

THE TRANSITION OF BEHAVIORAL HEALTH SERVICES INTO COMPREHENSIVE MEDICAID **MANAGED CARE:** A Review of Selected States



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CONTENTS

Acknowledgments.....	3
Executive Summary.....	4
Methodology.....	7
Limitations.....	9
Evolution of Managed Behavioral Health Services.....	9
Goals of Carve-in States.....	11
Goals of Carve-out States.....	13
Selected State Experiences.....	14
Reported Benefits of Carve-in.....	17
Lessons Learned.....	18
Key Findings and Observations.....	18
Opportunities and Recommendations.....	24
Conclusion.....	26
Appendices.....	28

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EXECUTIVE SUMMARY

Many states include behavioral health (BH) services as one of the benefits administered by comprehensive Medicaid managed care organizations (MCOs), also referred to as carved-in behavioral health services. According to the 2019 Kaiser Family Foundation 19th Annual Medicaid Budget Survey, 30 states exclusively or otherwise cover BH services for adults with serious mental illness (SMI) and/or children and adolescents with serious emotional disturbance (SED) under comprehensive MCO contracts.¹⁰

In some states that recently implemented carved-in BH benefits, the move caused significant service disruptions for consumers and caused providers to experience numerous and costly administrative processes to receive service cover authorizations or payments. Because of substandard rollouts, some states and MCOs had to devote attention to fixing implementation errors rather than focus on their primary objective, which is improving consumer outcomes through more effectively integrated physical and behavioral health care.

The National Council for Behavioral Health commissioned the development of this report so authors could examine carve-in implementation experiences in selected states. The National Council can use report findings to offer recommendations to state and federal policymakers so unintended negative consequences are remedied quickly or avoided entirely. Authors researched and reviewed several materials and conducted interviews with 28 stakeholders, including current and former leadership and staff from state Medicaid agencies, state and county BH authorities, state BH provider associations, BH treatment providers, a county-operated specialty behavioral health plan and a member of a state's legislature.

Authors interviewed individuals from carve-in and carve-out states to understand perspectives about current systems and planned BH reforms. Interviewees included current and former officials in Arizona, Kansas, Louisiana, New York, Ohio, Oregon, Tennessee and Washington (BH carve-in states) as well as Maryland and Pennsylvania (states where BH is carved-out of comprehensive MCOs, but administered by other types of managed care entities).

Authors reviewed and analyzed Medicaid procurement materials and MCO contracts, which make clear that states intend BH carve-in to result in: integrated behavioral and physical health care and clinical integration (Arizona); coordination of care and integration of physical and behavioral health services (Kansas); decreased fragmentation and increased integration across providers and care settings, particularly for enrollees with behavioral health needs (Louisiana); improved health outcomes and recovery, reduced unnecessary emergency and inpatient care and increased network capacity to deliver community-based recovery-oriented services (New York); integration of



behavioral and physical care (Ohio); a continuum of care that integrates mental health, addiction treatment dental health and physical health seamlessly and holistically (Oregon); integrated delivery of physical health, behavioral health and long-term care services (Tennessee); and integrated behavioral health services that support a bi-directional delivery of care model (Washington).

However, interviews suggest that states fell short of goals in many respects. Several themes emerged from interviews – described more fully in this report – and findings revealed that payment delays and service disruptions only partly reflect the problems related to carve-in. Clearly, some of the challenges are a direct result of the planning, design and rollout of the new managed care arrangements. Other issues are more deeply rooted. While assuring sufficient time to plan a successful implementation is key to effective integration of physical and behavioral health care, it would be a mistake to assume that implementation problems alone were at issue.



Authors observed that there are more fundamental challenges to achieving a successful model of physical health care and behavioral health care integration than a hurried implementation schedule. For example, stakeholders reported the lack of recovery-oriented measures; few, if any, measures of effective service integration with physical health care; little movement toward the level of accountability desired by states; and inadequate involvement of the state BH authority.

Authors noted other key takeaways, including that financial integration does not automatically result in effective clinical integration and that in some states, Medicaid and MCO leadership lacked the expertise in, and understanding of, BH populations, systems and services. Authors also made observations that seem to point to state Medicaid agencies' failure to address systemic barriers to ensure BH providers' effective participation in managed care, including:

- Lack of true, historical collaboration between leadership and staff from state Medicaid agencies and state BH authorities in some states.
- Lack of investment in and uneven use of health information technology (HIT) and health information exchange (HIE).
- Lack of financial reserves in BH provider organizations to manage with interrupted cash flow.
- Lack of an administrative infrastructure (even beyond HIT) within BH provider agencies to manage increased administrative demands from multiple managed care plans.

While no single solution can address all these issues, it is critical that state Medicaid agencies take stock of the already vexing BH services environment and make plans to ensure the success of sweeping reforms, even if that means making incremental changes over a longer period of time. Clearly, states will continue using managed care strategies; however, there is an opportunity for states to assess the serious implementation problems with recent carve-in rollouts and make improvements, including in states where carve-in has already occurred.

There are also opportunities for states still in the pre-implementation stages to avoid similar outcomes. The number of new states pursuing BH carve-ins may have slowed down for people with SMI, but states continue to seek more holistic approaches to address care needs of persons with SUD. Federal partners should require states to demonstrate readiness on all fronts prior to launching such significant system changes that affect vulnerable populations who are already at high risk of early mortality and increased comorbidity. Given the similarities between BH carve-in and managed long-term services and supports (MLTSS), the Centers for Medicare and Medicaid Services (CMS) should increase its monitoring of large-scale BH delivery system and financing reforms and hold states fully accountable for assured end-to-end systems testing, continuity in provider payments, service access and quality.

