugs were a large driver of cost growth, though they accounted for a much higher percentage of spending for mental health patients overall (Mark, Yee, Cutler, Camacho-Cook, Cummings, Ogiefo & Walsh, 2015)

Figure 1: Percentage of Spending Attributed to Different Types of Care Settings, 2014

Care Setting	Percentage of Spending Attributed to Care Setting	
	SUD Patients	Mental Health Patients
Specialty Centers	38%	14%
Hospitals	33%	27%
Office-Based Professionals	15%	17%
Long-Term Care	2%	7%
Pharmacy	4%	27%
Insurance Administration	8%	8%

Source: Behavioral Health Spending and Use Accounts: 1986-2014. Submitted to SAMHSA. September 29, 2015. By Tami Mark, Tracy Yee, Eli Cutler, Jessica Camacho-Cook, Nicholas Cummings, Ame Ogiefo & Christine Walsh.

Importance of Medicaid to Mental Health and SUD Services

As the largest public payer for mental health and SUD services, Medicaid plays an important and growing role in defining the availability of behavioral health services

for people who need them.[1] The importance of Medicaid as a payer for mental health services has grown rapidly. Medicaid paid for 17% of mental health spending in 1986. By 2005, Medicaid accounted for 28% of mental health expenditures (Garfield, 2011) and is predicted to grow to 30% by 2020 (Mark, Levit, Yee & Chow, 2014). In 2011, 9.86 million Medicaid enrollees were diagnosed with a behavioral health condition. These individuals cost Medicaid a total of $131.18 billion dollars, and represented about 20% of all Medicaid enrollees. This small group of enrollees represented 48% of all Medicaid spending (for all of their sources of care) (MACPAC, 2015), representing a tremendous cost savings opportunity for state Medicaid programs.

The group of people with a behavioral health condition are comprised of both children and adults. Most children on Medicaid who were diagnosed with a behavioral health condition in 2011 were not eligible for disability or child welfare assistance (3.09 million compared to .69 and .32), although the latter two groups are the most costly (MACPAC, 2015). Children with behavioral health diagnoses tend to suffer most often from attention deficit disorder / attention deficit hyperactivity disorder (ADD/ADHD), followed by depression, behavioral or conduct problems, anxiety, substance use disorder, autism, or Tourettes syndrome (Centers for Disease Control, 2013). Those on Medicaid were also very likely to suffer from a learning disorder, a speech or language problem, or a developmental delay (MACPAC, 2015).

Most adults on Medicaid (not dually eligible for Medicare) who were diagnosed with a behavioral health condition in 2011 were similarly not eligible for disability (1.53 million adults were eligible through disability compared to 2.22 million who were not).

[1] Mental health and substance use disorder benefits will be collectively referred to as "behavioral health benefits" throughout this paper.

The costs associated with adults eligible for Medicaid due to their disability status were substantially higher than for those who were not (MACPAC, 2015). Nearly thirty-seven percent of adults on Medicaid suffered from a mental illness or drug abuse, and adults on Medicaid were more likely than those with private insurance or those who were uninsured to suffer from a mild, moderate, or severe mental illness (MACPAC, 2015).

Medicaid's role is typically combined with other funding mechanisms to create a fragmented system by using different purchasers to pay for different types of services and providers. In 2013, most community mental health services nationwide were covered by a mix of Medicaid funding, block grants from federal agencies like SAMHSA, and state general funds. Supported employment, residential services, state psychiatric hospitals, and inpatient services were all primarily supported by outside sources (state general funds and Medicare) (SAMHSA, 2013).

Medicaid's role as a purchaser of behavioral health services can also complicate efforts to integrate behavioral health services with other types of services because of legal, regulatory, and administrative barriers associated with the program. One such barrier is the Medicaid Institutions for Mental Diseases (IMD) exclusion, found in section 1905(a)(B) of the social security act. It prohibits Medicaid payment for inpatient care provided to patients between the ages of 21 and 65 who are receiving care in an institutional setting, and includes hospitals, nursing facilities, and other institutions with more than 16 beds that provide diagnosis, treatment or care for people needing mental health treatment. The law has been a part of Medicaid since its inception in 1965 and was designed to ensure that states had primary responsibility for funding inpatient psychiatric services. It inhibits access to residential facilities for Medicaid patients.

CMS has at times approved 1115 waivers designed to waive the IMD exclusion. The waivers were recently reinstituted by the Center for Medicaid and Medicare Services in a bulletin published on July 27, 2015. The bulletin informs state Medicaid Directors of new options for using 1115 demonstration programs to offer a care continuum for individuals with SUD so that states may receive federal financial participation for costs that are not eligible otherwise (such as the IMD exclusion) (CMS Informational Bulletin: Medication Assisted Treatment for Substance Use Disorders, 2014). In order to take advantage of this option, states will be expected to meet a variety of expectations, including providing comprehensive, evidence-based benefit design, including Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening services, withdrawal management, medication-assisted treatment, care coordination, and long-term services and supports. CMS also expects states to increase their quality standards for providers and build a strong network of providers, improve care coordination and care transitions, improve integration of physical health and mental health, safeguard against fraud and abuse, ensure that clinically intensive services are medically necessary, improve community integration, develop strategies to address prescription drug abuse and opioid use, improve services for adolescents and youth with substance use disorder, improve quality measure reporting, and improve collaboration between Medicaid and other relevant agencies.

Further, a new Medicaid managed care rule provides new regulations which will allow states to request permission for federal reimbursement for Medicaid beneficiaries ages 21-64 receiving services in an eligible facility if their stay is 15 days or less from a hospital, nursing facility or other institution with more than 16 beds providing mental

health or substance use disorder treatment. The rule covers hospitals and inpatient facilities providing psychiatric or SUD crisis residential services, but does not include non-crisis residential SUD services.

Historic Changes in Behavioral Health Service Delivery

The growth of Medicaid's role in defining the scope and delivery of mental health services available in the United States has been shaped by the history of mental health services and changes to public policy. Instituted in 1965, Medicaid caused major restructuring of state mental health systems by shifting the financial responsibility for these services from state governments to the federal government. A study by Rashi Fein (1958) found that states were responsible for approximately 59% of overall spending on mental health services in 1956, before the Medicaid program was established in 1965. By 1971, state spending had dropped to approximately 23%, where it has remained (Frank & Glied, 2006).

Accompanying this shift was a profound change in the way that services were delivered, as states had tended to focus resources on the development of state mental hospitals and affiliated institutional settings, and the federal government encouraged community-based treatment. For example, the federal government spurred the development of community mental health centers through the Community Mental Health Act of 1963, which provided federal funding for community mental health centers and encouraged deinstitutionalization. In 1955, inpatient spending constituted 77% of mental health spending (Frank & Glied, 2006). By 1975, this figure had dropped to 28% (U.S. President's Commission on Mental Health, 1978).

This shift was advanced in 1999 by a Supreme Court decision *Olmstead v. L.C.,* a decision spurred by two women, Lois Curtis and Elaine Wilson, who were confined in mental hospitals long after their treatment ceased and they were declared ready to be moved to a community institution. *Olmstead v. L.C.* said that unjustified segregation of people with disabilities constitutes discrimination and is in violation of the Americans with Disabilities Act, and that public entities need to provide community-based services when such services are appropriate.

Affordable Care Act Incentives for States to Expand Mental Health Coverage

The role that federal Medicaid law plays in the evolution of mental health and substance abuse services will continue to grow because of the ACA, which expanded the Medicaid program to adults with incomes below 133% of the federal poverty level. By December, 2015, 30 states had adopted Medicaid expansion, expanding Medicaid enrollment to 10,728,200 newly eligible enrollees (Kaiser State Health Facts). Notably, Kansas and Texas were not among the states that decided to expand Medicaid.

Medicaid expansion will also infuse state Medicaid systems with new federal dollars, providing necessary financial resources to support state behavioral health systems. Spending for mental health services is estimated to increase 7.8% by 2020 in states that expanded Medicaid (Mark, Levit, Yee & Chow, 2014). The Medicaid expansion population was supported 100% by federal money through 2016; the rate of federal support will now gradually decline until 2020, when this population will be supported 90% by federal funds (assuming current law stays in place).

Furthermore, the ACA provides new regulations that encourage states to expand the behavioral health benefits that will be covered by Medicaid, and expansion of these

benefits creates a new incentive to provide well-coordinated care for individuals with both physical and behavioral health needs. Two key mechanisms in the bill encourage expansion of these benefits: a requirement of mental health parity, (SAMHSA, 2016) which newly applies the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicaid; and the inclusion of behavioral health services in the ACA's 10 essential health benefits.

The MHPAEA mandates that benefit limitations can be no more stringent for mental health services than for medical/surgical services. It is particularly focused on financial requirements (such as co-pays) and treatment limitations (such as numbers of covered days), and includes requirements for parity in both quantitative (such as the aforementioned) and non-quantitative treatment limitations, such as prior authorization and other medical management processes.

On November 13, 2013, a final regulation was published in the federal register that aims to "prevent inequity between those who have mental health and substance abuse benefits in the commercial market and Medicaid" (SAMHSA, 2016) by improving the availability of mental health and substance abuse services. The Mental Health Parity and Addiction Equity Act required managed care plans to provide financial requirements and treatment limitations for behavioral health services that are on par with those offered for physical health benefits. The effectiveness of meeting this aim will be determined by how this law is implemented from state to state. In fact, some states (such as New York via "Timothy's Law") were already offering parity in their Medicaid programs prior to the law's enactment, though each state's definition of parity differed. A summary of key

provisions of 33 key state parity laws was published in 2003 (Rosenbach, Lake, Young, Conroy, Quinn, Ingels & Crozier, 2003).

However, MHPAEA does not mandate that behavioral health coverage be provided. It simply ensures a minimum standard for behavioral health benefits that are provided. But, the ACA also contains a requirement that states cover 10 essential health benefits. One of these mandated benefits is behavioral health coverage. The following types of plans must have the 10 essential health benefits, according to the new law: 1. Insurance plans sold through the state health insurance exchanges; 2. Small group and non-group plans that do not participate in the exchanges and do not have "grandfathered" status; 3. Medicaid benchmark and benchmark-equivalent plans for individuals who are newly eligible for Medicaid (Farley, 2011). Federal regulations were written to be flexible, and did not prescribe a single benefits package that must be provided. Instead, states were granted broad leverage by the United States Department of Health and Human Services (HHS) to determine which specific services and procedures within each benefit category would be covered and to what extent. States were permitted to select their own "benchmark" plan to serve as a baseline for the essential health benefits package in the state. States were permitted to choose between four options, including: 1. Any of the three largest small-group plans in the state; 2. Any of the three largest state employee health plans; 3. Any of the three largest federal employee health benefits program (FEHBP) options; or 4. The largest insured commercial non-Medicaid HMO plan operating in the state (Farley, 2011).

A paper published by the Commonwealth Fund found "significant variation in how states have developed their essential health benefits package, including their

approaches to benefit substitution and coverage of habilitative services." (Giovannelli, J., Lucia, K. & Corlette, S., 2014). States had the option of extending full Medicaid coverage or a selected benchmark benefit, which may provide a more limited range of behavioral health services. For example, if a state chose the more limited benchmark benefit, individuals with psychiatric disabilities could lack access to the rehabilitation and recovery-focused services often available to Medicaid beneficiaries (Bazelon Center for Mental Health Law, 2014). Forty-five states and the District of Columbia chose a small-group, limited benchmark plan (Farley, 2011).

Definitions of Physical and Behavioral Health Integration

There are multiple levels and definitions of integration, particularly at the clinical level. In 2013, SAMHSA published a paper which outlined a continuum of integrated physical and behavioral health care, based on the level of collaboration occurring within the system. Using this framework, SAMHSA identifies the following six levels of integration, focusing at the clinical level (SAMHSA-HRSA Center for Integrated Health Solutions, 2013):

1. Coordinated care with minimal collaboration;
2. Coordinated care with basic collaboration at a distance;
3. Co-located care with basic collaboration onsite;
4. Co-located care with close collaboration and some system integration;
5. Integrated care with close collaboration approaching an integrated practice; and
6. Integrated care with full collaboration in a transformed/ merged practice.

The Agency for Health Care Research and Quality (AHRQ) further defined integrated care as "care that results from a practice team of primary care and behavioral

health clinicians working together with patients and families and using a systematic, cost-effective approach to providing patient-centered care for a defined population. This care may address mental health and SUD conditions, health behaviors, life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization." (Zivin, O'Malley, Bigby, Brown & Rich, 2016).

MACPAC clarified in their March, 2016 report to Congress that integration can happen at additional levels of the Medicaid system. Their report expands the definition of clinical integration, which includes care coordination, colocation, data sharing, and working with external partners, as described above, to include screening and referral to treatment (an evidence-based practice called Screening, Brief Intervention and Referral to Treatment (SBIRT) is most commonly considered, though the definition also includes mental health screenings and basic monitoring of physical health conditions by behavioral health providers). The report also considers interdisciplinary training of providers to be a feature of clinical integration.

System-level integration is characterized by MACPAC as happening at an administrative or payment level. A basic tenant of payment-level integration is to streamline a system in which funding for behavioral health comes from multiple sources. Similarly, integration that takes place at an administrative level streamlines the administration of behavioral health services from multiple state agencies (MACPAC, 2016). State Medicaid agencies that are uncertain of how to promote clinical level integration and want to achieve the cost benefits of Medicaid managed care may choose to streamline physical and behavioral health services at the payment level with the hope that integration will be pushed down to the clinical level. As part of their effort for

integrating payment of behavioral and physical health services into one Medicaid managed care contract, the state must determine what level of administrative integration is optimal, streamlining oversight responsibilities for the Medicaid and the behavioral health agencies.

Barriers to Clinical Integration

Limited Behavioral Health Workforce

Physical and behavioral health integration relies on a robust provider infrastructure to provide a full array of physical and behavioral health services. However, concern regarding a shortage of both physical and behavioral health workers has been a predominant theme of policy discussion in recent years, and is worsened by a reluctance on the part of some providers to accept Medicaid patients. Nationwide, provider shortages proliferate particularly in rural areas. In response to these shortages, the Health Resources and Services Administration (HRSA) tracks the areas of each state that have a shortage of health professionals.

SAMHSA sought to collaborate with HRSA to support investments in training the workforce to practice in integrated settings. In 2014, SAMHSA published Leading Change 2.0. Advancing the Behavioral Health of the Nation 2015-2018, which describes their efforts to reduce the impact of behavioral health on American communities. SAMHSA details efforts to improve availability of prevention services, improve integration of behavioral and physical health, establish trauma-informed treatment approaches, expand recovery supports, promote the use of health information technology, and improve the workforce supply needed to support new demands in behavioral health

care. As part of the latter goal, SAMHSA has established numerous grant programs meant to disseminate evidence-based behavioral health care, has provided technical assistance, and has developed cross-training programs for behavioral health, primary care, specialty care, and peer providers.

An April, 2015 report by the Congressional Research Service notes the interest Congress has taken in improving the cost of, quality of and access to mental health services, and that Congress has held hearings on these topics and introduced legislation. However, the report notes that most of the regulation of the workforce occurs at the state level through licensing and defining scope of practice for mental health professionals (Heisler & Bagalman, 2015).

Federal Rules Governing Private Health Information

Rules preventing sharing important health information about an individual across providers also inhibit physical and behavioral health integration. The two rules that govern how entities must handle confidential information are 42 CFR Part 2, enacted in the 1970s, and the Health Insurance Portability and Accountability Act (HIPAA), enacted in the 1990s. While HIPAA generally governs how protected health information must be handled, it does not require consent to release information for treatment purposes. However, 42 CFR Part 2 contains a provision requiring patient consent for all releases of identifiable health information which identifies the patient as having a past drug or alcohol problem, except in cases of medical emergency. This consent provision may be a barrier to integrated care, as the rules require written consent which identifies the purpose, timeframe, and organization that they are allowing their information to be shared with.

A new rule was proposed which allows more general designation for patient consent. This rule and Supplemental Notice of Proposed Rulemaking were formally published in the Federal Register on January 18, 2017. The new rule also allows for easier communication through electronic health records and includes a one year pilot project with 5 state health information exchanges to support physical and behavioral health integration through improved communication of health information. However, the effective date of the rule has been delayed from its original date of February 17, 2017, due to turnover in the Presidential administration.

State Rules Governing Information Sharing

Apart from adhering to 42 CFR and HIPAA, states often have laws which are designed to protect the confidentiality of patient information, and these laws can inhibit information sharing both on the provider level and among state agencies. In particular, a large number of complex laws can yield more variation in how the laws are interpreted, and behavioral health providers may tend to be more cautious than other types of providers in releasing information (Houy & Bailit, 2015). Complexity and confusion can also cause the process of releasing information to become slower and more time consuming. In Massachusetts, these barriers included a requirement to house SUD records separately from other health information and a “need to know” standard for authorizing access to health information (Houy & Bailit, 2015). Further, a study of barriers to integrated care in Massachusetts found that ‘Massachusetts regulations and organization interpreting these regulations do not envision a multidisciplinary, multiagency care team model when considering how the ‘need to know’ standard is applied (Houy & Bailit, 2015).

Licensure

Because physical health, mental health, and substance use disorder services historically have been provided and financed through different delivery systems, they have also typically been financed separately, which can lead to conflicting or overlapping standards. Early adopters, such as the state of Massachusetts, which have already tried integrating these separate systems are finding that legal, financial and regulatory barriers such as state licensing rules can impede successful integration. For example, in Massachusetts outpatient primary care clinics and mental health clinics are overseen by the Massachusetts Department of Public Health / Division of Health Care Quality, and substance use disorder programs are overseen by the Department of Public Health's Bureau of Substance Abuse Services, and there are different licensure standards for each facility type. Obtaining a license is resource-intensive and each facility type requires different program content, including treatment programs and discharge requirements, and has varying staffing requirements. Further, it is reported that there is not a common understanding of when the need to obtain an additional license would be triggered (Houy & Bailit, 2015). Massachusetts has identified options for addressing licensing barriers in the state, which include: 1. Issuing an administrative bulletin to clarify requirements (such as when a behavioral health facility offering outpatient primary care would trigger the need for a license or vice versa); 2. Simplifying requirements to recognize a behavioral health integration model; 3. Changing regulations (such as simplifying requirements for SUD programs to be less cumbersome or building more flexibility into staffing requirements); and 4. Allowing providers to waive some requirements. They also

recommended convening an advisory committee to inform regulatory revision, with input from key stakeholders (Houy & Bailit, 2015).

Billing

State Medicaid billing policy may contain restrictions that can limit the scope of physical and behavioral health integration. Common restrictions include limiting providers' ability to bill Medicaid for both a physical and a behavioral health service on the same day, and limiting behavioral health billing to particular types of providers (MACPAC, 2016). In addition, physical and behavioral health integration can require new services or the use of new provider types that haven't traditionally been billed by Medicaid, such as billing for care management services that promote physical and behavioral health integration, using community health workers or peer specialists to promote integration, providing warm hand-offs for services, billing health and behavior codes by Medicaid providers, and billing for telehealth services (Houy & Bailit, 2015). SAMHSA and the National Council for Behavioral Health have begun tracking Medicaid reimbursement requirements by state for the purpose of offering better support to providers as they try to surmount these reimbursement barriers.