To ensure effective planning and smoother implementation of BH benefits carved-in to comprehensive Medicaid managed care organizations, states should:

1. Use existing data resources to document their understanding of the BH service system, including an analysis of population demographics, chronic health conditions, cost drivers and total cost of care of persons with SMI/SED or SUD, service utilization and trends and care gaps.
2. Assess current provider and service capacity and determine whether a sufficient network is available to attend to population health needs.
3. Describe and quantify outcomes to be achieved with carve-in, including health, quality of care, financial and member experience outcomes and have a formal pre-/post-evaluation plan for the implementation.
4. Collaborate with the state's BH authority and provider networks' clinical leadership to develop a clinically informed theory about how to accomplish change and confirm which evidence-based services will support desired changes.
5. Conduct internal Medicaid agency reviews of readiness across all program phases (e.g., planning, design, pre-implementation, go-live, monitoring), particularly related to requests for proposals (RFP) development, outcomes measures identification, MCO contracting, rule promulgation and handbook development.
6. Conduct external behavioral health provider readiness reviews with respect to contract negotiation, coding, claim submission and payment reconciliation abilities and be prepared to offer technical assistance and training to behavioral health providers without prior experience in managed care contracting and billing.
7. Stage implementation based on readiness and resource constraints and establish a clear communications strategy to keep members, providers and other stakeholders informed about timeframes, progress and delays.
8. Conduct and evaluate small-scale pilots (e.g., regional rollouts) to identify implementation details that may be in need of refinement or overhaul before full implementation of reforms.
9. Ensure MCO readiness by confirming appropriate governance and staffing, provider network and services adequacy, claims processing capacity, reporting capabilities and development of internal policies and procedures.
10. Institute formal end-to-end systems testing and require MCOs to report on outcomes and document which services were not paid during testing.
11. Ensure provider readiness by assessing staffing and workforce capacity, claims submission capacity, EHRs and use of HIT/HIE.
12. Develop an oversight, monitoring and evaluation framework for program integrity and general quality improvement purposes.

METHODOLOGY

For purposes of this report, we define carve-in as BH benefits provided through integrated, comprehensive MCOs whereby the MCO has contractual responsibility for payment and coverage of physical and behavioral health services. We define carve-out as behavioral health services provided through a managed behavioral health care organization (MBHO) or under a fee-for-service system (FFS). For purposes of this report, carve-out also refers to FFS BH benefits administered by administrative service organizations (ASO). In practice, states have implemented a wide range of models, including models where some BH services are carved-in to comprehensive MCO arrangements while some BH services are carved-out to specialty MCO or FFS arrangements. In this report, we do not attempt to address all the variations in each state. States included in our stakeholder interviews as a carve-in state include most or all BH services in an integrated, comprehensive MCO arrangement, and carve-out states include all or a substantial array of BH services through an MBHO, FFS or ASO arrangement.



Authors reviewed news articles, trade association publications, multi-state comparison reports, nationwide environmental assessments and state materials to understand the implications of BH benefits carved-in to comprehensive MCO arrangements. We also reviewed state Medicaid agency procurement documents and resulting MCO contracts to understand states' goals for pursuing BH carve-in and the outcomes metrics states are using to demonstrate achievement of goals.

In addition, authors participated in a telephone conference comprised of National Council state association executives to clarify the scope and intent of report, discuss report topics and key areas of exploration and identify additional key informants to participate in structured interviews.

Authors conducted telephone interviews with a total of 28 stakeholders from eight carve-in states (Arizona, Kansas, Louisiana, New York, Ohio, Oregon, Tennessee and Washington) and two carve-out states (Maryland and Pennsylvania) to understand their perspectives about their own state's current and planned BH delivery system.

Informants included current and former officials from state and county BH authorities, state Medicaid agencies, state BH provider association executives and staff, BH providers, county BH MCO officials and a state legislator. Interviews conducted with officials from Kansas, Louisiana, New York, Ohio, Oregon and Washington used a structured interview guide, which was shared with interviewees prior to each call ([see Appendix A](#)).

Questions in interview guides were organized across the following seven categories:

- 1. Current System and Status:** Stakeholders were asked to describe the current Medicaid managed care structure in their respective states and any changes contemplated by the state.
- 2. Purpose of Reform.** Stakeholders were asked about states' goals for adoption of (or plans to adopt) a new managed care structure for Medicaid BH services.
- 3. Stakeholder Engagement.** Stakeholders were asked about roles and processes for engaging stakeholders in the development and design of the reform, who the primary drivers were in development of reform and the types of engagement strategies used by the state.
- 4. Implementation and Operations.** Stakeholders were asked about implementation processes and effectiveness of readiness assessment reviews. Respondents also weighed in on how effectively the state prepared providers for implementation and what worked, as well as what did not go smoothly.
- 5. Performance.** Stakeholders were asked about whether states have undertaken any steps to identify and track quality performance measures for populations and integrated care outcomes. Interviewees were also asked whether data shows the movement to managed care results in achievement of states' quality goals.
- 6. Health Information Technology and Exchange (HIT/E).** Stakeholders were asked whether the state created an HIT/E plan to align technology capabilities with the strategic goals of the managed care transition and whether the state implemented HIT project management steps to support transformation process.
- 7. Summary and Lessons Learned.** Stakeholders were asked to describe one-to-three changes that would have improved the state's experiences and whether they see potential in a comprehensive MCO approach to improve health care outcomes for individuals with SMI/SED or SUD.

[Appendix B](#) contains summarized themes from stakeholders across the seven interview categories and reflect responses from carve-in and carve-out states.

After completion of structured interviews, authors also reached out to three former Medicaid directors who led significant BH carve-in reforms in Arizona, Ohio and Tennessee and were willing to share their insight in terms of their vision and initial goals, the implementation experience and lessons learned.

Individual telephone interviews with the Medicaid directors centered on the following questions:

1. What problems were you trying to solve and what goals did you want to achieve with carve-in?
2. Compared to other reforms you have implemented, was planning and rolling out integrated BH services/funding more or less challenging or about the same?
3. Looking back, what would you have done differently? What would you do the same or relatively the same?
4. What do you think is important for stakeholders to understand about decisions you made in terms of structure, design, timing, etc. of carve-in?

Responses and findings from all interviewees are incorporated throughout this report.

LIMITATIONS

Although authors discussed the purpose of the report with a large national specialty BH MCO at the suggestion of The National Council, there was no additional outreach to MCO staff or leadership to conduct formal interviews. Authors were concerned that MCO staff and leadership would need permission to speak on the record and concerned about the amount of time necessary to get clearance from the health plans. Realizing that limitation, authors engaged in informal discussions with a former MCO BH executive to discuss their viewpoint. However, that person's views are only representative of the implementation experience at that health plan. For those reasons, authors did not include findings from the key informant.

EVOLUTION OF MANAGED BEHAVIORAL HEALTH SERVICES

Managed Medicaid BH services are not new. In the late 1980s and throughout the 1990s, a number of states moved BH services for treatment of SMI/SED and SUD populations from FFS to managed care, typically under specialty BH carve-out arrangements.^{iii,iv} Over time, many states elected to transition BH services to comprehensive Medicaid MCOs in an effort to integrate financing and services to facilitate improved coordination of physical and behavioral health care.

The National Council for Behavioral Health published two previous reports focused on identifying trends and analyzing key findings from states regarding integrated managed care and specialized BH benefit models. In 2011, the National Council released "Increasing Access to Behavioral Healthcare: Managed Care Options and Requirements," which served as a systematic review of various state managed care approaches to serving the needs of Medicaid enrollees with SMIs and emotional disturbances.^v A follow-up report, "Behavioral Healthcare through Integrated Managed Care: Options and Requirements," was produced in 2014.

Both reports center on the comparison between carve-in and carve-out arrangements. Highlights of these reports included:

- MBHOs were described as having more experience working with community behavioral health providers and as more likely to contract and credential with providers serving clients with complex behavioral health needs. Conversely, MCOs were described as lacking in ability to coordinate care for people with SMI and having more restrictive credentialing for BH clinicians. In addition, MCOs were found to often not recognize credentials for SUD providers unless the individual was a master's-level clinician.
- Both reports mentioned findings from a study on Healthcare Effectiveness Data and Information Set (HEDIS) data that showed MCOs across the country scoring significantly lower for mental health than for physical health.
- With regard to BH benefits, the reports presented general concerns that MCOs, which historically often cover only acute services, only have experience authorizing services through traditional medical necessity processes and standards. MBHOs were viewed as having more flexible prior authorization requirements.
- MBHOs were reported to have more experience and be nimbler in their ability to finance care via multiple funding streams (in addition to Medicaid).
- Concern was expressed that the MCO carve-in model could have fewer contractual incentives to provide and coordinate care to people with SMI, resulting in more frequent and costly use of emergency and inpatient services.

Despite these concerns, the trend nationally over the last decade has been toward adoption of carve-in models for BH services. According to the Kaiser Family Foundation 19th Annual Medicaid Budget Survey,^{vi} at least 40 states contract with MCOs to deliver physical health care services to at least some portion of the Medicaid eligible population. In 26 states, individuals with SMI/SED who are non-dually eligible for Medicaid and Medicare and not enrolled in long-term service and support systems (LTSS), are mandatorily enrolled in a Medicaid MCOs for at least their physical health care services. Other states with managed care arrangements allow voluntary enrollment of some or all of this population. Only two of the 40 states exclude all individuals with SMI/SED from enrollment in managed care for physical health care services. Increasingly, behavioral health services are covered along with physical health care services in many of these states' MCO contracts. In these 40 managed care states, behavioral health services are:

- **ALWAYS** carved-in for specialty outpatient mental health in 23 states, sometimes carved-in in seven states for some populations or geographic areas and always carved-out in only 10 states.
- **ALWAYS** carved-in for inpatient mental health in 28 states, sometimes carved-in in five states and always carved-out in only seven states.
- **ALWAYS** carved-in for outpatient SUD in 29 states, sometimes carved-in in four states and always carved-out in only seven states.
- **ALWAYS** carved-in for inpatient SUD in 29 states, sometimes carved-in in five states and always carved out in only six states.

Only one state in 2019 and one state in 2020 reported plans to introduce MCO arrangements for the first time for any set of services and populations. This suggests that the movement to adopt managed care arrangements in states that do not use managed care at all may have plateaued. There may, therefore, be less urgency in most of the non-MCO states regarding changes in how BH services are delivered.

However, within states that already use MCO arrangements, there is still significant activity to expand use of those arrangements for additional populations or services. None of the states with managed care expansion plans for 2019/2020, as reported in the Kaiser survey, were focused on BH populations or services, but the Kaiser report does show that states using managed care for any populations or services are much more likely to expand MCO use going forward than to limit it. This suggests that managed care states where BH services are now carved-out or are carved-in for only some populations/geographic areas might anticipate some future interest in movement to a fully carved-in model.



EARLY CARVE-IN MODELS

Pennsylvania and Maryland had early experience with carved-in BH services.

PENNSYLVANIA - Medicaid beneficiaries were mandatorily enrolled in managed care plans in 1986 with the establishment of the HealthPASS pilot program in Philadelphia. HealthPASS served a “primarily poor, minority and inner-city population with high rates of drug abuse, alcoholism and mental illness.”

The BH capitation was roughly \$20 per member per month (PMPM). The MCO subcontracted with a BH plan and the PMPM to the BH plan was roughly \$10 PMPM. Aside from PMPM capitation rates, several other challenges were cited including serious disruptions in health care for beneficiaries once the health plan went bankrupt in 1989, low payment rates to providers, lack of qualified state personnel to oversee a managed care system and lack of developed systems in place by the new plan.^{vii}

MARYLAND - HealthChoice, the statewide Medicaid managed care program, was implemented in 1997 under a Section 1115 Demonstration Waiver. Since that time, specialty mental health services have been carved-out of the HealthChoice benefit package with delivery of those services overseen by an ASO. Following a multi-year stakeholder process to streamline disparate systems of care for individuals with co-occurring SMI and SUD, the state elected to carve-out SUD service from its HealthChoice benefits package.^{viii}

Since January 1, 2015, all specialty MH and SUD services for Medicaid recipients have been administered by the ASO. Preliminary findings suggest that the carve-out of SUD services and integration of benefits under the ASO have not yet significantly impacted the utilization of high-cost services.

GOALS OF CARVE-IN STATES

There are multiple reasons that Medicaid carve-in states included in this review pursued comprehensive carve-in models for BH services. Chief among those cited in our interviews with state officials and other policymakers was concern that individuals with SMI and SUD are poorly served by the traditional delivery system that is siloed between physical health care and behavioral health care.