Delivery System Options for Medicaid: Medicaid Managed Care vs. FFS

Since the 1990s, there has been increased use of Medicaid managed care plans to offer acute care services to expanded populations and geographic areas. (Howell, Palmer & Adams, 2012). States can choose whether to administer their Medicaid mental health programs using fee-for-service (FFS), which allows states to directly administer their program, or risk-based managed care, which is an arrangement through which states work directly with managed care plans to administer their Medicaid programs. A hybrid

arrangement known as primary care case management (PCCM) is similar to fee-for-service, while allowing a separate payment for case management activities. Administration of benefits using a managed care plan adds an additional layer of complexity because of the addition of managed care plans, but more a more predictable cost structure for the state. Successful implementation depends on state oversight.

Federal Laws Governing Oversight of Managed Care Plans

The Balanced Budget Act of 1997 governs state authority over managed care plans. Because of the Balanced Budget Act (BBA), states are not required to have a federal waiver to implement Medicaid managed care as long as they adhere to particular access and quality mechanisms. For example, the BBA says that states must have a service agreement with their managed care plans, must specify access requirements for provider networks, must provide external quality review (often provided through a designated external quality review organization), and must offer beneficiaries a choice of managed care plans; and that an actuary must designate rates paid to managed care plans as “actuarially sound”.

CMS released a final rule updating managed care regulations to be in better accordance with the goals of the ACA on April 25, 2016. In particular, these rules are intended to promote better integration of care and incorporation of higher need populations that have traditionally been excluded from managed care (Rosenbaum, 2015). Among other things, these rules support states in their efforts to reform their delivery systems, aims to expand coordination of care for beneficiaries with special

needs, and implements new rules limiting the amount of direction that a state can give to their managed care plans - for example, stating that they may partner with their managed care plan to pursue broad goals but may not direct expenditures - and a new "reasonableness" standard for coverage and authorization of services. The rules amend the time and distance standards, specifying that such standards must be set for behavioral health providers, and also provide factors that states must consider in setting those standards.

Chapter 3: Literature Review

Overall Research on the Impact of Managed Care on Cost, Quality, and Access

The action of including new behavioral health services in a risk-based managed care plan has both upside and downside potential that goes beyond any potential impact on integration that may be achieved. In much of this section, I discuss the potential impacts of risk-based managed care on care delivery, because continued provision of quality physical and behavioral health services is critical to the goals of integration.

Risk-based managed care offers numerous benefits to states, and is often touted as a way to improve quality of care while controlling costs. Managed care plans are often able to manage costs by overseeing health care utilization and negotiating payment with Medicaid providers. These roles could theoretically have positive or negative impacts on Medicaid beneficiaries (or both). Oversight of health care utilization could help drive the receipt of necessary preventive services, drive patients toward lower cost or more effective care, and prevent patients from over-utilizing certain types of services by impacting patient perceptions of their level of needed care, but also by impacting their access to it. Mechanisms that health plans use to drive changes in care include prior authorization, provider contracting and care management.

A tool used by managed care plans to oversee health care utilization is prior authorization. Prior authorization permits the managed care plan to obtain information about a patient and services sought and make a determination regarding whether the service is needed. Prior authorization procedures are touted as a way to control the utilization of unnecessary services but they could also inhibit or delay the receipt of

necessary services. The potential adverse consequences of prior authorization are often overseen by states by tracking patient appeals and complaints.

Another tool used by managed care plans to improve the cost of care is provider contracting. Provider contracting can result in higher quality care (by limiting provider networks to those who meet quality standards) or lower cost care (by limiting provider networks to those willing to offer services at a low price). However, provider contracting also restricts the network of providers that are available to beneficiaries. This is most commonly overseen by states through geoaccess reporting, which tracks provider networks offered by managed care plans by plotting members and providers on a map to ensure all members have proper access to providers.

A final tool used by managed care plans to improve quality and reduce costs is case management. Typically, select Medicaid beneficiaries (often those who are high-cost, high-need, as those with co-occurring physical and mental health conditions frequently are) are also offered case management services by their managed care plan. Case management programs identify high-risk or high-cost populations and offer them additional medical or social services to help manage chronic illness or prevent disease, and is key to the concept of care integration. This is the one service offered by managed care plans that may allow the Medicaid beneficiary to access additional care, rather than restricting it as prior authorization and provider contracting do (Anderson, 1995). For those who need behavioral health care, case management may offer help with housing, social services, or community support or improve integration of physical and mental health benefits. Case management may also be geared toward the needs of particular populations. For example, it is popular among managed care plans to identify those who

are most frequently using the emergency room and concentrate resources on improving the health status of this population. Goals for case management can be determined by the state or by the managed care plan; often the two work together.

A synthesis of the literature on the impact of managed care on cost, quality, and access was published by the Robert Wood Johnson Foundation in 2012. This synthesis found little evidence of cost savings due to Medicaid managed care, a mixed impact on access to care - it was likely to raise access to primary care and reduce utilization of inpatient and emergency room care-- and a lack of literature showing any discernable impact on quality of care (Sparer, 2012). None of the studies examined were specific to behavioral health carve-out plans.

Research on the Managed Care Carve-Outs

If a state chooses to offer separate physical and mental health benefits[2] and to use risk-based managed care to provide mental health benefits, the state may choose to use a specialty carve-out firm to provide mental health benefits. Carve-out plans typically have specialized expertise in providing mental health benefits and contracting with mental health providers.

A comprehensive literature review found that mental health carve-out plans are adept at reducing costs, primarily through directing patients to less costly providers for treatment. Studies generally find that behavioral health carve-outs reduce utilization of inpatient care (Burns, Teagle, Schwartz, Angold, Holtzman, 1999; Raghavan, Leibowitz, Andersen, Zima, Schuster & Landsverk, 2006; and Cook, Fitzgibbon, Burke-Miller, Williams, Kim, Heflinger & Stein-Seroussi, 2004). They are also broadly associated with reducing occupancy rates in private psychiatric hospitals, which were 72% in 1986 - the

[2] Most states offer separate mental health carve-out plans that do not include SUD services

year before the large-scale introduction of managed behavioral health - and had fallen to 63% by 1994 (Frank & Glied, 2006). One study looked at for-profit managed care plans as compared to not-for-profit plans and found that both reduced inpatient costs, but for-profit plans were also successful at reducing outpatient costs. (Bloom, Wang, Kang, Wallace, Hyun & Hu, 2011). Managed care plans may reduce outpatient costs by reducing the prices paid to providers, or limiting the number of visits per outpatient episode (Strum, 1999; Frank & Lave, 2003). Managed care for mental health services was also found to reduce psychiatric emergencies by 28% (Catalano, Coffman, Bloom, Ma, & Kang, 2005).

Individuals' utilization of mental health services is thought to be particularly sensitive to increases in out-of-pocket spending, another way that managed care plans may reduce their own costs. These changes in utilization can be both positive and negative. The RAND Health Insurance experiment, one of the first studies to examine the impact of out-of-pocket payments on utilization of health care, found that utilization of mental health care increased roughly twice that of ambulatory care in response to the same decrease in out-of-pocket costs (Newhouse, 1993; Manning, Wells, Buchanan, Keeler, Valdez & Newhouse, 1989). The RAND Health Insurance experiment provided an early assessment of decreased health care utilization caused by increased costs, and found these changes to be economically efficient. This literature provided an economic reason to limit mental health benefits and require large out-of-pocket payments.

Prior authorization processes are used by carve-out plans by restricting access to services that the health plan deems to be of little medical value and are a major concern for opponents of managed care. However, a study of the prior authorization processes of

51 health plans found little evidence of services being denied (0.8%) or approved at a lower level than that requested by the provider (1.3%) (Koike, Klap, & Unutzer, 2000).

Studies on the impact of prior authorization on drug regimes for those with behavioral health disorders have been more mixed. One study showed that prior authorization had a small but statistically significant impact on the utilization of some types of antidepressants, antipsychotics, and sedatives (Simeone, Marcoux, & Quilliam, 2010). Another found increased penetration of antipsychotic medications, reduced polypharmacy, and reduced adherence (Robst, 2012). Other studies have found negative impacts of prior authorization processes on the receipt of mental health care. For example, one study found reductions in prescribed psychotropic drug use and increased use of mental health services for beneficiaries with schizophrenia (McLaughlin & Ross-Degnan, 1994) and a second study found that prior authorization for non-preferred antipsychotics reduced the market share of those drugs in two states (Law, Ross-Degnan & Soumerai, 2008).

A study of the impact of managed care on adults with severe mental illness (SMI) finds that the risk arrangement has adverse impacts on quality when managed care plans and providers are not adequately funded to maintain a minimum standard (Ridgely, Mulkern, Giard & Shern, 2002). Another study found a strong association between a plan's total spending on their mental health enrollees and their access to specialty treatments, indicating that specialty services may be the first to get cut in a poorly funded environment (Weissman, Pettigrew, Sotsky & Regier, 2002). These studies indicate that adequately funding Medicaid managed care plans providing behavioral health services is

critical to ensuring access and quality of services, and may also be important to provision of high-quality additional services, such as care coordination.

Implementation Differences

Implementation differences between state mental health carve-out programs may account for differences in managed care's impact on cost, access (defined as provider contracting and workforce development), and quality (defined as prior authorization of services and care management) of mental health services. State policymakers must relinquish some level of control over their Medicaid program in exchange for managed care plans to draw on. Managed care also allows states to consider what they want to buy for their Medicaid dollars and ensure (using proper oversight mechanisms, such as contracts with managed care plans) that their managed care plans are held accountable for implementing Medicaid in a way that supports these goals.

A study published in 2000 examined whether and to what extent states were using Medicaid managed care to become more prudent purchasers by specifically examining how contracts and other oversight mechanisms were being used to support adequate financial performance by Medicaid managed care plans, quality assurance and quality improvement, adequate network capacity, and consumer protections such as the right to appeal a denied service. This study found that Medicaid managed care states had improved the amount and quality of data that they were collecting, but needed to make continued strides towards these goals. It also found that many states lacked adequate analytical or political capacity to use data to properly oversee managed care plans (Fossett, Goggin, Hall, Johnston, Plein, Roper & Weissert, 2000). Another study of state agency efforts to promote evidence-based practices in SUD treatment found that states

with indirect contact with providers, such as those with Medicaid managed care, used recommendations and requirements to ensure that beneficiaries were able to receive evidence-based practices, and identified a number of contextual barriers that could interfere with their goals (such as workforce, funding, integration and collaboration among medical settings - otherwise known as care management) (Rieckmann, Abraham, Zwick, Rasplica & McCarty, 2015).

Research on the Impact of Integrating Physical and Behavioral Health Services

The integration of physical and behavioral health services into one managed care plan (or system-level integration) is not expected to directly impact health outcomes for Medicaid beneficiaries (programs and infrastructure created by this integration, such as care coordination, may). Instead, it is expected to alleviate challenges associated with having separate funding streams, to create a Medicaid environment that is more conducive to achieving administrative and clinical integration (Zivin, O'Malley, Bigby, Brown & Rich, 2016).

Most research on integrated care has focused at the clinical level on the Collaborative Care Model, which is an evidence-based approach to integrating behavioral health services into a primary care setting. It is defined by four core elements: 1. It is driven by a multidisciplinary team in a coordinated fashion; 2. It is responsible for the provision of care for a population of patients; 3. It makes systematic use of patient-reported outcome measures to drive decisions, and 4. There is a strong focus on quality improvement by making use of new information to adapt evidence-based practices (Vanderlip, Rundell, Avery, Alter, Fortney, Liu, & Williams, 2016). Studies have demonstrated that the Collaborative Care Model improves behavioral health outcomes.

For example, the Cochrane Collaborative conducted a meta-analysis of 79 randomized control trials, which compared Collaborative Care to usual care for patients with depression and anxiety and found significant short- medium- and long- term effects for adults on both conditions, as well as other clinical outcomes such as medication use mental health quality of life, and patient satisfaction (Archer, Bower, Gilbody, Lovell., Richards, Gask, Dickens, & Coventry, 2012). Since the review was published, additional studies have advanced our understanding of the impacts of the model. One review suggests that of the four components of collaborative care, having regularly scheduled case management visits with a psychiatrist was particularly correlated with strong outcomes (Vanderlip, Rundell, Avery, Alter, Fortney, Liu, & Williams, 2016). A cluster randomized trial on pediatric behavioral health problems demonstrated the effectiveness of the model on behavioral health outcomes and patient satisfaction for children and their parents, (Kolko et al., 2014) and a second meta-analysis of integrating behavioral health services into primary care setting serving children also found significant effects on behavioral health outcomes, indicating that interventions that targeted particular diagnoses or symptoms had even greater effectiveness. (Asarnow, Rozenman, Wiblin & Zeltzer, 2015).

There have been few studies examining the efficacy of integrating physical health services into a setting designed to serve the needs of those who suffer from serious mental illness. One such study conducted of SAMHSA’s Primary and Behavioral Health Care Integration (PBHCI) program, which offers grants to behavioral health clinics to help them develop screening and referral services, a way to track their patients’ physical health needs and outcomes, care management, and prevention services, found evidence of

improved outcomes for co-occurring diabetes, cholesterol and hypertension (Scharf, Eberhardt, Horvitz-Lennon, Beckman, Han, Lovejoy, Pincus & Burnam, 2014). Another meta-analysis of randomized and non-randomized controlled trials of interventions designed to bring primary care into a behavioral health setting found evidence that the enhanced care management may improve mental health and mental health-related quality of life and improve use of preventive services and physical health symptoms (Gerrity, 2014).

Chapter 4: Theory

Overview

This research project focused on mechanisms that states use to oversee their managed care plans while encouraging the integration of physical and behavioral health services and continued provision of high quality behavioral health services. It drew on Janet Weiss' theory of policy intervention to frame current policy mechanisms that states may use to oversee managed care plans, but also invited states to discuss other mechanisms that they are using that fall outside of the proposed framework.[3] The theory of policy intervention relies on three interrelated theories to describe how change is affected: a theory of the problem, a theory of desired outcomes, and a theory of intervention (Weiss, 1999). Weiss argues that developing a deeper understanding of any of the three components can lead to social improvement. In an example, she demonstrates that the federal government was able to increase access to community-based mental health services without a clear theory of the problem by developing a clear theory of desired outcomes - improving community care and professional control - and establishing intervention mechanisms (Weiss, 2000).

Weiss encourages researchers to probe "in sophisticated ways into the possible influences that policy can exert on the behavior of individuals, groups, households, firms, nonprofit agencies, government agencies, and other … target actors" (Weiss, 2000). The primary aim of this research is to improve our understanding of the mechanisms states use to impact the behavior of managed care plans in the context of behavioral health, determine how those mechanisms can lead to improved integration of services, and identify opportunities to improve current guidelines governing managed care plans to

[3] The framework includes my application of Weiss' concepts to the Medicaid context

better respond to the needs of states promoting integrated behavioral and physical health care.

Policy Interventions

Weiss argues that there are three mechanisms that can be used to influence policy interventions: authority, policy incentives, and ideas. (Weiss, 1999). This research will determine the extent to which these mechanisms are used by states to help manage and guide behavioral health Medicaid managed care plans, and how plan operations impact providers and patients in turn.

It is important that states effectively exercise these options, as Medicaid managed care plans may have different incentives in administering a Medicaid program than the state government that oversees them. For example, many Medicaid managed care plans are for-profit enterprises that must produce financial results for shareholders. As such, states must adapt strategies to ensure that managed care plans manage behavioral health benefits in a way that advances the state's own goals. Additionally, the use of managed care plans severs the direct financial relationship between states and providers, and providers are no longer directly responsible to the state. Authority and policy incentives can be thought of as inducements; these are the components that are subject to legal or financial limitations. Weiss argues that the impact of ideas may be more enduring than inducements, because the effects of ideas can linger, while the impact of inducements will cease when the incentive ceases (Weiss, 1990).

Authority

Contracts

States exercise control over their programs by drawing up lengthy contracts with managed care plans, specifying requirements for case management, quality improvement, prior authorizations, provider networks, rate of payment, and ongoing communication between the state and plan. After contracts are signed, they collect regular reports from the managed care plans, and often hire an external quality review organization to review key reports and metrics on an ongoing basis.

Policy/Regulatory Authority

States can also write legislation, rules and regulations, or establish state plans and standards to govern Medicaid behavioral health systems. These mechanisms can be used to establish specific guidelines, criteria and mechanisms that managed care plans and affiliated providers must adhere to if they will be funded by the state. For example, state legislation can be used to establish clinical practice requirements or to promote regulatory procedures for evaluating compliance (Rieckmann, Kovas, Cassidy, & McCarty, 2011).

Internal Coordination and Communication

Historically, behavioral health services have been administered and often financed through state agencies outside of Medicaid. State Medicaid administrators wishing to achieve their goals with regard to integrating these services into Medicaid must work effectively with these outside agencies, ensure that expertise housed in outside agencies is capitalized upon, and coordinate goals and policies to ensure that work done by each state agency compliments the work of other agencies.

For substance abuse, the Hughes Act of 1970 led to the establishment of a Single State Agency within each state, which was responsible for administering federal

substance abuse funds and developing and regulating services (Rieckmann, Kovas, Cassidy, & McCarty, 2011). The administration of Medicaid mental health services varies considerably across states, as states often delegate functions such as certifying and enrolling providers, defining covered services and setting rates, administering payments to providers, and collecting and reporting data to state mental health agencies, other state agencies, or private contractors (SAMHSA, 2007).

Policy Incentives

Financial Incentives

Managed care plans are funded by states on a per-member-per-month capitated basis. States determine prior to contracting with managed care plans whether they will pay each plan the same capitated rate or if they will instead allow the plans to bid rates that the state can choose to accept or reject. One danger in establishing rates before a managed care plan has experience with a population is that it cannot use this experience to predict future costs for managing the population. States that underpay their managed care plans may find that the low rates combined with the pressure of making a profit can cause quality of services to suffer or can create other uncertainties in the market.

Regular Reporting from Managed Care Plans

States often require managed care plans to produce certain quality metrics (such as the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) or the Agency for Healthcare Research and Quality's Consumer Assessment of Health care Providers and Systems (CAHPS)), which show how their plan performs along a variety of measures such as consumer satisfaction, consumer engagement in care, and utilization of health care services. These measures are

often collected and compared publicly across plans, providing an opportunity for health plans to compete with each other along dimensions selected by the state.

Ideas

Weiss concedes that ideas are not as familiar as policy tools as authority or policy incentives - or inducements - but are just as regularly used and useful. Ideas, Weiss contends, are most useful when used in conjunction with other types of inducements. She explains, "by ideas I mean propositions about the relationships between policy variables and social phenomena: they explain or describe what is, what could be, or what should be. They work as policy instruments by inviting people to *think* differently about their situation, by providing them with information about new alternatives or about the advantages or disadvantages of existing alternatives, making some perspectives more salient than others, directing attention toward some phenomena and away from others, or leading people to accept different values or preferences … Ideas may define policy problems, invent solutions, facilitate decision-making, guide evaluation, and signal the need to employ other policy instruments, without being used deliberately as levers of change." (Weiss, 1990). Weiss' application of ideas that can be used to promote policy change to the Medicaid context include: research and evaluation, technical assistance, training and development, and demonstration projects or pilot programs.

Research and Evaluation

There are several types of research which can influence decision-making and implementation of a new health policy in a state, including research on evidence-based medicine and public health research, but evaluations are the type of research that are most often commissioned by state level Medicaid policymakers. Research commissioned by

the state can help to frame a policy issue and can spur collaboration among different key players (Davis & Howden-Chapman, 1996).

Statistics also can be produced to help contextualize and legitimize problems with the behavioral health system (Weiss, 1990).

Technical Assistance

States may also provide technical assistance to their managed care plans to help them understand the health system infrastructure currently available in the state and identify weaknesses, or to help them credential providers. For example, a recent article by Andrews et al. reported ways that state agencies could help modernize to support ACA-related changes, such as improving health information technology, enhancing cross health-system collaborations, supporting enrollment outreach and providing technical assistance. It was noted that many substance use providers do not accept health insurance, so states could work with managed care plans to ensure more providers entered their networks. Andrews et al. also noted that many substance use providers do not employ physicians with medical or professional degrees, so states could raise quality standards by, for example, demanding that substance use providers meet American Society of Addiction Medicine (ASAM) criteria. Finally, the article noted that providers may lack the technology to bill health insurance programs or maintain electronic health records, and states could facilitate this to promote provider network adequacy. Andrews et al. found that "high-activity" states were most likely to be active in providing assistance with Medicaid certification, enhancing collaboration, and providing training to counselors (Andrews, Abraham, Grogan, Pollack, Bersamira, Humphreys, & Friedmann, 2015).

Demonstration Projects or Pilot Programs

When states are interested in testing out an approach, a demonstration project or pilot program may work well to promote the approach or determine its potential for success. The state may allow the health plan to develop something like this, or may work with a provider directly to implement a program.

Summary

This study seeks to understand on how states that are integrating physical and behavioral health by allowing one managed care plan to be responsible for both types of services rely on policy interventions such as authority (contracts, policy / regulatory authority, internal coordination and communication), financial incentives and reporting from managed care plans, and ideas (such as research and evaluation, technical assistance, and demonstration projects / pilot programs) to achieve better integration of services and continued provision of services. The primary aim of this research is to improve our understanding of the mechanisms states use to impact the behavior of managed care plans in the context of behavioral health, determine how these mechanisms relate to the continued provision of care and assist with the goal of treating patients in a more holistic fashion, and identify opportunities to improve current guidelines governing managed care plans to better respond to the needs of states promoting integrated behavioral and physical health care.

Chapter 5: Research Methods

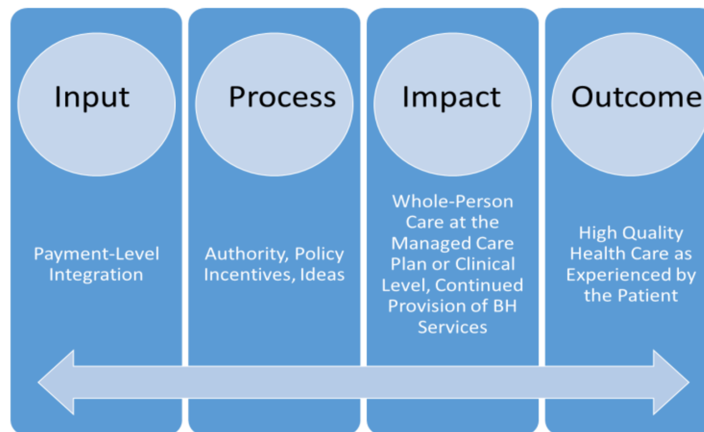
Overview and Research Questions

This study focuses on two key states that sought to integrate physical and behavioral health benefits in to one managed care contract in 2013 or 2014. A framework developed from Weiss' theory of policy intervention was used to identify key levers that states can use to ensure that managed care plans implement new benefits and make strides toward offering better integrated physical and behavioral health benefits for beneficiaries. The purpose was to explain how these oversight mechanisms could be leveraged to protect provision of behavioral health services while yielding improvement in the integration of physical and behavioral health benefits. Integration was defined broadly, and impacts on system-level integration were examined separately from impacts on clinical integration. These objectives were accomplished by gathering in-depth information on state Medicaid programs in Kansas and Texas. This study used a case study research design to develop an understanding of the oversight mechanisms being used by states implementing new behavioral health benefits using managed care plans. Data included documentation, including descriptive information available online (such as websites of stakeholder organizations) and through news sources, reports, waiver applications, contracts between the state and their managed care plans, and other oversight materials such as reports produced by the states' external quality review organizations; and semi-structured interviews with informants at all levels of the state's health system, including state, plan, and provider-level informants. This chapter provides an in-depth explanation of why these data and methods were chosen and how they were used to answer the proposed research questions.

Research Questions

1. What strategies did the state use to direct managed care plans' provision of behavioral health benefits?
    a. To what extent did they use their authority to manage their plans (i.e., contracts, policy/regulatory authority/ internal coordination and communication)?
    b. To what extent did they use policy incentives to manage their plans (i.e., financial incentives, regular reporting from managed care plans)?
    c. To what extent did they use ideas to manage their plans (i.e., research and evaluation, technical assistance, training and development, demonstration projects or pilot programs)?
2. How have these strategies been used to promote integration of physical and behavioral health services at both that managed care plan level and the clinical level?
3. How have these strategies been used to ensure continued provision of behavioral health services?

Figure 2: Research Framework



Study Design

Because the focus of this study is to understand state experience with regard to using managed care plans to promote integration of physical and behavioral health services, and how those experiences are influenced by state decisions and use of authority, policy incentives and ideas, the study relies on qualitative methods. Qualitative methods are preferred when an investigator is answering a how or why question; these methods offer depth of understanding to the researcher. Quantitative methods are preferable when an investigator seeks to understand causal relationships and is examining a measurable outcome; these methods focus on "generalizability" of results and offer breadth of understanding. State implementation policy research may utilize mixed methods to obtain both breadth and depth of understanding (Palinkas, Horowitz, Green, Wisdom, Duan, & Hoagwood, 2015). This study focuses on qualitative methods because there are no established quantitative methods for measuring integration of behavioral health and physical health care.

John Creswell explains in his 2012 book, "Qualitative Inquiry and Research Design: Choosing Among the Five Approaches" that the mode of qualitative inquiry

should be chosen based on which method best addresses the research question. The multiple case study design is effective for this analysis because it draws on multiple sources of information and is therefore a good design when contextual information is important to the analysis. In Medicaid research, states are natural cases because each state is given broad leverage from the federal government to establish its own Medicaid program, and the program that is established can be reviewed in the larger policy context. In this research, each state's case begins with the implementation of a single managed care contract for provision of both physical and behavioral health services. Yin (2009) states that case studies have a distinct methodological advantage in circumstances where "a how or why question is being asked about a contemporary set of events over which the investigator has little or no control." The case study "tries to illuminate a decision or set of decisions: why they were taken, how they were implemented, and with what result."(Schram, 1971).

According to Yin (2009) cases must be defined by spatial and temporal boundaries to separate them from their context. In the current study, cases will be defined by their state lines, and limited to the time when a single managed care contract was in effect for physical and behavioral health benefits (in Kansas) or when additional mental health benefits were added to the managed care contract (in Texas), in order to limit the scope of the study.

The first methodological question facing researchers committed to the case study design is whether to use a single- or multiple- case research strategy. A single case study is appropriate in cases where: 1. The case is a critical test of existing theory; 2. The case is unique; 3. The case is representative or typical; 4. The case is revelatory, or 5. The case serves a longitudinal purpose (Yin, 2009). This research includes 2 critical cases, a multiple case study design, in order to compare and contrast strategies used in different states.

This multiple case study design utilizes an embedded design that will investigate the following subunits within each state: state policymaker (broad perspective), health plan (intermediary), and provider/beneficiary (ground-level). This allows for analysis within and across sub-units, as well as cases. The main focus of investigation for each of these levels and methods for examination are described in Figure 3.

Figure 3: Focus of Investigation by Interviewee Type

Level	Focus of Investigation
State	• Development of Specific Goals • Policy Levers • Implementation Experience

Managed Care Plan	• Goals
	• Managed Care Processes
	  ○ Provider Contracting
	  ○ Prior Authorization Processes
	  ○ Case Management
	  ○ Care Coordination
	• Provider Network
	• Integration of Physical / Behavioral Health

Provider / Beneficiary	• Impact of Managed Care Plan on Provision of Behavioral Health Services and Care Coordination
	  ○ Prior Authorization
	  ○ Delays in Care
	  ○ Case Management
	  ○ Care Coordination
	• Integration of Physical / Behavioral Health

State Selection

A purposeful sampling strategy was used to identify information-rich cases for the most effective use of limited resources (Patton, 2002), targeting states that implemented behavioral health benefits in their Medicaid managed care contracts in 2013 or 2014. The objective of sampling was to identify states that are knowledgeable and experienced about contracting with managed care plans to improve integration of physical and behavioral health services (Creswell & Piano, 2011). Time is a critical element to consider because states that developed a single managed care contract earlier than 2013 may have forgotten the specifics of how contracts were developed, regulatory authority drawn on, or technical assistance provided, for example, to ensure integration of services. However, states that only recently integrated their physical and behavioral health services with the same managed care plan may not have had enough time to experience effects of

integration and care coordination at the ground level. Only four states (Arizona, Florida, Kansas, and Texas) newly implemented a single managed care contract for physical and behavioral health integration in 2013 and 2014, making them the critical cases selected for this analysis. Arizona and Florida[4] declined participation in the study, limiting the sample to the states of Kansas and Texas.

Data Collection

One strength of the case study design is its reliance on multiple sources of evidence. If the different sources of evidence corroborate findings, then the validity of the study is strengthened. The case study design also allowed for customization of interview protocols and deeper probing into key topics by thoroughly reviewing available documentation describing a case.

Documentation

I began by reviewing online documentation describing each state's Medicaid mental health system and move to include new behavioral health benefits in managed care contracts. This included a review of the Medicaid managed care system for behavioral health services, covered benefits and each states' contract with their health plans. Kansas had a very short standard contract, which was reviewed prior to the state interview. Topics related to integration of services that were in the contract were highlighted for discussion. Texas had a much longer and more complicated contract, so it was reviewed in the context of the recommendations from the Behavioral Health Integration Advisory Committee (BHIAC). Language on monitoring provider network capacity was also reviewed prior to the interview, and questions were developed. For

[4] The state of Florida was interviewed for this study, in addition to one managed care plan and one provider. However, the remaining six plans declined participation.

contextual information, waiver applications and related documents, websites of stakeholder organizations, and news articles were reviewed.

I also reviewed state licensing standards for community mental health centers (CMHCs) and primary care clinics in an effort to identify conflicting standards between the two. I looked for keywords such as “discharge”, “treatment”, and “staff”, because these were the three areas where Massachusetts had identified conflicting standards.

Key Informant Interviews

Semi-structured interview protocols were developed for each type of informant that responded to each of the research questions and built on the theory described in that chapter of this proposal. These protocols were then adapted to each state and informant based on document review.

Key Informant and Site Selection

The Medicaid Director of each state was initially contacted (Figure 4), and asked to identify the appropriate people within their agencies to participate in an interview. Additional key informants were identified through a combination convenience sample and snowball strategy. I relied on recommendations from interviewees, my own professional network, and Google searches to identify key personnel at managed care plans and providers or provider organizations. Key informants at provider sites were easier to identify through publicly available information than those at managed care plans, where state and personal contacts were critical. In Kansas, where there are three health plans, I reached out to informants at each and in Texas, where there are 19 health plans, I spoke with those that were taking part in key initiatives aimed at improving integration in the state (for example all health plans that were represented by the Texas

Behavioral Health Integration Advisory Committee were included, as well as those with Delivery System Reform Incentive Payment (DSRIP) projects designed to improve integration). My goal was to interview one informant at each health plan and 3-5 providers or consumer advocates in each state. A list of key informants and their affiliated organizations is included as Appendix A.[5]

Figure 4: State-level Initial Contacts

Arizona	
Thomas Betlach	Medicaid Director
Florida	
Justin Senior	Deputy Secretary for Medicaid
Kansas	
Susan Mosier, MD	Medicaid Director
Texas	
Gary Jessee	Associate Commissioner for Medicaid/ CHIP

Recruitment Strategy

Key informants were contacted by email and invited to participate in the study. The invitation described the purpose of the study and explained the parameters of participation. It specified the time commitment expected of key informants and explained potential benefits of participation. Each informant was allotted at least 5 business days to respond before receiving a reminder email. If the key informant had not responded to the invitation within 10 business days, they received a second follow-up email.

In order to be included as a case, it was critical that at least one state Medicaid informant and multiple health plan informants participated in interviews. Providers were identified through web searches (instead of asking for the state or managed care plans to

[5] Note that names of informants at managed care plans have been omitted, at their request.

provide names of providers). Providers and advocates were chosen based on their involvement in the integration effort.

Interview Procedures and Semi-Structured Protocols

Interviews took place between May, 2016 and January 2017, and were sequenced by stakeholder type, with interviews with state policymakers taking precedence above other stakeholder interviews in order to provide necessary contextual information regarding state oversight processes of managed care plans that was critical to question formation for remaining stakeholders. Because interviews were held with stakeholders across multiple states, they took place by phone. Interviews with state policymakers, managed care plans, and providers were scheduled for 60 minutes and other stakeholder interviews were scheduled for 30-60 minutes.

Interviews were tape recorded and transcribed. Each interview began with a description of the main objectives of the study and a request for consent to record the conversation. In the event that an interviewee did not consent to be recorded or the recorder failed, the interview proceeded and I took notes while interviewing the key informant.[6] I also discussed informed consent with the participants noting: that participation in the study is voluntary, specific answers were to be kept confidential and reported at the aggregate level (though key facts specific to each state will necessarily be identified), that the key informant need not answer every question. Some managed care plan informants asked that their name be withheld from the final report as a part of this process.

[6] In Kansas, the Amerigroup representative I spoke with declined being recorded. In Texas, Thyssen was not recorded because the conversation was very short and targeted and treated as a supplement to the Pittman interview; the tape recorder failed after the first few minutes of the Sherill interview.

Semi-structured interview protocols (Appendix C), developed to address the guiding research questions by incorporating Weiss' theory of policy implementation and tailoring questions to each state's specifics, were used to guide the flow of each interview. Questions were phrased to promote reflection and thoughtful response, and the interviewer was mindful of avoiding leading questions or questions that illicit no more than a "yes" or "no" response. A general semi-structured interview tool was reviewed by my dissertation committee, and later adapted for the needs of each individual interview. Following each interview, a memo was created that bulleted the main things learned in the course of the conversation to address each research question, and these were reviewed before each subsequent interview in that state. Using this process, the tool continued to be developed and refined throughout the data collection process.

Data Management and Analysis

Following each interview, I transcribed my notes and created a memo detailing how the contents of the conversation answered each research question (focusing on major themes and noting anything surprising that came up during the interview). Documents were stored on my personal, password-protected laptop. These notes and memos were used to guide qualitative analysis and also drawn on to develop questions for future semi-structured interviews as noted above. This iterative approach is a strength of qualitative research and allowed me to develop a deep understanding of the data as it was collected.

Qualitative data analysis was conducted using thematic content analysis (Holmberg, Green & Thorogood, 2004). All interview notes from the Texas case study were reviewed to build a draft list of nodes for coding, and this preliminary list was then coded against the Kansas interviews and amended as necessary. The list of nodes was

amended as the Kansas interviews were coded, and the coding list was then compared back to the study's initial purpose and research questions to create an outline of key findings and ensure that analysis would thoroughly answer each research question. Content under each node was then analyzed separately using NVIVO software, and answers compared across different types of informants and across different states to better understand how state oversight mechanisms for behavioral health compare across states, and how they related to care integration. Findings were written as case studies, with crosscutting observations written at an aggregate level. The individual case studies are descriptive, and aggregate perceptions of the impact of each state's approach on care coordination and care integration are presented. Individual opinions are not identified throughout the report.

Protection of Human Subjects

In order to ensure that this study is conducted with the highest ethical standards, a protocol describing study procedures (as outlined in this proposal) was submitted to the George Washington University's Office of Human Research Institutional Review Board (IRB). The purpose of the IRB is to review study procedures from the perspective of ethics and protection of human subjects. The IRB did not suggest changes to the study protocol.

Procedures offered for the purpose of protecting human subjects include: informing them of the risks and benefits of participating in the study, assuring confidentiality to key informants and respecting their right to decline participation in the study, allowing them to decline participation at any time, as well as informing them that their interview would be recorded, storing interview transcripts on a password-protected

computer, and reporting findings at an aggregate level when possible. Furthermore, I maintained current human subjects protection training through the Collaborative Institutional Training Initiative (CITI) while working on this study.

Chapter 6: Findings

Case Study of Kansas

Historical Information

Kansas implemented their comprehensive Medicaid managed care program, KanCare, which included all services and all populations in new Medicaid managed care contracts on January 1, 2013. The new program was implemented using three new Medicaid managed care companies that had not previously been operating in Kansas' Medicaid program, which were chosen through an RFP issued in November, 2011. Five managed care plans submitted a proposal to serve KanCare, and the three winning companies were chosen on June 27, 2012 ("History of KanCare, n.d.).

The new program was established through a Section 1115 waiver submitted to the Center for Medicare and Medicaid Services which describes the goals of the program: 1. Improving costs; 2. Improving fragmented care; and 3. Improving outcomes. The state describes how they plan to accomplish these goals through the following objectives ("State of Kansas Section 1115 Demonstration 'KanCare'Concept Paper", 2012):

- Moving all Medicaid populations into an integrated, person-centered model;
- Covering all Medicaid services;
- Establishing a safety net care pool to ensure access to essential hospital services; and
- Creating and supporting alternatives to Medicaid.

Kansas received approval from CMS on December 23, 2012.

The waiver also amended payment processes for Medicaid, by eliminating an existing supplemental payment program for hospitals and replacing it with an

uncompensated care pool and a Delivery System Reform Incentive Payment (DSRIP) program, which was designed to provide incentive payments to participating hospitals for their performance on specified performance metrics. Furthermore, it included monetary incentives for the managed care plans, which would be linked to performance on measures of prevention, health, and social outcomes ("State of Kansas Section 1115 Demonstration 'KanCare'Concept Paper", 2012).

Previous to KanCare, behavioral health services had been in a prepaid ambulatory health plan (PAHP) and a prepaid inpatient health plan (PIHP), respectively. Under these programs, services were carved-out to the local behavioral health clinics, which provided behavioral health benefits. Inpatient psychiatric and residential psychiatric services were not included in the PAHP.

In the new fully integrated program, the three winning managed care plans - Centene, Amerigroup, and United - were permitted to subcontract behavioral health services, as long as they demonstrated the capacity of the subcontracting behavioral health organization to meet relevant requirements. Two of these three managed care plans, Centene and United, are currently subcontracting these services to a subcontractor that is a subsidiary of their own plan (Cenpatico and Optum, respectively). Amerigroup does not subcontract behavioral health services.