Individuals with SMI/SED or SUD often experience significant physical health care comorbidities in addition to their BH needs. The literature supports the concern that this population experiences poorer health outcomes than populations without BH conditions, including earlier death from untreated or undertreated chronic conditions.^{ix} In addition, many state Medicaid programs have recognized that individuals with BH conditions often have higher costs for physical health care services compared to individuals with the same physical health care challenges who do not have a comorbid BH condition. Medicaid agencies, therefore, tend to believe that having one care management entity responsible for coordinating all services for the individual can result in improved outcomes, and potentially lower costs, overall.

Several state officials noted that a siloed delivery system provided no single party to hold accountable for outcomes for the target population and that a bifurcated system created financial incentives to cost-shift across payers/systems, rather than to improve overall care for the individual. Further, some officials noted that a siloed system did not provide sufficient understanding of what Medicaid was purchasing, especially when in many systems BH services were being provided in both the “physical” health care system (e.g., MCO coverage of BH drugs, BH delivered in primary care settings including FQHCs, emergency department services, some BH inpatient hospital services) in addition to services provided in the specialty BH system. Medicaid leaders often cited a goal of ensuring that whole person care would be front and center and achievable, noting they could hold MCOs accountable and track spending and outcomes more efficiently.



Some Medicaid officials expressed frustration with what they saw as historically ineffective collaboration between Medicaid and the publicly organized behavioral health care system, or with the failure of physical health care MCOs and BH specialty plans to work together effectively to improve service integration for individuals served in both systems. Medicaid officials in some states noted the difficulty of accomplishing clinical integration when there was no integration at the payer level, including creating unintended barriers to the development of new models of integrated care at the provider level, and noted that innovative providers had complained about these barriers.

State Medicaid programs often cite a need for more accountability from the BH provider system and noted that the Medicaid program was already pursuing increased accountability from the physical health care system through a variety of managed care initiatives. Bringing BH services into the same contracts already in place for most or all of the rest of Medicaid services was seen as an obvious and logical next step by many Medicaid agencies, with the added advantage of increasing Medicaid’s ability to directly oversee a part of the delivery system that traditionally may have been administered by other authorities. Obviously, this interest in an integrated model is strongly and often proactively supported by the Medicaid-contracting MCOs already operating in the state, which find it in their financial interest to lobby to expand their contract responsibilities to include behavioral health benefits.

Other goals of integrated models cited in our interviews with stakeholders in various states include promoting attention to social determinants of health, ensuring improved access to primary care and prevention services for individuals with SMI and improved access to recovery services. Some states have undertaken benefit or reimbursement redesign as a part of, or in anticipation of, moving to an integrated model of service delivery.

Medicaid interest in revisiting BH benefit design is another indication of the higher level of attention and priority being given to behavioral health care needs within the Medicaid population, attention driven in part by the effects of the opioid epidemic, as well as by the increased demand for Medicaid mental health services often experienced by states that have expanded eligibility to adults under the Affordable Care Act (ACA). [Appendix C](#) contains additional state-specific goals for integrating BH into comprehensive managed care structures. Goals were extracted from Medicaid procurement materials and MCO contracts.

GOALS OF CARVE-OUT STATES

Importantly, key informants interviewed in Maryland and Pennsylvania, the two states in our review that still maintain a specialty behavioral health managed care delivery system, identified similar goals and issues as relevant to public discussions regarding the future of behavioral health delivery for the Medicaid population. Policymakers in both Maryland and Pennsylvania continue to wrestle with how to improve coordination of services across physical and behavioral health care systems for individuals who have comorbid conditions and to debate whether and how to improve accountability within the behavioral health system. A state official in Pennsylvania noted that, regardless of structure, the state's goal is to promote the best outcomes for persons with BH conditions.

Interestingly, both Maryland and Pennsylvania were early adopters of a carve-in model for BH services, but both moved back to a carve-out approach to managed care after a few years of unsatisfactory experience with their carve-in models.

While there are stakeholders in both states that continue to advocate for improvements in integration of services and outcomes for individuals with SMI/SED or SUD, the arguments expressed against returning to a carve-in model focus on:

- Existence of strong county-based systems that are able to focus on managing BH services.
- The ability of existing BH carve-out systems to create a robust specialty BH provider network.
- Specialty BH systems' ability to achieve state goals for increased access and service penetration for BH services while achieving BH system savings.
- The ability to reinvest system savings and fund essential county services for persons with BH needs.
- Specialty MBHOs having more than 30 years of experience addressing social determinant of health issues for clients.
- Carve-out arrangements allowing for more focus on innovation in outcome measures and development of solid outpatient measurement systems for mental health services.
- Lack of evidence of carve-in arrangements improving lives of people with BH and PH conditions.

In both states, strong concern was expressed that the experience in states that have adopted carve-in models for BH services has generally involved serious disruption for the BH system, including damaging financial stress to providers, without demonstrating significant improvements in service integration and outcomes for individuals with SMI/SUD. Many stakeholders in these states argue for a recommitment to existing carve-out arrangements and believe that issues regarding the need for improved service integration with physical health care services can be addressed through clearer contractual requirements or implementation of new benefits that promote whole-person care (e.g., Medicaid health home services).

SELECTED STATE EXPERIENCES

Despite the good intentions reported by state Medicaid programs to adopt integrated contract models that combine physical health care and behavioral health care into a single MCO design, the implementation experience in state after state has been difficult. In many states, the BH provider network was described as "not ready" to do business with multiple managed care entities by the go-live date. State officials and providers alike often described implementations that felt "rushed" to meet a Medicaid-identified reform date, or failed to assure an effective readiness review and assurance prior to go-live. Most, if not all, states experienced periods during which BH provider service authorizations and/or claims payments were delayed, and some states like New York and Ohio reported many months and even years of continuing claims payment challenges. Providers in many states described cash flow challenges that have undermined the financial viability of many specialty network providers.