The KanCare contract was initially a three-year contract with two one-year option periods, making the total contract period 5 years (the same amount of time the state's 1115 demonstration is in effect). Instead of building separate contracts with each managed care plan, the state used the Request for Proposals (RFP), which was developed jointly by the Medicaid Department and the Kansas Department of Aging and Disability

Services (KDADs), each state's response to it to serve as the contract. However, the state has since amended these contracts (though the majority of these amendments were reportedly rate changes). Amendments were made following a stakeholder process that included state meetings with 8 different entities, including the managed care plans.

Kansas implemented a Section 2703 Health Homes targeted toward the seriously and persistently mentally ill (SPMI) population, but the state Medicaid agency did not see improvement on quality measures and determined that the health homes were not successful. The program was not renewed as of July 1, 2016, when the enhanced funding from CMS expired. An informant said "We saw no material difference in quality outcomes or utilization outcomes from the population affected by health homes as compared to the control group. We looked at inpatient utilization, emergency room visits, and primary care visits. We saw no distinct differences and I think it's because we already had the care coordination within the KanCare program".

Kansas has taken advantage of federal dollars available for creating Medicaid health homes, but eliminated the program when the federal match was eliminated. Though there was considerable interest from the CMHCs and KDADs in the federal opportunity to create certified community behavioral health clinics (CCBHCs), another opportunity to enhance integration in the state, a lack of support from the Medicaid agency meant that the state ultimately did not apply for a CCBHC planning grant from SAMHSA.

Administrative Integration

In Kansas, both the Kansas Department of Health and Environment (KDHE), which houses Medicaid, and the Kansas Department for Aging and Disability (KDADs),

which houses behavioral health, have oversight responsibility for the state's three managed care plans. KDHE generally makes the policy decisions while KDADs is charged with oversight of day-to-day operations and implementation. Oversight is a joint effort between the two agencies. Issues pertaining to behavioral health claims, eligibility, and providers are often brought to KDADs initially, which also offers licensing and direct oversight for the CMHCs, and KDHE will be brought in if needed. They are not fully integrated at the administrative level, which means they need to be able to work effectively together to draw on the relative expertise housed in each department.

Key informants noted that KDADs had undergone a lot of change since the new managed care program had been underway. There was a loss of institutional knowledge as the managed care plans hired key staff away from the agency, compounded by a restructuring and decentralization of the state department of social and rehabilitative services (which resulted in mental health and intellectual and developmental disabilities going to KDADs immediately prior to KanCare's implementation). One key informant reported that "there was a (KDADs) reorganization at the same time that implementation was being done. [That created] challenges and confusion around who was responsible for what." Managed care plan informants found the oversight structure to be somewhat confusing, and provider informants also noted that often KDADs and KDHE seem to offer opposing guidance or have different policy goals.

In spite of the lack of clarity regarding the respective roles of the two organizations, key informants generally expressed positive and collaborative working relationships with oversight staff, particularly key Medicaid staff members. However, both providers and managed care plans expressed that the transition to KanCare had

caused many of the state's top experts to be hired away from the state by the managed care plans, which left the state (particularly the KDADs agency) with both less expertise and less overall capacity. One key informant said of KDHE, "now they have basically one employee to oversee each billion dollar managed care plan".

The concerns expressed by key informants were echoed in a decision by CMS to deny Kansas' request to extend their 1115 waiver for an additional year, after conducting site visits to the program and meeting with key stakeholders to address complaints received by the agency throughout 2016. The Topeka Capital-Journal reported that a letter from CMS director of state demonstrations, Eliot Fishman, to the Kansas Medicaid director Mike Randol cites the following concerns:

- Kansas failed to establish clear roles and responsibilities for employees who administer and operate KanCare;
- Limited coordination between the Kansas Department of Health and Environment and the Kansas Department for Aging and Disability Services poses a risk to the health and safety of Managed Long-term Services and Supports participants, who may experience difficulty managing their benefits;
- Kansas didn't engage in sufficient oversight of the managed care organizations, and while the state receives many reports from the managed care plans, no evidence was found of significant analysis or subsequent program changes based on the reports;
- Kansas' oversight of the managed care plans diminished over the past four years, as evidenced by on-site reviews of the managed care plans and subsequent

reports; the 2013 annual report was a comprehensive document but the 2014 and 2015 reports were only two pages long, with little substance;

- Kansas' approach to tracking, monitoring, and overseeing provider network adequacy and access to care for KanCare consumers is limited, and CMS expects a more robust oversight process including proactive monitoring; and
- Kansas doesn't have a comprehensive system for reporting, tracking and trending critical incidents.

The state is expected to create a corrective action plan, detailing their response to these concerns and providing dates by which changes will be implemented. CMS expects the plan by February 17, 2017 (Shorman, 2017).

Facilitating the Provision of Behavioral Health Services by Managed Care Plans

Because the three managed care plans in Kansas were offering behavioral health services for the first time, the state needed to provide an infrastructure to help the managed care plans understand quickly how to administer these services. For this reason, all three managed care plans operating in the state were asked the question "What were the primary things your plan had to learn quickly to operate in KanCare?" All three of the managed care plans noted that learning the landscape and history of the state was critical to accomplish quickly. Two of the three plans also said that they needed to do some legwork to ensure that their plan would offer an adequate network, which included credentialing providers. Two also said that the nuances of claims payment needed to be learned quickly.

Rather than turning to well-written policy documents or contracts, managed care plan informants noted that they hired staff that already had experience working in the

state's behavioral health system which allowed them to educate the rest of the staff about the nuances of working in the state. Managed care plans hired directly from KDADs and from the local provider community. For example, one managed care plan informant said, "we hired people who had been targeted case managers with the different waivers and who had worked in the local market". It was also noted that mastering the state's current program was critical to engaging with the CMHCs, who were already reluctant about the new role the managed care plans would have in the KanCare program. The CMHCs had historically had more direct responsibility over the behavioral health benefits and some were reluctant to relinquish that responsibility.

State Medicaid staff reported that active engagement of the managed care plans' executive teams was critical to a smooth implementation process. The state Medicaid and managed care plans had regular discussions around the direction of KanCare broadly, what expertise the plans have from working in other states that may apply in Kansas, their plans for behavioral health, and progress on developing a pay-for-performance program for providers. During these meetings, the state also raised issues that they were seeing and sought to work toward a solution. Examples include claims payment, and better alignment among the three managed care plans in their processes for providing services. One key informant said, "We really just hit the high level of the issues. We don't get into the specifics of how to resolve issues when we meet with the managed care plans. We walk through the issue and get their feedback. These are all put into a policy process and (the agency) will later spell out the policy that we want in a policy document. We then have an internal meeting to get final approval for the policy." The state may also provide technical assistance and guidance on performance improvement projects.

(Each year the plans are required to undertake both joint and individual quality improvement projects.) Meetings of this steering committee of the state and managed care plan executive leadership dwindled over time, eventually meeting every two weeks.

The state reported that care coordination requirements, network adequacy standards, and the expectation of a risk assessment screening are among the more important contract requirements to hold managed care plans to in order to ensure successful integration of behavioral and physical health services. Reportedly, what is critical about these stipulations from the state perspective is that they are very specific.[7] It was reported that monitoring these provisions was the second most important aspect of them, and the state reported monthly conversations with the plans regarding care coordination, monthly monitoring of network adequacy, and that they use the data from the health risk assessments "to try to tease out whether there are things the managed care plans should provide more assistance on in terms of getting patients services."

State Medicaid informants noted that they were not aware of any significant challenges due to subcontracting arrangements, and did not have specific contractual requirements for those who chose to provide behavioral health services through a subcontracted behavioral health organization (BHO).[8] However, provider informants noted that the presence of BHOs makes managed care more administratively burdensome for them. Two of the three provider informants reported that key contract provisions they

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[7] A review of the four pages of the RFP dedicated to Care Coordination requirements suggests that a lot of ground is covered and that the managed care plans needed to provide specific details of how their programs would work in their response back to the state, which the state could then hold them accountable for. The RFP itself does not contain a lot of specific guidance regarding how the managed care plan should conduct its care coordination activities.

[8] Language in the RFP reads "If a CONTRACTOR(S) intends to subcontract portions of the products or services, the proposal shall include specific designations of the tasks to be performed or deliverables to be produced by the subcontractor. The subcontractor shall be required to produce firm and staff qualifications to demonstrate their ability to perform the services delegated. The subcontractor qualifications shall be presented in a separate section of the proposal. Copies of any teaming agreements planned to be executed between the CONTRACTOR(S) and subcontractor(s) shall be included in the proposal. The CONTRACTOR(S) is required to certify and warrant all subcontractor work."

would like to see include standard screening procedures, processes, and forms for all three managed care plans, so that providers do not need to learn three separate processes.

The Kansas Medicaid informant reported that one thing that he would advise a state to do when developing contracts, which he had not done, would be “to have some very strong language and penalties related to submission of good encounter data because everything … rate setting, evaluating quality outcomes, understanding services that are provided to members … relies on high quality data.”

Using Managed Care Plans as an Information Hub

Key informants at all levels of the system were asked to comment on the advantages of having both physical and behavioral health services in one managed care contract. There were mixed perceptions regarding whether this truly improved integration. Informants from managed care plans and states were better able to articulate advantages than providers or advocates, who tended to see this level of integration as primarily a cost containment measure. The state and managed care plans thought that the ability for the managed care plan to act as the single coordinating entity for both types of services was a real advantage of the arrangement, noting that this allowed for all claims to be processed through a single system, and for physical and behavioral health case management to be provided together.

Providers noted that the managed care plans’ comprehensive data set was not often used in service of them as they cared for patients. The Association of Community Mental Health Centers had actively sought it in order to support initiatives they were pursuing around technology and performance measurement, but decided to work with encounter data after they were not able to obtain it from the managed care plans. One

managed care plan informant in Kansas corroborated this story; not all of the information that the plan was able to obtain made it into the electronic medical record, which could be shared.

A major weakness of the current care coordination system mentioned by two provider/ consumer advocate informants is the lack of comprehensive planning for care coordination. One state-level informant said "the whole idea (of KanCare) was to have all encompassing services coordinated within one entity … you'd have a hub for managing physical health, behavioral health, long term care, etc. … the CMHCs (also have) case management. You have that structure but also need to bring it to a higher level. It has been difficult to bring that together."

Among managed care plans and providers/ advocates, there was great emphasis among key informants on the importance of care coordination taking place at the local level, rather than on the managed care plan acting as a hub of information and coordination. Two managed care plan informants and the three provider / advocate informants all noted the importance of care coordination taking place at a local level in order to adequately address social determinants of health, rather than taking place at the managed care plan level. Despite this emphasis on local level care coordination, the managed care plans also noted the importance of having a care coordination team on staff that included both behavioral and physical health personnel, and providing care coordination services that complied with their contracts.

Provider informants noted that overall discussion and practice of care coordination had increased due to KanCare and that the plans seemed to understand the importance of understanding the locality. One provider informant said that the plans

have "more and more understanding that they can't (provide care coordination) telephonically." The other said, "more people have been trained (to provide care coordination). Discussion and practice have increased."

The need to provide care coordination locally can also translate to a lack of uniformity, as each of the CMHCs has different financial and social services to offer, which means that how robust the care coordination is varies widely from CMHC to CMHC. Furthermore, the care coordination services that are provided by Medicaid are sometimes only one component of care coordination. Providers may receive incentives from other payers or from other government sources (for example, FQHCs have separate funding to create a framework for care coordination), which can further hamper uniformity of care coordination offerings across the state.

Incentives for Clinical Integration

In order for clinical integration (at the level of improving coordination, collocation, or collaboration among providers) to occur, the biggest challenge for states and managed care plans is to ensure that providers in the state are invested in care coordination and care integration. Most key informants thought that financing was critical to this. One key informant said "[Providers] are driven by their business needs. Funding sources are very important to them. They are constantly pushing against the time limits of their day, and they want to know what is going to bring them a return on their investment in their practice. If they bring on a new doctor or nurse practitioner, open a different kind of service, have a licensed counselor on staff, will they be able to succeed financially."

All three of managed care plan informants noted the importance of financial incentives to providers to support better care integration, and all provider informants mentioned the move to value-based care as being critical to successful integration of services. However, only one of the three plans had an active Alternative Payment Model (APM) designed to provide such an incentive. The plan provided additional payment to CMHCs who committed to providing some physical health care, and the payment is based on performance on ten quality metrics, which include things like emergency department use, general inpatient use, primary care, follow up within seven days, follow up for children with attention deficit hyperactivity disorder (ADHD), employment status, and diabetes screenings. The CMHCs reported that the pay-for-performance arrangement had been a key element of relationship-building among the CMHCs and this health plan, providing a place where the two entities could work together toward a common goal.

The CMHCs reported that this pay-for-performance program was a follow-up to the state's health homes program, which was deactivated on July 1, 2016. The managed care plan that instituted the APM said that the health home program was effective at reducing health care costs and even testified before a legislative committee in favor of the results.

One of the remaining two plans had proposed a model, but reported difficulties operationalizing it. As such, it had been reduced to a relationship with six CMHCs that provided an incentive for ensuring that beneficiaries who were recently hospitalized receive appropriate follow-up care. The last plan had no concrete plans to develop an APM, stating that it was "still at the stages of discussion".

Even for states that do have the financing, setting up the financing structure can be difficult and can take time. For example, one key informant said that "Behavioral health Accountable Care Organizations (ACOs) are difficult to do because how do you attribute a group of people? In a federally qualified health center (FQHC) you can assign them as primary care provider to a panel of patients. But in behavioral health you can't assign them. There is choice."

The state of Kansas holds the three managed care plans responsible for their performance on quality measures through a pay-for-performance program, which withholds money from the plans and puts these dollars at risk if the plan does not perform on quality metrics. The withhold program was a part of the 1115 waiver, and specified that 3-5% of total payments would be used as performance incentives to motivate continuous quality improvement ("State of Kansas. Section 1115 'KanCare Concept Paper', 2012). However, the measures that are included in the pay-for-performance program are not behavioral health measures at this time. Instead, they include: timely processing of claims, encounter data submission, timely credentialing of providers, grievances, appeals, and customer service ("State of Kansas. Section 1115 'KanCare Concept Paper', 2012). A Medicaid informant said "This is our fourth year of pay for performance. We have seen some movement of measures. It's not perfect. But, I think we are moving in the right direction. It's a dynamic process. We are constantly changing the measures to reflect the outcomes that we want."

Managed care plans are responsible for reporting their performance on a wide variety of behavioral health measures. Kansas Medicaid holds managed care plans accountable for a vast array of quality metrics ("KanCare Program: Medicaid State

Quality Strategy, 2014). They are using HEDIS and HEDIS-like measures, homegrown measures, and National Outcome Measures (NOMS) data to measure most physical and behavioral health outcomes.[9]

Another barrier to clinical integration can be primary care provider discomfort with behavioral health issues. Multiple key informants noted that primary care providers often don't feel comfortable talking with patients or caring for their mental health or substance use disorders. Often, it would be advantageous to the patient to go see a primary care doctor once a year who could also deal with their depression or make sure they are taking their medications. Primary care can also be an optimal setting for discovering risk of behavioral health issues and providing early intervention. For this reason, one SUD provider in Kansas found it was helpful for his clinic to provide SBIRT services in hospitals.

Ensuring That Clinical Performance Is Not Hurt By Managed Care

In Kansas, it was reported that a number of legislators are very involved in the oversight of KanCare. The legislature has a dedicated KanCare Oversight Committee, authorized by Senate Bill 459, comprised of six House representatives and five Senators, which met regularly to oversee implementation of KanCare, ensure access to care, and promote quality of care benchmark measures being met (Shields, 2012).

The formation of the committee had a palpable impact on KanCare implementation in the state. CMHCs reported that they were able to form relationships with these legislators, and that it was particularly easy to engage them on issues where

[9] The measurement strategy seemed to elicit support from most key stakeholders, who often suggested that the measurement strategy was a good starting point before providing particular feedback about certain measures that weren't working or that needed additional refinement. One key informant reported that the state was on its 23rd or 24th amendment of the metrics, indicating that the state was very focused on ensuring that the data is correct and willing to learn as they go. Another provider-level informant noted that sometimes the population that was being measured included people who could not be impacted by the provider. One example of this would be a member who presents at a CMHC with a severe psychosis who only presented at the CMHC so that they could be screened into a mental health inpatient facility.

they were hearing a lot of complaints from beneficiaries. An example of a place where the committee played a key role, as reported by both managed care plan and providers/ consumer advocates was in ensuring that behavioral health medications and children's services continued to be authorized. Providers noted that legislators were effective in holding the managed care plans accountable, and managed care plans noted that the process resulted in "reasonable alternatives" to a prior role that would not allow any authorizations of behavioral health medications.

Involvement of Stakeholders in Design and Implementation

In January 2011, Governor Brownback charged Lieutenant Governor Jeff Coyer and a group of his cabinet members with the task of convening stakeholders to reform Medicaid. The group met with select stakeholders in January, including the Kansas Medical Society and the Kansas Hospital Association, and published a short summary of ideas with a call for responses from the public. With a grant from five Kansas foundations, they then contracted Deliotte Consulting, LLP to elicit stakeholder ideas on Medicaid reform in the state. They conducted three public forums (in Wichita, Topeka, and Dodge City), conducted a web-based survey, led conference calls with stakeholder work groups, and hosted a wrap-up forum. Deloitte published a summary of findings in September, 2011. Four themes emerged: 1. Creating a Medicaid system that supported integrated, whole-person care; 2. Preserving and creating a path to independence for beneficiaries; 3. Alternative Access Models; and 4. Utilizing Community Based Services. Within the recommendation of supporting integrated, whole-person care, the Deloitte summary suggests integrated behavioral and physical health services, improved care

transitions and case management, and financial alignment in a risk-based capitated managed care model.

Key informants reported that the stakeholder process was open to them, and that it helped to set the tone for relationship building among key stakeholders and imparted a new perspective. However, its primary purpose was to devise an overall strategy of containing costs while supporting quality outcomes in Medicaid. The process for stakeholders to become involved in the implementation of KanCare was controlled primarily by state Medicaid policymakers. The state Medicaid staff held stakeholder meetings every Friday starting in the month of July before the program was implemented to provide needed technical assistance and to discuss pressing questions related to the upcoming implementation of KanCare. The state also sought stakeholder comments as a part of the policy approval process.

Stakeholder meetings, which included providers and consumer representatives as well as the managed care plans, were also held regularly. Care coordination and opportunities for improving it were discussed during these meetings. The frequency of these meetings was also reduced over the course of the contract, beginning as daily calls in the early stages of implementation, and becoming monthly meetings by the summer of 2016. One managed care plan informant said of the state Medicaid staff, “I have never felt not supported… I have never felt that the state does not have the consumers’ best interest at heart. They support us and make sure we have everything we need to be able to do what we can. Their hands are tied by the budget crunch, but they would love to be able to do more.”

Despite the effort at engaging stakeholders in the policy process, no one in the state discussed efforts to promote innovation at the ground level in Kansas.

<u>Barriers to Integration</u>

Network Adequacy

Network adequacy is an issue impeding integration of behavioral health services with physical health services in both states. Two types of network adequacy issues impede the successful provision of behavioral health services in Kansas, making integration of services that are not available difficult or impossible. These two types include those specific to access to specific types of providers, often due to geographic location (with rural areas, such as the western half of Kansas, being especially problematic), and those that impede the ability to offer a full care continuum of services.

The public behavioral health system in Kansas is comprised of three main players: community mental health centers, which are the core of the system, substance use disorder facilities (several of which are also CMHCs or FQHCs), and state mental health hospitals, which provide inpatient services for beneficiaries that are approved for admission by a CMHC ("Adult Continuum of Care Committee Final Report", 2015).

There is a documented shortage of mental health hospital beds in the state. Key informants also reported a shortage of psychiatrists in the state, and telemedicine was used to remedy that deficiency. It was also reported that the state lacks intermediate levels of care, which can cause behavioral health services to be used inefficiently. It was noted that there is fairly good access for most substance use disorder services except for detoxification services, and that there are only two places in the state that offer medication assisted withdrawal, suboxone, or opiate outpatient withdrawal.

In Kansas, the CMHCs are mandated to provide emergency behavioral health services, much like hospitals are for physical health emergencies. They are also the sole providers of particular mental health services, as the only provider entity permitted to bill particular mental health codes. This status ensured that the managed care plans would contract with them, since the plans were required to provide access to a full array of services.

To help ameliorate issues associated with provider networks being limited in rural areas, telemedicine is proving useful, and the speed and security offered through telemedicine is causing it to be trusted and grow rapidly. It was noted that current KDHE cabinet secretary has an educational background in both health care and health information technology, and lends political support for its quick adoption.

Billing

Key informants also pointed out the technical difficulties of paying for integrated care, with a particular emphasis on same day billing. One key informant put this aptly, "Licensed providers are not supposed to bill for multiple services in one visit. But that is exactly what integrated care calls for … If you're the federal government, you don't want to get into a situation where every time a patient goes in for medical management you throw in a general health screen and call it a physical and then double bill for it … we get into this difficult situation where we want to incentivize crossover care but we don't want to pay for it as though it were multiple visits with multiple professionals." A resource developed by SAMHSA's Center for Integrated Health Solutions notes that same day billing is permitted by Medicaid in FQHCs in the state, but goes on to say that this only applies, "only if the patient suffers illness or injury subsequent to the first visit on the

same day requiring additional diagnosis and treatment which are different from the first visit." (SAMHSA-HRSA Center for Integrated Health Solutions, n.d.).

SAMHSA's resource also indicates that Kansas Medicaid doesn't cover a range of Health and Behavior codes, alcohol codes (including annual alcohol misuse screening and brief face to face counseling for alcohol misuse), tobacco screening, mental health assessments, group therapy, and crisis intervention codes.

Licensing Barriers

A review of state licensing requirements for CMHCs and primary care clinics in the state of Kansas revealed that KDADs issues licenses for the CMHCs, and the state relies on federal guidelines for primary care clinics. No specific barriers to integration were identified by the review of regulations issued for CMHCs. A review of state treatment guidelines, discharge planning guidelines, and staffing requirements revealed no staffing requirements that specified number of type of staff that must be employed by the CMHC, only that staff need to be properly credentialed and licensed by the state. Discharge guidelines specifically call for involving outside treatment providers in discharge planning, as appropriate. Treatment guidelines promote coordination with other agencies and treatment providers, as appropriate

Case Study of Texas

Historical Information

In September, 2014, Texas Medicaid launched a managed care carve-in, which included targeted case management and mental health rehabilitative services. These new services were mandated in all Texas Medicaid programs, including STAR (for kids, newborns, pregnant women, and families with children) and STAR PLUS (for elderly or

disabled individuals) via Senate Bill 58. Previous to this mandate, substance use disorder services were carved in to the managed care plans, as well as some mental health services, such as medication management, counseling, and physician services (The Hogg Foundation, 2014). The new program was launched following an intensive planning phase, during which Texas Medicaid staff worked closely with the BHIAC to revise current managed care contracts, worked closely with stakeholders, and developed an approach to oversight. The activities authorized by Senate Bill 58 also included authorization of the BHIAC and two health home pilot programs designed to improve integration of physical and behavioral health services.

Texas pursued integration using their 19 existing managed care plans (Texas Medicaid and CHIP: Managed Care Health Plans, n.d.) simply expanding their behavioral health responsibilities and providing guidance for broader integration of physical and behavioral health services. Because of the limited benefit previously provided, these plans had previously established relationships with the Local Mental Health Authorities (Texas community mental health centers, or hereafter referred to as CMHCs). Managed care plans also had to pass a readiness review to demonstrate capacity for providing services. Following implementation, the state sought to increase physical and behavioral health service integration and design metrics to measure progress.

Two years prior to passing SB 58, the state of Texas applied for an 1115 demonstration waiver from CMS, which permitted them to create the Delivery System Reform Incentive Payment (DSRIP) program in the state. DSRIP is also important to the integration effort in Texas described in this report because it provided a source of funding that became available to CMHCs and other key stakeholders that were interested in

innovations designed to improve health care delivery and integration in the state. Interested stakeholders formed regional healthcare partnerships that developed joint projects to improve health care delivery. Twenty such partnerships were formed, and stakeholders determined their projects and which performance metrics their projects' success would later be measured on. Ten percent of DSRIP funding was set aside for the CMHCs for the purpose of expanding mental health services in the state. All 39 CMHCs currently participate in the program (The Hogg Foundation, 2014).

Texas had not yet implemented their health home pilots during the time of the interviews, though the same legislation that integrated targeted case management (TCM) and rehab services into managed care contracts called for the creation of two health homes. The health home pilots would be incorporated within managed care plans. The BHIAC had not yet made recommendations regarding how to implement them. However, a few of the managed care plans had made their own plans to incentivize providers to act as health homes by providing a full array of services to beneficiaries. They are using DSRIP funding to provide an enhanced rate to select CMHCs to staff a physical health providers in their clinics, and then they are asking their beneficiaries to select these CMHCs to be their designated health home. It was expected that the health home pilots would build on these currently existing efforts.

In Texas, key informants also noted that efforts at integrating physical and behavioral health care outside of the Medicaid system were important, both at the patient level (ensuring that Medicaid patients received access to services outside of Medicaid), and at the legislative level (in setting precedent for expanding integration). Service coordination, administered through managed care plans to ensure that beneficiaries have

access to necessary services provided through the FFS system was also integral to ensuring access to the full continuum of physical and behavioral health services and that these services are centrally planned, particularly for the population with serious and persistent mental illness (SPMI) and kids with a history of developmental behavioral health issues. Texas began a service coordination program to provide four such visits for the latter population in November, 2016, built on the one that was already in place for those with SPMI. Another key informant also noted that in Texas, the private sector was pursuing efforts to better integrate care, and these efforts were influential in the sense that care integration was being seen by elected officials as the new standard because of these efforts.

Administrative Integration

The state Medicaid agency did not engage the behavioral health agency in sharing an oversight role for the plans' new behavioral health benefits, ensuring that all oversight came from one administrative agency. Health plan informants noted that the Texas behavioral health agency was not a source that they would want to turn to for help in understanding Texas' behavioral health system. This was partly because the behavioral health system tended to be very county-based, without a lot of standardization at the state level. One key informant noted, "This bulkinization is difficult. It's not systematic at all. Things aren't rolled up to a higher level through the state mental health agency, and information is not available at a rolled up level."

In order to ensure that this ground-level information was captured to develop an effective oversight process, Texas Medicaid policymakers reported that a stakeholder body, the Texas BHIAC, guided them in their oversight role of implementing the new

mental health services. The BHIAC provided specific recommendations to ensure that managed care plans approved new services, and to ensure that CMHCs, the historical providers of targeted case management and rehabilitation services, were contracting effectively with the managed care plans to continue providing these services. They also are broadly involved with the effort to improve integration of physical and behavioral health services in the state and have issued recommendations from that vantage point. Other stakeholders reported that people writing regulations and those charged with oversight came to BHIAC meetings and gave feedback directly to the committee regarding their recommendations. For example, they would inform the Committee if they thought a recommendation wouldn't be feasible, or if they were already working on something similar. Regulators would come to meetings and then send questions afterward or ask for one-on-one meetings to discuss issues more thoroughly. The Committee also took it upon themselves to meet with legislators and report back to those who had created the committee, to ensure that they understood the progress being made and the recommendations that had come out of it. A state Medicaid policymaker said that the stakeholder committee, "had a lot of weight because it was legislatively mandated… (which helped to) circumvent bureaucratic inertia".

Medicaid policymakers emphasized the importance of developing and devoting resources to a strong oversight program in order to ensure that managed care plans develop programs that are aligned with state goals. One key informant stated, "[The managed care] contract is only as good as how well you manage it. Our contract is a sprawling document of nearly 1000 pages… You have to monitor the things that you want to see change on. You have to emphasize from the start how you will do the

tracking of that stuff. If you have calls with the managed care plans about something they will do it. But if you just put something in the contract and you don't follow up on it, they might invest their resources in those things that they know you will ask about."

Facilitating the Provision of Behavioral Health Services by Managed Care Plans

Because the targeted case management and rehabilitation services were newly added to the Medicaid managed care contracts, managed care plan informants were asked the question, "What were the primary things your plan had to learn quickly in order to implement the new targeted case management and rehabilitation services?". All but one of the plans said that they had already been offering these services as an optional Medicaid service, and therefore did not have as much of a learning curve as a plan that had never offered these services would have. The managed care plans reported that their biggest challenge was learning how to credential, code and bill these services to align them with the new Medicaid benefit and ensure that they were offering the services in compliance with state requirements. The managed care plans sought guidance from the state to ensure that this happened, which came in the form of calls with the state and other opportunities for comment and feedback.

Texas has a uniform contract with all of their managed care plans, which they simply amended to include the new, targeted case management and rehabilitation services. The contract with the managed care plans is renewed every year on September 1. Texas also issues a policy manual, which includes the operational requirements for the plans, and is a more flexible mechanism for providing regularly updated guidance to the managed care plans. The state makes frequent changes to their policy manual, and the plans reported that they find out about these changes through direct communications with

the state, "they will lay out new requirements and obligations. And then they will also issue new language to the plans for comment and then they will revise. They've been doing a lot of revisions lately."

The managed care plans said that the contract is important, but is not the best mechanism for communicating requirements to them. One of them said the contract is, "a big club, not a fine-tuned device... it's long and details how to do certain things, but we always ask ourselves 'what is the true intent?'"

Managed care plan informants in Texas reported that the state met with them frequently to provide technical assistance, often provided in response to a specific question generated by one of the managed care plans. Each plan had an assigned managed care representative that they could ask questions of, but for clinical advice they often turned to the provider community. One managed care plan said that they held internal staff workgroups to identify questions and concerns for the state. They also participated in state-led workgroups with other managed care plans where they could collaborate.

The state also worked directly with the plans to create and manage their performance improvement projects. Four of the states' 19 managed care plans (Amerigroup, Cigna Health Spring, Superior, and United) had a performance improvement project aimed at improving care transitions and care coordination to reduce behavioral health related admissions and readmissions (Performance Improvement Projects, n.d.).

Using Managed Care Plans as Information Hubs

Key informants at all levels of the system were asked to comment on the advantages of having both physical and behavioral health services in one managed care contract. Managed care plans described themselves as the single coordinating entity under Medicaid managed care as the entity with access to data showing a full medical history on each patient. However, provider informants noted that the managed care plans sometimes had difficulty routing information to them and were advocating for rules in the contract that would help them obtain the most critical pieces of information from the plans. For example, the community mental health centers in Texas are interested in a contract requirement for managed care plans to notify them when one of their patients is admitted to the hospital. One managed care plan informant also noted that they were in conversations with the state to identify pieces of information like this that should be shared with community mental health centers to promote better care integration and better care transitions. Another informant felt that managed care moved health care decision making away from the families and that the statewide perspective of a managed care plan can lead them to make decisions that fail to consider the particular services and relationships present in the beneficiaries' local area (for example, the plan may recommend care that isn't available in one's local area). This is a particularly important consideration in a large state like Texas.

In Texas, only one of the four managed care plans interviewed for this study said that they provided both service coordination and a separate case management team that interfaced with all aspects of the health care system (including those that provide for a patient's social determinants of health) as part of their care coordination program for

Medicaid beneficiaries, truly improving integration of services by acting as a hub of information for patients. (Two of the other three talked only about service coordination,[10] and the fourth was not asked about case management). This plan described having both a physical and a behavioral health team providing case management services to beneficiaries in a coordinated way, by working closely with each other and with medical providers. This managed care plan informant said that these teams, "all collaborate and provide different ideas and education… we just make sure that everyone is aware of the services that (the patient is) receiving… we are there to bridge the gap if providers aren't in the same office or the same building." To ensure these services are integrated, the plan hosts case management rounds and integrated care team rounds, which help ensure integration. These rounds were described as, "a way of thinking about what is working and what is not. Representatives from provider facilities, and our clinical and quality staff get together and talk about what is working and what is not. Do we need to call in more social services or more programs? Sometimes the facilities know about services and programs that we don't know about. This is about collaboration and data sharing and strategizing on a level that can give communication and education to both sides." During these huddles, they may also identify particular beneficiaries with behavioral health needs that warrant a discussion with the broader group. Although this did not appear to be a broad practice in the state, the state has proposed contract language, which will become effective March 1, 2017, to require that

[10] In Texas, most provider and managed care plan informants described care coordination as two distinct services: service coordination, which was the responsibility of the managed care plans, and targeted case management, which was (newly) paid through the health plans but administered by providers. Service coordination was generally thought of as "coordinating health care", and mostly consisted of nurses (although it was reported to be driven by a behavioral health specialist in cases where behavioral health needs are predominant) ensuring that appointments are scheduled and services are coordinated. Targeted case management, as defined by provider representatives, is focused on whole person care and providing for the social determinants of health. Provider informants noted that targeted case management used to be paid as a lump sum to the CMHCs, and now the CMHCs receive a fee-for-service payment for targeted case management from the managed care plans.

managed care plans provide three-way calling between a member (or authorized representative of the member), the managed care plan's member services hotline and provider's staff to ensure that appointments are made in a timely fashion.[11]

The same health plan commits to working with individual patients on their care transitions by identifying one person who will follow the beneficiary as they go through the transition from an inpatient to an outpatient setting to ensure that their care is coordinated. When asked about the secret to successful care coordination, this managed care plan said that it was "having people knowledgeable about the resources out there is key."

Incentives for Clinical Integration

In Texas, managed care plan informants were interested in improving clinical integration at the level of colocation. All four of the managed care plan key informants in Texas talked about the importance of collocating behavioral and physical health services and said that they thought that providing financial incentives to providers was key to better integration of physical and behavioral health services. Three of the four plans had an incentive already in place. The fourth plan said that they were having conversations about alternative payment models for providers and described it as a "next step" when asked what their next steps would be "I think we want to look at value-based contracting options… Engaging providers on (care coordination and integration) is the next step as well as making sure that we are always hiring people that have a comfort level with both areas. Most of our members have behavioral and physical health needs. We need to train staff on both." ("Executive Commissioner's Commitment to Improving Member and Provider Experience in Medicaid Managed Care, 2016).

Notably, the three managed care plan informants who said that they were already engaged in alternative payment mechanisms for their providers all sat on the BHIAC. (The one who did not yet have an APM was not on the committee). One of these plans was using DSRIP funding to provide an enhanced payment to CMHCs who employed a physical health provider, and was working with appropriate beneficiaries to select this CMHC as their PCP. The model was described as a fee-for-service model, but with hopes of eventually incorporating quality metrics and additional incentive payment for meeting quality metrics. The second managed care plan was also incentivizing CMHCs to offer salaried physical health staff, this time through a capitated payment. They are focusing the model primarily on those with the highest acuity mental health needs (those that are SED and SPMI).

The third managed care plan described a pilot program with a center serving children and women, which was also a provider center that was owned by them, by paying for the additional services needed to ensure that needed physical and behavioral health services are provided at the site. They believe they have successfully removed barriers to accessing behavioral health care through this model, referencing utilization statistics which showed that pediatric patients seen at this center accessed mental health care 20% of the time, compared to 9% of their pediatric patients seen in other pediatric centers around the state. The key informant said "but now they are paid for episodes of care and encounters but this is a major stumbling block. To do an APM you need to have an APM delivery system."

The managed care plan contracts require that plans "move down the path of value-based contracting with providers", which was strongly supported by the CMHCs.

The contract provision allows the plans flexibility to determine what their value-based contracting programs will be, but requires that the plans submit to Texas Health & Human Services Commission (HHSC) an annual inventory of these initiatives. They are also invited to quarterly one-on-one web-based meetings where they are asked about their value-based payment initiatives. In his response to stakeholder feedback on improving managed care, the Executive Commissioner writes, "there are observable increases in the numbers of providers who are being paid via such value-based contracting arrangements. HHSC observes that plans tend to adopt HHSC's pay-for-quality measures for their value-based contracting with providers." ("Executive Commissioner's Commitment to Improving Member and Provider Experience in Medicaid Managed Care, 2016).

The state also has their own pay-for-performance program for the managed care plans which withholds or awards additional money based on plan performance on standardized metrics (4% of their capitation rate is at risk for the managed care plans). There are no measures that are specific to behavioral health within this pay for performance program, though potentially preventable events was included as a quality measure at the time of the key informant interviews with state Medicaid staff (although it was later removed as a measure). Behavioral health needs were found to be one of the major reasons behind potentially preventable readmissions. The technical specifications for all quality measures included in the Texas Pay for Quality Program are available online (Texas Pay for Quality Program Technical Specifications, n.d.).

The state seemed to be fairly early in their process of determining what metrics to use to assess the quality of behavioral health care. Most key informants did not express strong opinions about behavioral health quality metrics. However, a representative of the

CMHCs in Texas noted that the addition of behavioral health quality metrics is important to CMHCs because, "(if) more behavioral health metrics are added (it would) give the managed care plans more motivation to work with the CMHCs." Specific metrics that have been suggested by the Texas Council of Community Centers include: (E. LaMair, personal communication, August 24, 2016).

- NCQA Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Dependence;
- NCQA Adherence to Antipsychotic Medications for Individuals with Schizophrenia;
- NCQA Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications;
- NCQA Medical Assistance with Smoking and Tobacco Cessation; and
- NCQA Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction.

The BHIAC also noted that their next step would be to identify key metrics that could be used to measure progress on integrated care. At the time of this writing, no information had been published on these metrics.

<u>Ensuring that Clinical Performance Is Not Hurt by Managed Care</u>

Another key function of the state is to ensure that the behavioral health system is not hurt by its inclusion in the managed care contracts. Texas had designed several

contract stipulations to ensure continuity of care for enrollees. One such stipulation designed to protect the provider network was to provide "significant traditional provider" status to the CMHCs, which meant that the managed care plans would have to offer them a contract for the first three years (providers had to accept the contract terms and rates).

Another such stipulation was designed for those managed care plans that subcontract behavioral health services to a behavioral health organization (BHO). Managed care plans are permitted to subcontract with a BHO, but they bear risk for managing them. In order to advance coordination between entities, Texas required that all provider sites be reimbursed through one contract with the health plan. They also required integrated care coordination for physical and behavioral health, and the service coordinator is required to reside within the managed care plan. They added provisions to the contract saying that they need to share the integrated technology so that the BHO can see the medical history of the member and has access to all the information that the managed care plan has. They also require that the managed care plan and its BHO use similar authorization forms and procedures. Claims payment and approval of behavioral health services always resides with the BHO in these situations.