Stakeholders in some states reported the following:

- The early pressure by Medicaid on MCOs to demonstrate availability of an adequate specialty BH network within a short implementation timeframe sometimes resulted in **poor network oversight by MCOs**, which allowed some service activities to be delivered by less than fully qualified providers.
- States were concerned that there are **few, if any, measures of effective service integration with physical health care**.
- While some Medicaid agencies could point to some positive outcomes for covered beneficiaries post-reform, most stakeholders, including state officials, reported that there had been **little movement toward the level of accountability desired**. As one interviewee noted, almost all the energy expended in the first years of integrated contracts focused on figuring out how to get claims paid and provider cash flow restored to preserve networks and access.
- One state official described supporting intensive efforts in a couple of communities which undertook reconsidering the design and administration of BH specialty networks under the integrated model, but reported that they have **not yet seen significant delivery system reform across the state**, even after several years of integrated MCO contracts.
- More than one state noted that the **Medicaid program has to reconsider and implement new MCO contracting and measurement strategies** in an attempt to move the system focus toward achieving service or outcome improvements for the BH population.
- One state noted that, when it implemented carve-in, the **health plans had little experience with managed care and none in behavioral health**. Those factors were not a good test case for carve-in.
- Another state discussed a general **lack of sophistication in MCOs related to BH** as revealed in an early 1990s carve-in experience, but also mentioned that during that same era, the BH system functioned under very large grants with significant flexibility but little accountability. The combined effect of these realities caused early efforts at an integrated product to be rolled back and services were carved-out. As managed care continued to struggle on all fronts, the state decided to conduct an honest appraisal of the system, reduce the number of health plans per region and pursue BH carve-in over a decade later where the structure remains in place.
- Several states reference that **involvement of the state BH authority was essential**, particularly to develop contract language that incorporates BH and integrated care language. One state also acknowledged the readiness assessment process was too short and understands that **MCOs would have benefitted from better preparation and understanding of covered BH services**.

- Preservation of BH funding and reinvestment of savings into BH services was mentioned by several states as a priority. However, **some states are struggling to protect BH funding**, despite spending targets. Getting states to enforce medical loss ratios is also reported as problematic.
- Through implementation, states learned that **integrating funds does not necessarily result in integrated care on the ground** as many MCOs subcontract BH services to specialty BH plans.
- HEDIS measures remain the standard performance method across states since they are claims-based. State and local mental health regulators expressed **concern about the lack of recovery-oriented measures** in place to assess improvements in housing stability, employment and integration.
- Stakeholders in a few states reported **challenges associated with MCO's authorization and payments for certain BH services** (e.g., ACT and SUD residential) that may be denied by the plans due to incorrect systems configuration or lack of understanding of the service itself. A few states cited **lack of understanding of the overall population by MCOs**. States are revisiting criteria for services approval and in some cases requiring approval of plan.
- State BH authorities historically managed Medicaid and state-only funds. **Medicaid now controls BH funding, which changed the dynamic between Medicaid and BH agencies**. Historically, BH agencies were sought for their expertise and insight, but the reality is that the agency that holds the funding calls the shots. As a result, **the BH authority has become a shell of its former self**.

National and local media coverage of Arizona's and Ohio's experiences with BH carve-in follows. The examples illustrate the perspective of providers and other stakeholders that found recent implementation of comprehensive contracts to be disruptive, time consuming and costly. In addition, opposition to Maryland's proposed carve-in is included as it reflects the level of distrust of other states (i.e., Michigan and Pennsylvania) that do not want to experience similar disruptions in their systems.



Arizona

In 2010, Arizona implemented carve-in in Maricopa County for persons with SMI. By October 1, 2018, BH carve-in was in effect statewide for the remainder of populations with SMI conditions though BH services for children in foster care remained carved out.

The goals of including BH services in comprehensive managed care contracts were to remove silos, meet individuals' complex mental illness and co-occurring physical health needs and ensure a single point of accountability for care.

Shortly into implementation of the new service delivery structure, Arizona Health-Complete Care Plan (AzCH-CCP), a Centene subsidiary, was hit with a \$125,000 sanction by the Arizona Health Care Cost Containment System (AHCCCS) for violation of its contract for claims-processing failures. News articles cited that the managed care company had wrongly denied about \$868,000 worth of claims for 12 specific providers and incorrectly loaded reimbursement rates for almost 2,000 providers upon moving its provider network into a single database system. One article written for Tucson.com claimed that some Tucson-based mental health providers were on the verge of closure after struggling to mitigate losses from months of unpaid or underpaid claims.^{xii}

In February 2019, Mental Health Weekly published a report analyzing provider issues in Arizona following the state's transition of behavioral health integration into managed care. The article focused on the struggles of Arizona mental health providers due to unpaid claims, credentialing issues, service reductions and staff layoffs attributed to the transition.^{xiii} Former state officials acknowledged that the health plan dropped the ball on provider payments.



Ohio

Ohio implemented BH carve-in statewide on July 1, 2018, for beneficiaries with mental illness or SUD. Goals for integrating BH services into MCOs were to improve health outcomes by paying for quality, allow for more person-centered care integration based on the needs of the whole person, improve access to care through implementation of federally-mandated provider network requirements, allow for value-based payment and rewarding providers based on quality of services provided and ensure long-term sustainability by being better able to predict budgets under full-risk managed care contracts.^{xiii}

In October 2018, The Columbus Dispatch published an article citing troubling Medicaid payment reduction data collected by the Ohio Council of Behavioral Health and Family Services Providers. According to the Ohio Council, Medicaid payments measured from January through June 2018 were \$65 million or 11% less than payments during same period the year prior. The article attributed the loss of payments to behavioral health directly to the integration of the behavioral health system into managed care.^{xiv}

Another article by The Columbus Dispatch centered on the October 2018 closure of Northeast Ohio Behavioral Health in Stark County. The agency had served clients for nearly three decades, but struggled to remain afloat following implementation of the state's Behavioral Health Redesign. The agency's owner, Robin Tener, cited late payments and unclear claims rejections from Medicaid managed care plans as key issues that led to the closure. "It has been absolutely devastating for our organization and for our clients and it's a system that is broken," she said. In April 2019, the Ohio Council of Behavioral Health and Family Services Providers published a survey focused on representing provider experiences of providers across Ohio nine months after integration of behavioral health benefits into managed care. The study found that 40% of provider organizations had reported laying off staff and reducing service access. In addition, some 58% of providers reported having less than 45 days cash on hand. The vast majority of providers expressed no confidence that Ohio's five managed care plans were on target to resolve claims payment and billing issues anytime soon.^{xv}

Results of 91 provider organizations responding to a February 2020 Ohio Council survey of providers' current financial indicators shows that:

- 46% have less than 30 days cash on hand, an increase from April 2019 when 39% of organizations surveyed reported less than 30 days cash on hand.
- Organizations are implementing a variety of cash management strategies and have had to implement additional cash management strategies since last year.
- 55% of organizations are using cash reserves to meet basic operational costs.
- 64% of organizations that accepted a cash advance have had to implement additional cash management strategies due to payback of the cash advance

The state continues to meet with stakeholders as well as evaluate the depth and impact of coding and payment changes. The state established a rapid response team of 25 Medicaid staff to provide individualized assistance to more than 150 provider agencies and associations. Rate increases were implemented for certain services where payments were determined to be insufficient. The state is also implementing a centralized credentialing process to ease administrative burden on providers to allow for more time on delivery care.^{xvi}

In an effort to improve ongoing services delivery and access for all Medicaid beneficiaries, the Ohio Department of Medicaid issued Request for Information (RFI) #2, Feedback Regarding Ohio Medicaid's

Future Managed Care Program, to offer potential future MCO bidders and other stakeholders some insight about how Ohio's future managed care program will be structured and designed. The purposes of RFI #2 were: (1) gauge the capacity of a redesigned managed care system to support changes and innovations the Ohio Department of Medicaid (ODM) is considering for the future of the Ohio Medicaid program and (2) solicit feedback from respondents regarding best practices and experience in implemented potential new approaches. With regard to BH services, the RFI indicates that, "State continues to work with behavioral health providers, managed care organizations and other stakeholders to stabilize the integration of behavioral health services into managed care and achieve the following goals: emphasize a personalized care experience, improve wellness and health outcomes, improve care for children and adults with complex care needs, support providers to deliver better patient care and create greater confidence in the system through transparency and accountability."^{xvii}



Maryland

In 2019, planned carve-in legislation was strongly opposed by the provider community and mental health advocacy organizations. Organizations like Maryland Nonprofits said the bill would risk "jeopardizing treatment for patients not in Medicaid and the coordination among high-risk populations." The Community Behavioral Health Association of Maryland argued that the behavioral health carve-in would "divert provider resources away from treatment." The bill was eventually withdrawn.^{xviii, xix}

REPORTED BENEFITS OF CARVE-IN

Reported benefits of carve-in follows, as described by three former Medicaid directors who – although encountered significant challenges advancing their systems – remain steadfast in the belief that integrating care within a single accountable entity is the most viable solution. Each used a different approach aligned to the circumstances and conditions in each state. Former Medicaid directors report that:

- States with long-standing use of managed care strategies, including managed BH benefits, were able to incrementally pursue BH carve-in given existing service structures, mechanisms, oversight protocols and staff. The significant change in these states was really about integrating care either at the health plan or provider level and not understanding for the first time how BH operates in a managed care environment.
- BH carve-in created opportunities for more solidified partnerships between Medicaid and the state mental health authority. Carve-in enabled Medicaid staff to understand policy and payments for state-funded BH services and created opportunities for Medicaid to engage with persons with lived experiences. State BH authorities also worked closely with Medicaid to develop MCO contract language and write administrative rules and policies for Medicaid-funded BH services.
- Alignment of measures occurred because of carve-in. One state reported that, prior to carve-in, the state could not calculate HEDIS measures or have a basis for benchmarking behavioral health care, as it had been doing for several years on the physical health side.
- Integration at the plan level allowed the state to mandate use of a single case management system for MCOs as well as requirements for behavioral health/physical health case managers.
- Providers offering both behavioral health/physical health could contract with MCOs more flexibly, rather than maximizing services and payments available through siloed systems.

LESSONS LEARNED

Despite less than optimal implementation experience in many states, Medicaid officials remained steadfast in their commitment to a carve-in model of service delivery for behavioral health services. States acknowledge where planning, contracting and implementation oversight could have been improved and described ongoing efforts to address problems of implementation and system operation. Most carve-in states described specific initiatives to improve timely payments and service authorization. Some noted specific redesign of reporting and/or financial incentives to better assure MCOs are held accountable for improved behavioral health outcomes, rather than allowing responsibility to be passed to subcontractors.

One former state Medicaid director acknowledged that MCOs were not ready and the state probably should have implemented a regional approach. The same Medicaid director noted that leadership did not appreciate the low numbers of privately insured individuals served by BH providers (which served a largely Medicaid and uninsured population). Medicaid leadership also did not realize the proportion of unlicensed staff working for small provider organizations. As a result, the impact of fee-schedule changes affected those organizations more significantly and resulted in less revenue to small providers than the state had anticipated.

As one state was transitioning to BH carve-in, the state required a move to FFS rates instead of the traditional bundled payment arrangements and case rates. Many BH providers did not have experience with FFS, which further complicated the implementation of system reforms. While reporting under FFS was intended to increase the level of provider accountability for services delivered, Medicaid acknowledged that, in hindsight, it was trying to do too much at one time by implementing benefit and reimbursement reforms at the same time as moving to a managed care arrangement.

KEY FINDINGS AND OBSERVATIONS

Given the frequency of stakeholders' observation that providers, plans and states "weren't ready" for go-live, it is tempting to conclude that the key to improved outcomes in integrated models, at least at rollout, is simply to increase time for planning and readiness review. Authors agree that improved readiness review is critical. Most importantly, an effective readiness review must be designed to address key implementation challenges.

End-to-end systems testing is critical and allows the Medicaid agency, provider and MCO to do a side-by-side comparison of whether or not the MCO system is configured to pay out as expected compared to prior payment systems. Equally important is assurance that MCOs' care management strategies and communication systems and protocols are fully aligned across behavioral health and physical health care. MCO leadership training would permit their understanding of a state's BH benefits, service definitions and provider qualifications, increase familiarity with the state's system and lower the plan's learning curve.

While assuring sufficient time to plan a successful implementation is key for effective integration of physical and behavioral health care, it would be a mistake to assume that implementation problems were solely due to a rush to go-live. Authors offer the following observations from a review of the experiences in eight carve-in states and focus on the underlying challenges that seem to have the biggest impact on success of the carve-in models in some or all of these states. These observations suggest that there are more fundamental challenges to achieving a successful model of physical health care and behavioral health care integration than just a rushed implementation schedule. Each has implications in terms of system design, stakeholder engagement and performance expectations.