Of the recommended contract stipulations issued by the BHIAC, key informants noted that there was particular support for a requirement that all managed care plans use the same prior authorization guidelines. The state uses assessment tools called KANS (for children) and ANSA (for adults) to assess people and assign them to a level of care, which ensures that managed care plans cannot deny care that is determined to be medically necessary. These instruments are currently being reviewed, but any proposed changes to the instruments will need to be discussed with the BHIAC.

Involvement of Stakeholders in Design and Implementation

A key aspect of Texas' approach which empowers stakeholders while also encouraging relationship-building among them is the BHIAC. A key difference between Kansas and Texas is that, in Texas, the legislatively mandated BHIAC was itself charged with guiding policy development, implementation, and oversight, instead of offering feedback to a contracted third party to relay to the state, which was instrumental in empowering key stakeholders.

Stakeholders outside of the BHIAC noted that the committee was useful because they knew that recommendations produced by the BHIAC had been vetted by stakeholders at different levels of the system and this vetting process inherently gave the recommendations more clout. Other key informants noted that the committee has weight with legislators for the same reason. One key informant said, "As we go back to our constituents and our networks, we are sending a big message to the entire state (about the direction that the system is headed)." Key informants also noted that state Medicaid officials actively engaged with members of the BHIAC outside of regularly scheduled meetings to elicit their feedback on key policies or how to seek guidance on how managed care was faring.

This created a feedback loop, where all the major players (the different types of stakeholders included in the committee, the Medicaid oversight agency, and the legislators) were all closely involved with vetting recommendations for improving integration. Obtaining real-time responses to legislators' and regulators' feedback enabled the committee to put forth recommendations that they thought would be feasible and not overwhelm regulators by putting forth too much change too soon. One key

informant said, “We wanted to set the stage and change the environment. We wanted to change how philosophically we looked at or how HHSC (the Texas Medicaid agency) looked at the delivery of Medicaid services from a behavioral standpoint … It’s a marathon, not a sprint.”

Within the BHIAC, key informants noted that they found that there were many areas of agreement entering the process. Initially, many committee members agreed on what the overarching goals should be for the behavioral health system and thought that improvement was needed in general. They also agreed on some of the specific ways to go about improving the behavioral health system and integration of care. For example, many members initially felt that there was a need for more peer specialists as well as additional housing resources for needy beneficiaries, and they wanted the system to be more focused on addressing the social determinants of health.

The BHIAC helped stakeholders identify these key areas of agreement, while also broadening committee members’ perspectives so that they could see the system holistically. One key informant said, “Not everyone agrees on everything we come up with in total, but we have buy-in and an understanding of why a recommendation is important. We’ve made recommendations that I think in another environment would have gotten a strict thumbs down from some people on the committee or their constituents or the industry that they represent.”

Members of the BHIAC noted that it helped stakeholders at all levels understand each other’s perspectives on integration. For example, one managed care plan informant noted that stakeholders didn’t really understand the managed care plan role or the requirements that they faced from the state and that the BHIAC “allowed [the managed

care plan] voice to be heard". A community mental health center was able to leverage the group to broaden stakeholder understanding of what integration could look like at the CMHC level, while also educating about differences in environment faced by CMHCs in different regions of the state that could impact integration.

The BHIAC is comprised of a broad array of Medicaid stakeholders. In their second report to the Health and Human Services Commission, the group describes themselves as comprised of:

- Individuals with behavioral health conditions who are current or former recipients of publicly funded behavioral health services or family members of individuals living with a mental illness;
- Representatives of managed care organizations that have expertise in offering behavioral health services;
- Public or private providers of behavioral health services; and
- Providers of behavioral health services who are both Medicaid primary care providers and providers for individuals who are dually eligible for Medicaid and Medicare.

The group is headed by Dr. Octavio Martinez, Executive Director of the Hogg Foundation for Mental Health, a foundation dedicated to improving mental health for the state of Texas. The Hogg Foundation had been lobbying Texas legislators in the state to improve physical health and behavioral health integration for some time, and had funded pilot projects on the topic in 2006. The Foundation has also hosted conferences on integrated care in the state and written papers and other resources dedicated to the topic. Dr. Martinez and other members of the group were appointed by then Executive

Commissioner of HHSC, Dr. Kyle Janek, who sought geographic and philanthropic diversity on the committee.

The biggest downside of the way that the BHIAC is structured is that its creation through the 83rd legislature in Texas makes it vulnerable to changes in the political environment in Texas. For example, the 84th legislature created a statute that eliminated all previously appointed legislative committees, but gives the Executive Commissioner of the HHSC permission to keep those that are perceived to be needed. At the time of interviews, committee members noted that BHIAC was scheduled end in December 2016, but was likely to be continued by the Executive Commissioner of the HHSC.

Creating a Culture of Innovation to Support Integration

State Medicaid staff stressed the importance of ideas, emphasizing that innovation needs to happen at the ground level and a key role that the state Medicaid agency plays is to provide resources, support, and flexibility to key stakeholders to allow it to happen. They stated that they wanted to incentivize the managed care plans to do something different. "We make them whole so that they are not at risk. Getting them to (do something different to address mental health and substance abuse problems) is one of the best ways to change the culture … If we just held them to our contract, they could take the money and if they are making a profit, they don't have a reason to be innovative. But, if you give them the flexibility to be innovative and you give them the resources to do different things, it's a different model."

The sentiment of stakeholders needing resources and flexibility for innovation to occur was echoed by key informants operating at other levels of the system. For example, a managed care plan informant said, "Allowing innovation to occur is

frightening to regulators. They have a responsibility and rules that they need to operate under. But, you can't micromanage innovation. If you try to micromanage it, you'll get stagnation." Another managed care plan said "(the state) is really trying to be innovative and they are doing as much as they can to help this happen without creating a penal environment. They realize that each health plan is different and they want to give the plans the flexibility to have the best programs they can."

The state also engaged in pilot projects and offered grants to foster innovation. The alternative payment models encouraged by the state and described previously in this paper is one example. The health home pilots are a second example. The state also successfully applied for federal grant and demonstration money, such as the Money Follows a Person demonstration, which allowed pilots in the state to support Medicaid beneficiaries with serious and persistent mental illness who want to leave nursing facilities in favor of receiving care in a community setting. They also initiated a self-directed care pilot, which will allow patients to direct their own health care services and choose which services to purchase outside of the Medicaid benefit, and applied for the CCBHC planning grant. They also allowed managed care plans the flexibility to do their own pilot projects. For example, United hosted a pilot, which allowed for 30 days of unrestricted peer support services to beneficiaries over the age of 65 and which reduced inpatient admission.

Barriers to Integration

Network Adequacy

A dearth of behavioral health providers was reported by key informants in Texas, and supported by a recent report on the work force of health professionals in the state. The report states that as of November 23, 2013, 207 of Texas' 254 counties were designated as health professional shortage areas by the federal government for mental health. In most counties, there was a shortage of psychiatrists and 199 counties (representing about 23.1% of Texas' population) lacked a sufficient core of mental health professionals - including clinical psychologists, psychiatric nurses, clinical social workers, licensed professional counselors, and marriage and family therapists (Texas Department of State Health Services, 2014). Managed care plans indicated that they contracted with a variety of available CMHCs and private providers. However, the CMHCs were heavily counted on to provide a full care continuum to patients.

It was reported that CMHCs did not have the resources to serve all individuals in the state who were in need of behavioral health services. They were thought to have a specific client base. One key informant reported that CMHCs tend to serve individuals who have more social and financial troubles than other types of providers. Their patient population was defined as acute and chronic, and their patients often suffer from bipolar disorder, schizophrenia, and major depression suicidal ideation. One key informant said, "It leaves hundreds of diagnoses that don't get treatment from (the CMHCs)." The lack of psychiatrists is problematic for some CMHCs, who would like to discharge stable patients to a local psychiatrist for ongoing care and make room for new patients, but cannot find providers available to discharge them to. Provider willingness to participate in the Medicaid managed care program may also be problematic due to issues with

provider billing (Executive Commissioner's Commitment to Improving Member and Provider Experience in Medicaid Managed Care, 2016).

A state Medicaid informant noted the importance of ongoing monitoring of the provider network. "When we rolled in the new benefits, we had (the managed care plans) send monthly lists with the providers they were contracting with and the percentage of claims that were paid within a certain time period to make sure we nurtured the behavioral health safety net."

In an effort to begin to rectify network deficiencies, key informants noted interest in increasing the number and reach of certified peer specialists. Currently in the state, certified peer specialists can only serve one provider, limiting their reach. Texas Medicaid has also started to address the care continuum issue by requiring CMHCs to have the full continuum of services available. However, key informants acknowledged that certain levels of care (levels 4 and 5) are still problematic, as well as newer services such as ACT teams which are expected to become more available over time.

Billing

Key informants also pointed out the technical difficulties of paying for integrated care. These are services that traditionally were not coded and billed, and managed care plans struggled with how to bill for something when there isn't an available code. The Texas Council of Community Centers pointed out in a stakeholder meeting with HHSC Commissioner Chris Traylor that many needed behavioral health services are not currently reimbursable, such as provider-to-provider communication, phone conversations with members, services provided by multiple providers in the same group on the same day, and member navigation. Key informants suggested that one solution

would be to develop a payment system designed to address this barrier, providing rates that are enough to promote innovation. “A state will have to pay the provider prospectively and not count every encounter.”

It was expected that over time codes would be developed as services were used more frequently, but the short-term solution is “creative contracting”, or attaching modifiers so that the codes did not conflict with a service already being provided and the plan would know which services they were paying for. However, the problem with that, as described by one key informant was, “As new services are introduced and models are created, the description for existing codes no longer really describes what you’re wanting (providers) to do. The provider is concerned about it looking like fraud and abuse. They didn’t really deliver the service that the code says they delivered.” These coding issues will need to be worked out with CMS, because they reflect CMS coding standards. Furthermore, some CMHCs reported that they were not reimbursed for primary care or care coordination at all.

Furthermore, a resource developed by SAMHSA’s Center for Integrated Health Solutions shows that Medicaid doesn’t reimburse Community Health Centers for a host of behavioral health services, including health and behavior codes (including assessment, reassessment, and individual, group and family therapy), alcohol and substance services (such as an annual alcohol misuse screen, or brief face to face counseling for alcohol misuse), tobacco counseling, and mental health codes such as crisis intervention.

There are additional barriers with rates, as well, such as the rule some states have that a physical and mental health encounter can’t both be delivered on the same day or

only one will be reimbursed. In Texas, it was reported that the claims system may not accept two types of group therapy in one day.

Information Sharing

A key element of improved integration of different types of services is communication among partners, and information sharing is key to that communication. The importance of having all of a beneficiaries' health information housed in one place was stressed. However, true information sharing among providers was thought to be one of the most aspirational forms of integration, because of the presence of two critical barriers: the difficulties of developing an integrated electronic medical record and the legal barriers posed by 42 CFR Part 2 (revised) which bars sharing individuals' behavioral health information.

For example, an interoperable electronic medical record that could be shared among providers was recommended to the state of Texas by the BHIAC in a report. In the report, the BHIAC recommends that all managed care plans adopt integrated technology systems for physical and behavioral health and that technology should be leveraged to allow all providers and managed care plans access to a member's full medical record without compromising the beneficiaries' confidentiality ("Senate Bill 58: Behavioral Health Integration Advisory Committee Second Report to the Health and Human Services Commission", 2015). However, key informants noted that efforts at integrated health technology were in the stage of discussion or small pilot projects.

Texas Medicaid has a system that anyone who provides behavioral health services to Medicaid patients is required to use, but the system doesn't integrate with any

commercial medical director system so that creating an integrated medical record with behavioral and physical health components is complicated.

Stakeholders noted that one way around the information sharing barrier imparted by 42 CFR Part 2 is the colocation of primary care and behavioral health services into the same setting. This ensures that the provider has access to patient information about both types of care. One key informant said, “What makes (integration) possible is salaried physical health staff (in behavioral health settings), because these people aren’t subject to the 42 CFR [Part 2] constraints that traditionally prohibit communication with physical health staff from a behavioral health organization … this model doesn’t work with the local FQHCs, for example, which typically contract behavioral health staff and have been harder to get off the ground because of 42 CFR [Part 2].”

Licensing Barriers

A review of state licensing requirements for CMHCs and primary care clinics revealed that the state does not have their own licensing requirements for these provider types, instead relying on federal standards.

Cross-State Findings

Comparing across the two states, it is clear that Texas had a more successful approach than Kansas in terms of stakeholder engagement, administration of the program, and ensuring that the move to Medicaid managed care did not hurt access to behavioral health services. This may be partly attributed to their relatively longer history with Medicaid managed care, which resulted in a more sophisticated oversight approach (as determined by the legislature) and brought key stakeholders together. The stakeholder body, in turn, ensured that the program ran smoothly and that provisions

were in place which would promote continued provision of behavioral health services in the state. It also resulted in more sophisticated contract mechanisms to ensure that Medicaid managed care was not administratively burdensome to providers and to ensure effective communication between managed care plans and their behavioral health organizations.

Another key difference between the states was their use of quality metrics, with Kansas adopting broad use of a variety of metrics, while Texas was still identifying key metrics for later use. While Kansas took a broad and ambitious approach to quality measurement, they may now be in the process of further refining their measures following negative feedback from stakeholders regarding use of the SAMHSA's National Outcome Measures to measure behavioral health outcomes. Texas, by contrast, still seeks to develop valid and reliable measures that can be used to track outcomes.

Figure 5: Summary of Cross-State Findings

Mechanism	Kansas	Texas
Authority		
Policy/Regulatory Authority: Overarching Goal	Cost Savings	Innovation
Policy/Regulatory Authority: Involvement of Legislature	Involved in Oversight	Involved in Oversight and Integration
Contracts: Provider Network	Promotes MCP Contracts with CMHC	Promotes MCP Contracts with CMHC
Contracts: BHO Subcontracts	No Specific Requirements	Requirements to Advance Coordination Between Entities
Contracts: Prior Authorization	No Requirements	Plans Must Use Standard Prior Authorization Requirements
Internal Coordination and Communication	KDHE and KDADs have shared oversight	HHSC has sole oversight, but consults with BHIAC
Policy Incentives		
Financial Incentives		
Pay-for-Performance (State Level)	Withhold Program (no BH Metrics in Early Years)	Withholds and Bonuses (no BH Metrics)
Pay-for-Performance (Plan Level)	1 of 3 Plans Had Operational APM for CMHCs	3 of 4 Plans Had Operational APM for CMHCs

Quality Metrics	Large Number of BH Measures	Very Few BH Measures
Ideas		
Research and Evaluation	Little to No Impact	Little to No Impact
Technical Assistance	Ongoing, Regular	Ongoing, Regular
Stakeholder Involvement	Goal Identification	Ongoing Involvement

1. To what extent did states use their authority to direct managed care plans' provision of behavioral health benefits? Did these strategies promote care integration of physical and behavioral health services at the managed care plan or the clinical level? Were they used to ensure continued provision of behavioral health services?

The impetus of integration efforts in both states was an engaged executive branch, demonstrating the critical nature of the political environment in improving access to physical and behavioral health services. In Kansas, the actions of the Brownback administration were critical and SB 58 was prominent in Texas. These early political dimensions also grew to frame the entire oversight structure for each respective program, having enormous consequences for the way the programs were eventually implemented and received at the ground level. For example, the actions of the Brownback administration stemmed from budget crisis and a desire to provide medical care to Medicaid beneficiaries more efficiently. By contrast, in Texas, the actions of the legislature stemmed from the effective lobbying of the Hogg Foundation and the sense that integrated care is an industry-accepted best practice for medical care.

This difference in political environment created an immediate link between the legislators and the providers and advocates in Texas that was absent in Kansas. In both states, legislative engagement was key to providers and consumer advocates ensuring beneficiary protections, and to ensuring that their voices were heard by the system more

broadly, and the fact that stakeholders were granted an advisory role in the development and oversight processes in Texas ensured that a system was designed and continuously adjusted to meet the needs of providers and consumers for the most part. Although the process of pushing integrated care down from the managed care plan level to the provider level was similarly slow in both states, providers and consumer advocates in Texas seemed more confident that their voices were heard and that positive change was occurring than those in Kansas.

Oversight

These political dimensions led to an administrative oversight structure in Texas that was much more integrated than the structure in Kansas, and held a critical role in how the entire system was shaped. In Texas, the Medicaid agency was solely responsible for overseeing the managed care plans, but did so under the advisement of key stakeholders through the BHIAC, which helped ensure that they understood ground-level behavioral health operations. This structure was partly attributed to the fact that knowledge of behavioral health was local in Texas and not centralized at the state level. Instead, behavioral health knowledge was centralized through the BHIAC.

In Kansas, both agencies had an oversight role, but key informants did not find the behavioral health agency to be particularly helpful or effective due to diminished expertise caused by health plans hiring staff away from the behavioral health agency. Key informants also found that the two agencies often did not have a unified vision of the goals of KanCare, which further complicated the process of integrating behavioral and physical health care. For example, under the direction of KDADs (the behavioral health agency), Kansas' CMHCs invested resources in developing a plan to develop CCBHCs,

and these resources were wasted when the Medicaid agency ultimately did not support the effort.

Key informants in both states and at different levels of the system (state-level informants and provider-level informants) noted the importance of investing resources in overseeing managed care plans, noting that expertise and overall oversight capacity are critical to ensuring that managed care plans adhere to state expectations. However, neither state informant strongly emphasized the link between strong oversight and improved care integration / care coordination, which may have been related to a lack of a strong concept of what care integration should look like at the managed care plan and provider levels.

In both states, managed care plan and provider informants described care coordination as taking place at two different levels. At the managed care plan level, care coordination was an activity that focused on ensuring that health care services were coordinated. At the provider level, care coordination focused more on connecting the patient to needed social services to address social determinants of health. Only one of the seven managed care plan informants had a program that bridged the gap between service coordination and care coordination to address the social determinants of health. This managed care plan did this by implementing "case management huddles," which involved local providers' offices who were more familiar with available social services and could work directly with the managed care plans' case managers to ensure integrated, whole-person care.

These findings suggest that state Medicaid agencies need to consider how managed care plans will interface with providers to provide more comprehensive,

thoughtfully planned care coordination services which provide for all levels of a patient's needs. Absent collocation of physical and behavioral health services at one provider setting, managed care plans are best positioned to provide comprehensive care planning for patients needing both types of care. Their position is improved by the comprehensive data that they have about each patient, and their economies of scale, which improve their ability to hire both physical and behavioral health specialists to advise on patient care. However, they are more removed from the patient and from locally available services, and must partner effectively with providers to draw on these strengths. This suggests that states wanting truly integrated care should consider providing guidance to managed care plans on how to centrally plan care coordination services so that patients get both the best of high-level comprehensive planning from those with content expertise as well as local, individualized expertise. It also suggests that states need to find ways to ensure that providers are brought into the policy discussion about integrated care, in order to ensure it happens effectively.

In Texas, the move to include Targeted Case Management, typically provided by a CMHC, in the managed care plan benefit is an example of one option that states have to ensure these services are coordinated among managed care plans and providers, and at least one managed care plan in the state did develop a program to coordinate these services.

Key informants in both states emphasized the need for their managed care plans to have strong care coordination programs as a mechanism for improving integration, and met frequently with managed care plan executives to discuss these programs.

Legislative Action

An engaged legislature was critical to integration activities in both states. The legislature created a legal framework for the payment-level integration activities to take shape (for example, by creating the BHIAC and mandating that targeted case management (TCM) and rehabilitation services be placed into Medicaid managed care contracts in Texas). The legislature also provided oversight to help ensure that clinical performance wouldn't be hurt by the move to managed care (for example, by ensuring that behavioral health services received prior authorization in Kansas). The legislature also has a lot of control over the state's budget and can appropriate funding for key investments in integration to help circumvent billing barriers. In both states, it was critical that providers and advocates interested in improving integration and ensuring that their interests would be considered during the development of a new Medicaid managed care system develop a relationship with key legislators. In Kansas, both consumer complaints and effective engagement of providers and consumer advocates were critical to ensuring that legislators worked to ensure that prior authorizations were reasonable and that access to key medications and children's services was ensured. In Texas, the Hogg Foundation played a key role in the development and implementation of the BHIAC. The BHIAC went on to play a key role in the development of the system, which improved care integration at all levels.[12]

Contracts

There was broad consensus at the state and provider informant levels that a well-written managed care plan contract was an important vehicle for ensuring a smoothly operating Medicaid system and for encouraging integration of behavioral and physical

[12] In Texas, HHSC intended to form a separate workgroup to provide recommendations related to prior authorization processes, but ultimately decided to host its own stakeholder meetings beginning in the summer of June 2015.

health services. Provider-level informants uniformly advocated for standard procedures across Medicaid managed care plans to be included in contracts (including standard screening procedures, prior authorization procedures, and forms), in order to make Medicaid managed care less burdensome for themselves and ensure that their clinical performance wasn't hurt by the move to managed care. In Texas, prior authorization guidelines were made transparent to providers and consumers through the requirement that managed care plans use the KANS instrument (for children) and the ANSA instrument (for adults) to assess medical necessity and assign beneficiaries to a level of care that must then be prior authorized by the plan. In Kansas the lack of this uniformity was often cited as a weakness by providers of the KanCare program. Texas Medicaid informants also noted the importance of contractual requirements for those managed care plans that chose to subcontract behavioral health benefits to a BHO, and mandated that these managed care plans share integrated technology and data systems, integrate their care coordination programs for physical and behavioral health and use the same authorization forms as their BHO (Kansas had no such requirements). These contract provisions were used to ensure that clinical performance wasn't hurt by the move to managed care and the integrated technology was intended to improve clinical integration.

Another popular contractual requirement among providers in Texas was the requirement that managed care plans adopt a pay for quality program. This was seen as critical to clinical integration efforts, because it helped to circumvent barriers of the encounter-based payment system, which impeded integration of physical and behavioral health services.

State Medicaid informants tended to emphasize the importance of overseeing these contracts and noted "best practices," which made continuous oversight more plausible. In Kansas, state Medicaid informants noted the importance of developing specificity in the contract and of obtaining good encounter data to use to monitor plan performance. Texas Medicaid informants noted the importance of a flexible vehicle for adapting contractual requirements as the state gained experience with behavioral health benefits in Medicaid managed care through a policy manual.

2. To what extent did states use policy incentives to direct managed care plans' provision of behavioral health benefits? Did these strategies promote care integration of physical and behavioral health services at the managed care plan or the clinical level? Were they used to ensure continued provision of behavioral health services?

Pay-for-Performance and Alternative Payment Models

Both Kansas and Texas have adopted a pay-for-performance program for their managed care plans, which provides a financial incentive to plans to improve performance on selected quality metrics. The Kansas plan is based on a withhold, and Texas offers both a withhold and a financial incentive to plans with satisfactory performance on selected quality metrics. Neither program holds managed care plans directly accountable for mental health and substance abuse measures through their program. (In Texas, behavioral health was found to be a critical factor in avoiding potentially preventable events, which was measured). These programs may provide an incentive for managed care plans to create pay-for-performance programs or alternative payment models for contracted providers to ensure better performance on selected behavioral health measures, and the alternative payment structures for providers were a

key way that clinical integration was incentivized in both states. Texas also has a contractual requirement for managed care plans to develop these programs for providers.

Notably, all seven managed care plan informants (three in Kansas and four in Texas) discussed the importance of collocation of behavioral and physical health services to improve integration of these services and said that they thought that providing a financial incentive for providers to do this would be key. On both states, CMHCs were beginning to offer primary care services as a response to these financial incentives. Only two of managed care plan informants (one in Kansas and one in Texas) did not have an active financial program to encourage collocation, instead describing it as a "next step". Three informants (one in Kansas and two in Texas) provided incentives for CMHCs to provide primary care services in house, and these programs were widely regarded as the most promising by key informants at other levels of the system. For example, Texas Medicaid informants touted the promise of these models for enhancing care integration and Kansas CMHCs noted that this program had vastly improved their relationship with the managed care plan providing the incentive, developing a meaningful partnership based on the shared goal of improving quality of care and care integration. The remaining two models were small, less widely understood and not broadly implemented. One was an ACO-like model, where specific payment mechanisms had not yet been adopted and the other was specific to a health plan owned by a provider system, and incentives were specific to the provider system owned by the health plan and included payment for additional behavioral health services.

Reporting and Evaluations

While both states had a process in place to report select quality measures for managed care plans, these were not widely used to promote integration (probably because of the lack of established measures available to measure integration). Neither state had relied on evaluations or research to create an environment that promoted integration.

Behavioral Health Quality Measures

The two states employed vastly different approaches to using behavioral health quality metrics as a policy incentive to ensure integration of physical and behavioral health services. Kansas employed a huge number of both mental health and substance abuse measures to measure managed care plan performance, and developed their own metrics to look at things like integration with physical health. The metrics established in the state elicited general support from most key stakeholders, with some key stakeholders mentioning that more specific data is needed to measure the social determinants of health. Current data can be out of date, difficult to operationalize and difficult to track.

Texas tracks performance on standard HEDIS measures. Key informants did not express strong opinions about current quality metrics, because the behavioral health metrics were underdeveloped. The BHIAC indicated that a key next step was for them to identify measures of integration to recommend to the state, and the development of more behavioral health quality metrics enjoyed strong support from the CMHCs.

Rates

There was no evidence in either state that rates paid to managed care plans were inadequate to pay for the behavioral health services added to the standard Medicaid managed care benefits. However, in both states key informants noted the importance of moving away from fee-for-service payments toward capitated payments for providers in

order to better incentivize integration of physical and behavioral health services, and the new rates represented a capitated payment to managed care plans, which could then be passed down to providers. In both states, clinical level integration took place at the CMHC level, and it was noted that the CMHCs suffered from resource constraints. This indicates that dedicating additional resources to the CMHCs to help build their capacity to see patients, as Texas did with their DSRIP program, may help advance the states' goals of better quality and access to behavioral health services for Medicaid patients.

3. To what extent did states use ideas to direct managed care plans' provision of behavioral health benefits? Did these strategies promote care integration of physical and behavioral health services at the managed care plan or the clinical level? Were they used to ensure continued provision of behavioral health services?

Although both states used a stakeholder engagement process to ensure that different perspectives were included in the design of their programs, the scope of that process was broader and deeper in Texas than it was in Kansas, and a stakeholder group continued to advise the Medicaid agency throughout implementation of the program. In Kansas, stakeholders engaged with a third-party vendor to discuss goals for the development and implementation of KanCare. The stakeholder engagement process resulted in common goals for KanCare, like integrating behavioral and physical health services and improving care transitions and case management. Later, the state held stakeholder meetings to answer questions and provide technical assistance, but did not engage stakeholders in providing in-depth recommendations regarding the best way to move forward on these goals.

The process in Texas was much more intensive and longer lasting. In Texas, stakeholders provided guidance to regulators on how to structure their contracts with managed care plans and how they should oversee the program. They also provided guidance on how key stakeholders should communicate with one another in order to better align systems, the goals, payment and oversight structures that should be in place for health homes, and how to measures desirable outcomes associated with Texas Medicaid as well as behavioral and physical health integration. The scope of the charge in Texas was deeper, and the BHIAC was in a position to elicit broad agreement across different sectors of the health care system before publishing a recommendation. Combined with the fact that the BHIAC was legislatively mandated, this gave their recommendations a level of validity and a sense of being “vetted” that would not have otherwise been possible. The BHIAC acted to ensure that the system design and overall implementation happened in a way that would make sense for all key stakeholders, and was a major force in driving the overall success of Texas’ program.

In both states, key informants noted that the stakeholder engagement process was important for relationship building in the state and a sense of mutual understanding. Since managed care plans and providers must act as partners to enhance integrated care, these relationships were critical.

Chapter 7: Discussion

Both states lacked a cohesive vision for what integrated care should look like at the managed care plan and provider levels. Neither state had a clear idea of how they wanted coordination and collaboration among providers to improve, how care coordination services for Medicaid beneficiaries should be delineated among managed care plans and providers, or how and whether to incentivize collocation of providers. This vision was elusive because of the lack of experience with integrated care (both within the states and nationally), and a lack of clarity regarding what barriers would need to be surmounted. However, neither state outlined clear roles for the care coordination that would happen at the managed care plan level compared to the provider level. Providers are not directly accountable to the state under a managed care arrangement, but the state could require the health plans to develop a plan for how their care coordination plans will interface with their CMHCs and delineate clear roles and responsibilities for both entities.

Another place where more state-level planning would be beneficial is in the types of places where their population could most benefit from collocation. For example, both states developed systems where integrated care efforts at the clinical level were mostly focused on bringing physical health services into community mental health centers. But, as non-Medicaid expansion states, both states' Medicaid populations are likely to contain a lot of children suffering from ADD/ADHD, depression, behavioral problems, anxiety, SUD, autism, Tourette's, learning disorders, developmental delays, or speech and language problems, and CMHCs are not likely to be their first point of contact with the health care system. Further, CMHCs are often under-resourced, which can cause them to

triage their services to the Medicaid beneficiaries who are most in need of them. Only Texas had a plan to address the capacity issue of CMHCs, by offering additional resources to CMHCs through their DSRIP program.

These stumbling blocks, and the presence of other barriers in the system that the state Medicaid authority has no control over, such as privacy laws, were the primary reasons why key informants in both states noted frustration with the slow pace of integration activities, despite the fact that efforts to integrate behavioral and physical health services had been underway in both states for at least two years. An example of this lack of penetration is the fact that the discussion of integration had only penetrated specialty providers in both states, and had not yet permeated primary care, hospitals, office-based professionals, long-term care, or pharmacies. In fact, primary care settings may be better suited to offer integrated services to a population that does not suffer from acute behavioral health disorders.

There was a marked difference between the two states in their overall oversight strategy for promoting integrated care. Kansas took a top-down approach, relying heavily on data and quality metrics to tell them the story of managed care plan performance in the state. Their biggest struggle was to get the managed care plans and the CMHCs to work together. Perhaps partly because of the political and economic environment that Kansas is operating in, there was less concentrated focus on promoting innovation at the managed care plan and provider levels in Kansas. For example, Kansas policymakers were reportedly concerned about investing in innovations like the CCBHC grant because of potential costs to the state and dismantled their health homes program as soon as the federal match expired. By contrast, Texas was heavily invested in creating an

environment of mutual learning and innovation at both the managed care plan and provider level by leveraging the Delivery System Reform Incentive Payment (DSRIP) program and involving key stakeholders in oversight of the program. In Texas, state-level informants noted the importance of an oversight structure that provides resources, support and flexibility to stakeholders. They reported that an important goal for them is to incentivize the managed care plans to do "something different". This bottom-up approach seemed to foster a more hopeful culture in the state, where provider and advocate level informants reported meaningful progress on integration, as opposed to in Kansas where these informants generally felt that innovation had stagnated at the plan level and was failing to filter down to the provider level in a meaningful way.

In both states, managed care plan efforts to develop alternative payment models for CMHCs helped to circumvent payment barriers in the state and promote collocation of providers. The resulting infrastructure also helped get beyond barriers related to privacy and being unable to share information, because all care could be housed in a single clinic. Having robust behavioral health quality metrics helped to reinforce alternative payment models by providing a mechanism for measuring quality. These mechanisms were the only identified mechanisms that helped circumvent contextual barriers identified in the state.

Beyond these efforts to incentivize better integration at the administrative-, managed care plan-, and provider- levels in Kansas and Texas, providers indicated that they benefited from requirements which help ease the administrative burden of managed care, such as consistent prior authorization guidelines, forms, and processes, and an

engaged legislature which would intervene if indications of quality or access to care suffering arose.

Implications for Weiss' Theory

My findings are consistent with Weiss' theory that ideas may be more enduring than inducements, because the effects will linger. Texas had made more progress than Kansas in engaging providers in the process of integrating care. Simply getting stakeholders at all levels of the system on the same page regarding their goals for integrated care and working together was an accomplishment that would endure in the absence of their own oversight.

Further, the theory doesn't account for the fact that a policy change like improved integration of physical and behavioral health care requires far more than a simple directive from the legislature or a Medicaid agency. It requires a complete change in the structure of the system at every level. It is a goal that could be advanced by federal policy changes (for example, changes to the IMD exclusion, federal data sharing requirements, and coding standards) or state policy changes beyond the Medicaid or mental health agency (for example, changes to state licensing standards, which are currently most typically thought of in siloes). And, it is a goal that requires the participation of the state Medicaid and behavioral health agency, the legislature, the managed care plans, and providers of primary care, mental health care, and treatment of substance use disorders. State authority and policy incentives cannot be used to impact the actions of all of these key stakeholders in a way that will better promote integration. In order for all of these different levels of the system to operate in a way that

complements the goals of physical and behavioral health integration, they need to value that goal, which makes ideas among the more effective and enduring of the different mechanisms that states can use to promote the goal.

The only level of integration that did not require the involvement of multiple stakeholders was administrative integration. But the ideas of stakeholders could have helped the state agencies devise their true aims for integration, and then determine which state agency was best suited for helping managed care plans to further those aims, instead of working against each other, as seemed to take place in Kansas.

Policy Recommendations

As the field of integrated care grows and barriers and best practices become more apparent, states should develop a unified vision of their goals for integrating physical and behavioral health care at different levels of the system. These goals should be created with extensive input from managed care plans, providers, and advocates, and should be flexible enough to accommodate the different types of infrastructure available in different regions of the state. As a part of this process, states should identify barriers specific to their own system and work with the relevant partners to overcome those barriers. If a cohesive approach cannot be worked out between the Medicaid and the state behavioral health agencies, the state Medicaid program should hire staff that specialize in their own state's behavioral health system who will help to implement their vision.

Once a state has a good sense of what it wants to achieve, it can strengthen its system by offering quality measures and payment mechanisms that help to advance their goals. While many Medicaid programs across the nation show strong interest in value-based purchasing, the quality metrics to support these programs are currently

underdeveloped. States should look to Kansas for its innovative use of mental health and substance use disorder metrics, which go well beyond the nationally-endorsed measures for these conditions. Once those measures are developed, they should use them to pay for outcomes that they want instead of paying for encounters. This will give providers the flexibility they need to provide integrated, person-level services.

The strength of the managed care plan in an integrated system is as a central hub of patient information. This high-level view of the patient is sometimes not available to the provider, who may not have access to information about other types of care the patient is receiving. The managed care plans should capitalize on this information by ensuring that patient care is received efficiently (for example, that care is not duplicative and that prescription drugs are not contraindicated), and by using what they know about the patient to ensure care is coordinated between providers. Typically, managed care plans currently often only do this for the highest cost beneficiaries.

<u>Suggestions for Future Research</u>

As Kansas and Texas move forward in their efforts to better integrate physical and behavioral health care, they would benefit from more in-depth information about their current system and what is being accomplished through their efforts. Both states should take a close look at the CMHCs where care is being integrated to determine who is taking advantage of primary care services being newly offered in CMHCs and whether clinician-level integration efforts are being properly concentrated at the CMHC level.

It may also be helpful to take a closer look at the barriers to integration in both states. As I conducted key informant interviews, it was apparent that many people had the sense that legal, licensure, regulatory, and payment barriers existed but could not

identify precisely what those barriers were. The literature on barriers is sparse and newly developing, but as it continues to grow it may be helpful to revisit these barriers in the state through reviewing state documentation, talking with key informants, and conducting participant observations to develop a better understanding of existing barriers to integration in both states, so that they can be better circumvented by state policy.

Both states would also benefit from a more advanced nationwide understanding of what care integration should look like, what populations can be helped by specific efforts to improve coordination and collaboration among providers or collocation of physical and behavioral health services, and how managed care plans and providers can best work together to provide care coordination services for the Medicaid patients that they serve.

Once states have the information base that they need to develop clear goals for integration, they will need to establish a measurement approach that fits their desired goals, including valid, reliable performance measures that can be used as the basis for a pay-for-performance program.

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Appendix A: Key Informants

Kansas Informants			
1	Mike Randol	Director, Division of Healthcare Finance	KS Medicaid
2	Susan Fout	Commissioner of Behavioral Health	KS Department of Aging and Disability Services
	Brad Ridley	Commissioner of Financial and Information Services	
3	Anonymous Informant		Cenpatico / Centene
4	Anonymous Informant		Amerigroup
5	Anonymous Informant		United / Optum
6	Kyle Kessler	Executive Director	Association of Community Mental Health Centers
7	Les Sperling	Chief Executive Officer	Central Kansas Foundation
8	Amy Campbell	Director	Mental Health Coalition of Kansas

Texas Informants			
1	Allan Pittman	Program Management, Behavioral Health Specialist	Texas Medicaid (Texas Health and Human Services Commission)
2	Monica Thyssen	Manager, Health Plan Management	Texas Medicaid (Texas Health and Human Services Commission)
3	Greg Sherill	Market Lead	United / Optum
4	Anne Rote	President of Molina Texas	Molina
	Dr. Ayo Afejuku	Behavioral Health Medical Director	Molina
5	Terry Crocker	CEO, Tropical Texas Behavioral Health	Tropical Texas Behavioral Health
6	Lisa Doggett	Medical Director, TX Medicaid Wellness Program AxisPoint	Axis Point
7	Octavio Martinez	Chair, Behavioral Health Integration Committee	University of Texas
8	Dr. Angelo Giardino	Vice President and Chief Medical Officer	Texas Children's Health Plan
9	Elizabeth LaMair	Healthcare Policy Director	Texas Council of Community Centers
10	Dr. Johnny Gore	Senior Medical Director	Cigna Health Spring

Appendix B: Recommendations of the Behavioral Health Integration Advisory Committee

Holistic Treatment

1. All Managed Care Organizations (MCOs) must have integrated technology systems and care coordination systems for physical and behavioral health, even when the MCO subcontracts for behavioral health services.
2. Technology should be leveraged to allow all providers and MCOs to have electronic access to a member's full medical record without compromising confidentiality.
3. Care transitions from inpatient to outpatient and from outpatient to inpatient settings must be well coordinated. MCOs must emphasize coordinated discharge planning. HHSC should provide focused attention and oversight on the contract requirements related to discharge planning.
4. HHSC should use the term "Medicaid member" rather than "consumer" in written materials and oral presentations when discussing Medicaid beneficiaries regardless of their health condition or diagnosis.