Financial Integration Does Not Automatically Result In Effective Clinical Integration

Most state Medicaid officials interviewed believed that financial integration – combining funds available for reimbursement for physical health care services with funds available for reimbursement of behavioral health care services – was a critical element to achieving the desired integration of health care for individuals who have behavioral health care needs. These Medicaid agencies supported a combined capitation payment under an integrated MCO contract (in effect, a global budget for meeting all health care needs for the member) as critical to creating the right financial incentives for the health plan to seek improved outcomes for enrollees across both physical and behavioral health care. They believed a combined capitation gave MCOs the flexibility to provide the best mix of physical and behavioral health care services to meet individual needs, without regard to whether those needs are physical, behavioral or perhaps even social.

Unfortunately, many states reported that, in practice, a combined capitation paid to a single MCO did not automatically translate into an integrated service delivery model for the member. Multiple states reported that, rather than creating an integrated service delivery model, it was common for MCOs to subcontract the administration – and financial risk – or delivery of most behavioral health services to a specialty MCO or to a local BH agency or entity. For example, Oregon reported that the coordinated care organizations (CCOs) (Oregon’s version of integrated managed care, but with an emphasis on community-based planning and governance) generally chose, through a sub-capitation arrangement, to maintain what had been the pre-reform arrangements of having county mental health authorities administer the behavioral health provider network and oversee member access to BH services.

CCOs generally did not establish mechanisms (pay for performance, shared health information or other integration initiatives) that effectively changed the patterns of access to services or improved communication, care planning or coordination across physical and behavioral health providers. Other states reported that it was common for an MCO to sub-capitate BH services to a specialty MCO. While there might be an MCO care manager who had some cross-service oversight for high cost individuals, state officials expressed concern that the re-siloing of the available funds likely worked to perpetuate rather than reform the traditional separation between physical health care and behavioral health care providers. Sub-capitation by an MCO to another entity, especially in the absence of specific performance expectations and incentives regarding BH outcomes and service integration, appears to minimize the financial incentive to treat a person more holistically.

Further, it is common that integrated model contracts largely maintain pre-reform BH provider system design and state-developed prior authorization and care planning practices for behavioral health care services. States noted that these provisions were generally designed to provide reassurance to behavioral health providers, consumers and advocates that funding and services would not be reduced for BH care. However, these provisions also may further discourage or reduce MCO efforts to approach health care in a more holistic way for an individual with both physical and behavioral health care needs.

States Generally Failed to Adopt Significant BH Performance Expectations

As previously noted, many stakeholders cited the lack of a significant body of nationally recognized BH performance measures to draw from in creating state MCO contracts as a major barrier to pursuing robust accountability in integrated care models. Some state officials noted that, in the absence of performance incentives or financial consequences, many MCOs felt they could pass responsibility for the effectiveness of BH services to subcontractors. One state reported that some MCOs routinely referred the state Medicaid agency directly to the provider agencies when questions regarding access or quality were raised, rather than demonstrating that the MCO had assumed any level of responsibility for these issues.

During interviews, some state Medicaid agencies reported increased access to care management under the integrated managed care contracting arrangements. One state increased access to SUD treatment under the reformed arrangements. However, other state stakeholders described a lack of transparency related to quality measures and, in most of the states reviewed, few significant BH-related or SMI/SUD population-specific measures were in place.

Oregon officials identified the need for more appropriate measures and incentives to be built into future contracts to assure that expectations for BH services and for integrated care are more clearly established. The goal is to assure that MCOs are held accountable for outcomes, regardless of any sub-capitation arrangements. Oregon noted that this might require the state to develop its own measures, because nationally available measures still did not provide a sufficient framework.

One former state Medicaid director reported that, while early integration efforts did not necessarily produce documented improvements, the improved availability of data on BH services under the comprehensive MCO program allowed Medicaid to begin to assess adequacy of access and to identify gaps in care, something the program had been unable to do under the state’s prior system.

The concern is that, without a robust set of appropriate performance measures and incentives that make it clear to health plans and the BH provider system what the performance expectations are for service delivery and outcomes, actual service delivery reform is unlikely to occur. Rather, MCOs will more likely default to standard operating approaches that tend to focus first on reducing expenditures, rather than focusing on how to achieve the program’s desired outcomes in a cost-effective manner.

Lack of Medicaid and MCO Expertise Regarding BH Populations, Systems and Services

In multiple states, stakeholders believed that neither the state Medicaid agency, nor the contracting MCOs, demonstrated sufficient expertise and understanding of the state’s BH systems, services and provider networks when assuming responsibility for designing, overseeing or administering integrated contracts that included BH services. Stakeholders in some states also noted that state Medicaid agencies often failed to effectively incorporate significant BH system and clinical expertise in planning, contracting and overseeing integrated model design and implementation.

Historically, most state specialty BH systems for both Medicaid and non-Medicaid consumers have been overseen and administered by state and local behavioral health authorities or administered under specialty MCO carve-out arrangements that were overseen or administered by a BH authority. When states adopt an integrated model of managed care for physical health and behavioral health, the administration and



oversight of the integrated Medicaid contract typically moves to the state's Medicaid agency and its standard MCO administrative process.

Many stakeholders, even sometimes officials within the Medicaid agency, noted that the Medicaid agency was not fully prepared to assume the policy development and oversight of the specialty BH system for Medicaid consumers. As one example, stakeholders in more than one state reported that Medicaid did not seem to understand until after the system was in crisis what would happen when BH providers reported they had only 60 days cash on hand and MCO routinely took 90 days to pay claims.

In some states, the Medicaid agency appeared to have relied heavily on state mental health authorities to provide support in contract design and implementation strategies. Officials with the Louisiana BH authority described a relationship with the Medicaid agency that continues to strengthen over time, with clarity regarding areas of oversight responsibility, close collaboration between each agency's Medicaid BH-focused staff and increased shared expertise that flows both ways with the BH authority becoming more expert regarding Medicaid and Medicaid becoming more expert in BH. The New York Medicaid agency and the state's BH authority also each continue to play a significant role in oversight of that state's reformed and reforming system. However, other stakeholders in many states expressed real concern that too much of the role of policymaking and oversight had shifted to a Medicaid agency that had little depth or breadth of BH system understanding from either a clinical or an operational perspective.