Member Activation

1. Medicaid members must receive clear and linguistically appropriate information on their options in selecting a managed care plan and a provider, along with accurate information on which in-network providers are accepting new members.
2. Medicaid members should have easy access to understandable information on physical and behavioral health conditions, and how to maintain health

and wellness. This should include innovative technology solutions for accessing individual health records and opportunities for self-care.

3. MCOs should encourage and provide support for enhanced communication with the member and, when appropriate, the member's family

Access

1. MCOs should be encouraged to develop a continuum of care for Medicaid members with serious mental illness in lieu of traditional inpatient and outpatient Medicaid benefits.
2. MCOs must have an adequate network of public and private behavioral health providers.
3. When the level of care requested by the providers is recommended by the assessment instrument, the in-network provider should notify the MCO within one business day and no prior authorization is required to deliver the service package. Only deviations from the assessment instrument may require authorization by the MCO and all prior authorizations must meet parity requirements.
4. HHSC should develop a system, in collaboration with MCOs, to improve the efficiency and consistency of the credentialing process and to ensure prompt payment for in-network provider organizations that hire new staff, starting on the date the new staff person is available to see the MCOs members.

Administrative Simplification

1. HHSC should require a uniform Prior Authorization process across all MCOs.
2. HHSC should require MCOS to respond to authorization requests within 2 business days and authorizations should be retroactive to the date and time of the request for Mental Health rehabilitation and Targeted Case Management services.
3. HHSC should require MCOs to follow authorization guidelines for services and determination of medical necessity as defined by the State for Mental Health Rehabilitation and Targeted Case Management services. These guidelines should be developed in conjunction with MCOs, providers and other stakeholders.
4. HHSC should require MCOs to have robust and simple formulary and standard process across plans.
5. MCOs should be transparent with HHSC and providers on their utilization management policies and practices

Payment Mechanisms

1. MCO and provider contracts should align financial incentives across physical and behavioral health. Payments should align with improvements in overall health quality and slowing of overall healthcare costs.
2. Payment rules and requirements should facilitate expansion of models of care that encourage behavioral health providers and physical health providers to co-manage members in a team-based model.

3. Integrated provider sites should be reimbursed through one contract with the MCO, even when the MCO subcontracts with a BHO.
4. In pilot sites, new payment structures should incentivize and support person-centered care, member satisfaction, provider-to-provider communication, care coordination and care of members with complex health conditions to achieve recovery.

<u>Outcome Measurement</u>

1. Outcome measures should support a positive continuous quality improvement process and incentivize accountability at the state, MCO, provider and member level. A biennial review of metrics should be considered to ensure the metrics being gathered are fostering a successful integrated health care delivery model. MCOs and providers, with the support of HHSC, must develop mechanisms to share data on common members while Health Information Exchanges (HIE) in local communities are under development.
2. Measures should be tailored to meet the needs of children, young adults, adults, and the elderly.
3. All MCOs should assess their baseline level of integration, identify strategies to address areas needing improvement, and periodically assess integration improvement and its quality.
4. Member, provider, and MCO satisfaction measures should be monitored and openly distributed to facilitate feedback and transparency.

5. HHSC's philosophy in outcome reporting should be a public, transparent process to increase dialogue on integration, track changes over time, identify strategies to increase integration and describe what is happening in a community.

State Oversight

1. HHSC should develop a coordination plan for behavioral health services that includes all HHS agencies, along with other partnering agencies such as housing, education and criminal justice.
2. HHSC should routinely evaluate the adequacy of the MCOs network through a structured review process, with a focus on whether or not the provider is accepting new members.
3. HHSC Ombudsman staff should be thoroughly trained on the MCO contracts and have the ability to answer questions and assist with complaints in a timely and responsive manner.
4. HHSC Contract Management department should more actively engage Medicaid members and organization when a complaint is filed against an MCO. The Medicaid member, provider and MCOs should all play an equal role in the process.
5. The Behavioral Health Integration Advisory Committee should continue to advise HHSC on integration as the Medicaid program continues to integrate care.

6. HHSC should actively seek stakeholder input on the Medicaid Benefit Policy Review for utilization management practices related to SB58. The process should move as expeditiously as possible.

Health Home Pilots

1. HHSC should determine the outcome measures for assessing health home pilots in advance of operations. This process should include an informed group of stakeholders, including Medicaid members with mental illness, MCOs, providers, advocates, peers, and academia.
2. Health homes should be comprehensive and should have the capacity to provide holistic, person-centered care with a focus on recovery.
3. New payment structures should incentivize and support person-centered care, member satisfaction, provider-to-provider communication, care coordination and care of members with complex conditions to achieve recovery.
4. A quantitative and qualitative evaluation of the pilots must be built in from beginning to end. The evaluation should address process and outcomes clinically, administratively, and financially to facilitate the decision of taking lessons learned from the pilots to scale.
5. Health homes, and their MCO partners, must establish a continuous quality improvement program and report on outcome measures to support evaluation of the model.

Appendix C: Sample Interview Protocols

Sample Interview Protocol
State Informant

Thank you for agreeing to participate in this study.

My name is Ashley Palmer. I am a PhD student at George Washington University with an interest in the evolution of Medicaid due to the ACA. Your state has undertaken an important policy shift by integrating behavioral health and physical health into one Medicaid managed care contract as a way to achieve better integration of the two, and I'd like to learn about your experience with that policy so far. I'm particularly interested in learning about how you have leveraged your authority, policy incentives, or ideas to ensure that behavioral health and physical health care are well integrated.

I will be asking you about facts related to your program, and you may also express opinions during the course of the interview regarding what is working and what is not working. The facts will be written up as a case study of your state, but opinions will be included in cross-state analysis and will not be associated with you in particular. In return for your participation, I will share with you your state's case prior to publishing a paper, as well as the complete paper when it is complete so that you can see what strategies other states are using to ensure care coordination. You may also choose to skip questions or terminate the interview at any time.

I'd like to record our conversation today. The recording will be for notetaking purposes only and will be stored on my own password protected computer. It will not be shared. Is it okay if I record the conversation?

Do you have any questions before we get started? You can also ask questions throughout our conversation if they arise later.

Brief Introduction

1. How long have you served in your current capacity for your agency?
2. What role do you play in overseeing managed care plans?
3. Tell me about your major goals for integrating behavioral health with physical health managed care plans.

Authority (Contracts, Policy/ Regulatory Authority, Communication)

1. When you amended your managed care contracts to include behavioral health, did you work with the same managed care plans, or did you include new plans in the process?
2. What process did you use to write the language for the behavioral health pieces of the new contracts? (
    a. Did you take from your own previous bh contracts?

    b. Did you learn best practices from other states?
    c. Did you hire someone with expertise in writing this type of contract language?
3. When you were writing the behavioral health language, were there any pieces of the contract that you were particularly concerned about getting right? (Probes: care coordination, provider network standards, evidence-based practices for BH such as MAT, SBIRT, etc, quality standards)?
4. When you were writing the behavioral health language, did you consider who would be providing care coordination (provider or managed care plan) and how the two would interact?
    a. Do you have any advice for other states about how to do this effectively?
5. When you were writing the behavioral health language, which providers did you specify access standards for? (This is probably a question the investigator can answer ahead of time by reviewing the contract)
    a. How did you determine what those standards should be?
6. Since you have one integrated bh/ph plan, have you leveraged it to increase SBIRT in primary care settings?
7. When you were writing the behavioral health language, was there anything in particular (that we haven't already talked about) that you added to the contract to ensure better integration with physical health?
8. Now that you have a few years of experience, are there things you'd like to include in your contract that you didn't include initially?
9. Do you expect your contract to change as a result of the new managed care rule?
10. When you added behavioral health to your physical health contract, did you need to apply for a new SPA or another Medicaid authority?
    a. If so, why did you choose that particular pathway?
    b. What other pathways did you consider?
11. How did you coordinate with the (physical/ behavioral) health agency during this process?
    a. How did you determine which one of you should take ownership of the process?
    b. How did the other party stay actively involved?
    c. Did both agencies share a vision for the purpose of moving to an integrated plan?
12. Are there other ways, other than those we've just discussed, in which you used your authority to ensure that behavioral health and physical health are provided in a more integrated way?
13. Are there other ways, other than those we've just discussed, in which you used your authority to ensure better care coordination between physical and mental health?

Policy Incentives (Financial, Reporting)

1. How did you set rates for the new behavioral health services?
    a. Did you have to set new rates for both the physical and behavioral health services, or did your physical health rates stay the same?
    b. Were you able to use experience data to set the rates?
    c. Did the managed care plans propose rates, or did you propose them?
    d. How confident do you feel that the behavioral health rates are "Actuarially sound"?
    e. Have you received feedback from any of your plans about the rates being too low, too high, or just right?
2. Do you use pay for performance based on any indicators of care integration?
    a. IF so, do you think it is effective?
3. Do you expect any aspect of your payment to change as a result of the new federal managed care rule? (probe: which states that you may partner with them to pursue broad goals but may not direct expenditures)
4. Did you add any new reporting requirements for behavioral health or bh/ph integration?
    a. If you did, can you please explain what they are and how they will be used?
    b. Are they helping you achieve the results that you want?
    c. Are there other ways you will measure the progress of integration/ care coordination?
5. Are there other ways, other than those we just discussed, in which you are using data or financial incentives to ensure that behavioral health and physical health are provided in a more integrated way?
    a. Are there ways in which you'd like to use data or financial incentives, but aren't currently?
6. Are there other ways, other than those we just discussed, in which you are using data or financial incentives to ensure better care coordination between physical and mental health?
7. Are there other policy incentives that you are using to promote behavioral health/ physical health integration or care coordination?

Ideas (Research and Evaluation, TA, Demonstration Projects)

1. Is your state offering technical assistance to help managed care plans (or other stakeholders, such as providers) understand the importance of integrated care or better care coordination?
    a. If so, where do they most need assistance in your opinion?
2. Is your state offering technical assistance to help managed care plans (or other stakeholders, such as providers) overcome any barriers to better integrating care?

   a. If so, what are the barriers you are helping them overcome?
3. Did you implement integration statewide immediately, or did you start with a demonstration project or pilot program?
   a. If you began with a pilot program, do you think it has changed stakeholder perceptions of the benefit at all (i.e. buy-in)?
4. Are there other ways, other than those we just discussed, which you have used to influence managed care plans' ideas about the need for better care integration of physical/ behavioral health?
5. Are there other ways, other than those we discussed, which you have used to influence other stakeholders' ideas about the need for better care integration of physical/ behavioral health?

Experience of Implementation

1. Have behavioral health services been integrated with physical health in the way that you expected?
   a. What is going well?
   b. What has not gone as planned?
2. Are you monitoring behavioral health service provision?
   a. What are the early impacts of integrated care?
   b. Early impacts on care coordination?
3. Are you planning any changes to improve integration?
4. Which of the strategies that we talked about have been key to ensuring better care coordination?
5. Which strategies have not worked as you hoped?
6. What would you do differently?

Sample Interview Protocol
Plan Informant

Thank you for agreeing to participate in this study.

My name is Ashley Palmer. I am a PhD student at George Washington University with an interest in the evolution of Medicaid due to the ACA. Your state has undertaken an important policy shift by integrating behavioral health and physical health into one Medicaid managed care contract as a way to achieve better integration of the two, and I'd like to learn about your experience with that policy so far. I'm particularly interested in learning about guidance you've received from the state to ensure that behavioral health and physical health care are well integrated.

I will be asking you about facts related to your program, and you may also express opinions during the course of the interview regarding what is working and what is not working. The facts will be written up as a case study of your state, but opinions will be included in cross-state analysis. I will be speaking with representatives from other plans and other stakeholders in the state and will ensure that nothing you say can be attributed to you in particular. In return for your participation, I will share with you your state's case prior to publishing a paper, as well as the complete paper when it is complete so that you can see what strategies other states are using to ensure care coordination. You may also choose to skip questions or terminate the interview at any time.

I'd like to record our conversation today. The recording will be for notetaking purposes only and will be stored on my own password protected computer. It will not be shared. Is it okay if I record the conversation?

Do you have any questions before we get started? You can also ask questions throughout our conversation if they arise later.

Brief Introduction

4. How long have you served at (managed care plan name) in (state)?
5. Can you describe your current role?
6. Did (managed care plan name) have prior experience providing behavioral health services to Medicaid clients?
7. From your perspective, what were the primary things that your plan had to learn quickly when you integrated behavioral health in?
8. How did the state assist you in learning these things?
9. What other sources of information did you rely on?

Authority (Contracts, Policy/ Regulatory Authority, Communication)

14. Did you receive a new contract when you integrated behavioral health into your operations?

a. If yes, how did you use the contract to influence the way that your plan operated? What changes did you make because of the contract (provider network, services, care coordination, etc.)?
b. If no, how did you know what your new responsibilities were?
c. Did you connect with the managed care plans formerly providing behavioral health services in order to understand your new responsibilities?

15. Did the state (or contract) specify who would be providing care coordination (provider or managed care plan) and how the two would interact, or did the state allow you to make that determination?
16. How do you determine if you have adequate network adequacy for behavioral health?
    a. Are the state standards sufficient?
17. Since you have one integrated bh/ph plan, are you doing anything to increase SBIRT in primary care settings?
18. Tell me about your care coordination plans for members with physical and behavioral health needs.
19. Now that you have a few years of experience, are there things you'd like to include in your contract that you didn't include initially?
20. Do you expect anything to change as a result of the new managed care rule?
21. Do you coordinate with the Medicaid agency primarily?
22. What kind of interaction do you have with the behavioral health agency in terms of your Medicaid behavioral health patients?
23. Are there other ways that you've worked with the state to ensure better care integration or care coordination for behavioral and physical health?

Policy Incentives (Financial, Reporting)

8. How were rates set for the new integrated plan?
    a. Did you propose rates?
    b. Are your rates adequate?
9. Do you use pay for performance based on any indicators of care integration?
    a. IF so, do you think it is effective?
10. Do you expect any aspect of your payment to change as a result of the new federal managed care rule?
11. Do you have any new reporting requirements for behavioral health or bh/ph integration?
    a. If you did, can you please explain what they are and how they will be used?
    b. Are they helping you achieve the results that you want?

    c. Are there other ways you will measure the progress of integration/ care coordination?
12. Are there other ways, other than those we just discussed, in which you are using data or financial incentives to see if behavioral health and physical health are provided in a more integrated way?
    a. Are there ways in which you'd like to use data or financial incentives, but aren't currently?
13. Are there other ways, other than those we just discussed, in which you are using data or financial incentives to ensure better care coordination between physical and mental health?

Ideas (Research and Evaluation, TA, Demonstration Projects)

6. Is your state offering technical assistance to help managed care plans understand the importance of integrated care or better care coordination?
    a. If so, has this been helpful? In what ways?
7. Is your state offering technical assistance to help managed care plans overcome any barriers to better integrating care?
    a. If so, has this been helpful? How?
8. When you became responsible for behavioral health and physical health, were you immediately responsible for all Medicaid enrollees in the state or was it done in stages?
9. Are there other ways, other than those we just discussed, in which you have been influenced about the need for care integration or care coordination for physical/ behavioral health?

Experience of Implementation

7. Have behavioral health services been integrated with physical health in the way that you expected?
    a. What is going well?
    b. What has not gone as planned?
8. Are you monitoring behavioral health service provision?
    a. What are the early impacts of integrated care?
    b. Early impacts on care coordination?
9. Are you planning any changes to improve integration?
10. Which of the strategies that we talked about have been key to ensuring better care coordination?
11. Which strategies have not worked as you hoped?
12. What would you do differently?

Sample Interview Protocol
Provider Informant

Thank you for agreeing to participate in this study.

My name is Ashley Palmer. I am a PhD student at George Washington University with an interest in the evolution of Medicaid due to the ACA. Your state has undertaken an important policy shift by integrating behavioral health and physical health into one Medicaid managed care contract as a way to achieve better integration of the two, and I'd like to learn about your experience with that policy so far. I'm particularly interested in learning about guidance you've received from the state and changes you've seen with the managed care plan to ensure that behavioral health and physical health care are well integrated.

I will be asking you about facts related to your program, and you may also express opinions during the course of the interview regarding what is working and what is not working. The facts will be written up as a case study of your state, but opinions will be included in cross-state analysis. I will be speaking with representatives from other plans and other stakeholders in the state and will ensure that nothing you say can be attributed to you in particular. In return for your participation, I will share with you your state's case prior to publishing a paper, as well as the complete paper when it is complete so that you can see what strategies other states are using to ensure care coordination. You may also choose to skip questions or terminate the interview at any time.

I'd like to record our conversation today. The recording will be for notetaking purposes only and will be stored on my own password protected computer. It will not be shared. Is it okay if I record the conversation?

Do you have any questions before we get started? You can also ask questions throughout our conversation if they arise later.

Brief Introduction

10. How long have you worked at (provider name) in (state)?
11. Can you describe your current role?
12. Are you familiar with the move to integration of behavioral health and physical health in managed care?
13. In a few words, what are the things that changed because of this integration?

Care Integration and Care Coordination

1. Can you describe how care coordination has changed for your patients with both physical and mental health needs since the move to integrated managed care happened?
2. Can you describe other efforts to integrate care that have come from either the state level or the managed care plans since integration happened?

Policy Incentives (Financial, Reporting)

14. Do you use pay for performance based on any indicators of care integration or care coordination?
    a. IF so, do you think it is effective?
15. Do you collect any other additional quality metrics that you use for pay for performance as a result of this integration?
16.
17. Do you have any new reporting requirements for behavioral health or bh/ph integration?
    a. If you did, can you please explain what they are and how they will be used?
    b. Are they helping you achieve the results that you want?
    c. Are there other ways you will measure the progress of integration/ care coordination?
18. Are there other ways, other than those we just discussed, in which you are using data to see if behavioral health and physical health are provided in a more integrated way?
19. Are there other ways, other than those we just discussed, in which you are using data or financial incentives to ensure better care coordination between physical and mental health?

Ideas (Research and Evaluation, TA, Demonstration Projects)

10. Is your state offering technical assistance to help you understand the importance of integrated care or better care coordination?
    a. If so, has this been helpful? In what ways?
11. Are managed care plans offering any kind of technical assistance for providers to improve care integration or care coordination?
12. Is your state offering technical assistance to help you overcome any barriers to better integrating care?
    a. If so, has this been helpful? How?
13. Are managed care plans offering any kind of technical assistance for you to overcome barriers?
14. Are there other ways, other than those we just discussed, in which you have been influenced about the need for care integration or care coordination for physical/ behavioral health?

Experience of Implementation

13. Have behavioral health services been integrated with physical health in the way that you expected?

a. What is going well?
b. What has not gone well?
c. What needs improvement?
d. What aims do you work closely with the managed care plans to achieve?

14. Are you monitoring behavioral health service provision?
    a. What are the early impacts of integrated care?
    b. Early impacts on care coordination?
15. Are you planning any changes to improve integration?
16. Which of the strategies that we talked about have been key to ensuring better care coordination?
17. Which strategies have not worked as you hoped?
18. What would you do differently?