Further, many Medicaid programs appear to have overestimated the capacity for Medicaid-contracted MCOs to successfully manage and integrate care for individuals with SMI. Stakeholders in multiple states, sometimes including state officials, reported that the MCOs, even those plans that claimed experience in delivering BH services in other states, often seemed to lack significant understanding of the specific characteristics of a new state's specialty BH system, including details of benefit design, state care planning expectations, traditional utilization and adequacy of BH system financing, use and credentialing of non-licensed providers, and the interface of Medicaid covered and non-covered services within the community BH system.

Failure to Address Historic Barriers to Effective Participation in Managed Care

Many state Medicaid agencies appeared to have failed to understand – or at least failed to adequately address – the barriers to successful transition within the BH provider system, often seriously underestimating the time, training and capacity development it takes for BH providers and the new MCOs to be ready to successfully interface for timely provider credentialing, service authorization and claims payment. This may have contributed to so many states, in retrospect, believing their implementation was “rushed.”

Barriers to successful managed care reform in many BH systems can include:

- Lack of true, historical collaboration between leadership and staff from state Medicaid agencies and state BH authorities.
- Lack of investment in and uneven use of health information technology (HIT) and health information exchange (HIE).
- Lack of financial reserves to manage with interrupted cash flow.
- Lack of an administrative infrastructure (even beyond HIT) within BH provider agencies to manage increased administrative demands from multiple managed care plans.

Lack of Collaboration between State Agencies

The historical lack of true collaboration between leadership and staff from state Medicaid agencies leadership and state BH authorities in many states results in uneven understanding between the two agencies about the other's delivery systems and perhaps a lack of sufficient trust and shared understanding regarding system goals and needs. Further, Medicaid agencies may misunderstand or mistrust the role that BH authorities have played in the development and oversight of the specialty BH delivery system. This can interfere with the ability of state leadership and staff to communicate effectively regarding the design of reform, the level of support that might be needed by the BH provider system to transition to a comprehensive MCO contract environment, the level of training that MCOs might require to fully understand the state's BH service design and the safeguards needed for vulnerable consumers.

Lack of HIT Investment and Adoption

The significant federal investment in the development of EHR and data-sharing capabilities in the nation's physical health care system, which has taken place over a number of years, was considered a critical building block in efforts to seek increased provider accountability for health care costs and outcomes. These investments did not include BH care providers, and few states have been able to remedy this lack of investment in the information sharing capability of the specialty BH systems. Arizona negotiated a \$300 million CMS investment to improve behavioral health/physical health integration, including identifying complex members and connecting providers to state information exchanges. New York reported that it undertook an explicit HIT initiative for BH providers to build provider and system capacity for accountable care in an integrated managed care model and, since this initiative was concurrent with, not prior to, the move to an integrated model, the capacity is still in development. Louisiana noted that BH providers lost access to a free EHR option that had been provided by a specialty MCO in the state's carve-out plan that preceded the integrated model, and providers have had to purchase their own capacity under the new approach. Oregon plans to begin to address HIT issues in BH as they move into the state's 2.0 version of its integrated model.

Lack of Financial Reserves to Manage With Interrupted Cash Flow

It appears that state after state failed to anticipate what will likely be an inevitable interruption in cash flow for many BH providers, at least during a transition period of several months. Stakeholders reported that some states are more than a year into an integrated model and are still working on resolving claims payment issues under the carve-in Medicaid managed care model. Specialty BH providers are often small, not-for-profit agencies. Public reimbursement rates do not generally support building significant financial reserves, and these agencies typically do not have access to lines of credit or other arrangements that allow them to meet payroll and overhead costs when Medicaid reimbursements are delayed. More than one state reported the need, after implementation, to create work-around solutions to try to assure vulnerable providers would have funds to operate while claims payment problems are resolved with multiple MCOs. Some stakeholders noted that the work-around solutions themselves create system stress, since the need for documentation, reconciliation and possible repayment of some of the advanced funds create on-going administrative and financial challenges for small agencies.

General Lack of an Administrative Infrastructure to Meet MCO Demands

Many small provider agencies did not have sufficient administrative capacity or experience with billing third party billers, to handle the increased administrative demands of interfacing with multiple managed care plans (e.g., credentialing, contracting, rate negotiation, interfacing with multiple, non-standardized service authorization



and claims payment systems, increased reporting and data sharing). As not-for-profits, these providers typically lack access to capital for administrative investment and payment rates are typically not adjusted to account for increased infrastructure costs, time or implementation. In addition, some states undertook benefit and reimbursement reforms, often intended to improve access to community services and supports, as a part of or immediately preceding the movement to an integrated managed care model. While potentially beneficial in intent, these system reforms added to the administrative challenges and generally unfunded business costs faced by providers during this period of transition.

Despite Difficulties, State Medicaid Programs Continue Comprehensive Contracting

Difficult transitions to an integrated managed care model have not discouraged state Medicaid programs from continuing to pursue a comprehensive contracting model. In the carve-in states in this study, Medicaid officials view the movement to a more accountable health care system as having a very long arc. Interviewees noted that Medicaid has been pursuing incremental system reforms toward improved accountability in the physical health care system for decades. From the Medicaid perspective, while BH and LTSS present increased complexity, they also represent areas of significant opportunities for improvement. Authors heard from directors who, without having all Medicaid services included in an integrated model, are unable to identify where the gaps in the system are and cannot fully address the high cost populations that are the key to managing the program going forward.

Medicaid agencies are comfortable with resolving issues as they arise and, in some cases, view the fact that they are even beginning to more fully understand the challenges in BH as a step in the right direction. Medicaid officials seem generally convinced that they have the right tools and processes with managed care to make progress and improvements over time. They also report hearing from “early adopters” and innovative providers that there is support for state efforts. Some interviewees in both Medicaid and state behavioral health agencies reported that they view at least some of the naysayers as belonging to providers that reject all change, and specifically all efforts to bring increased accountability to the health care system. Some noted that not all providers may be best positioned to be successful in a more accountable system. These state officials indicated that they want to assure access to services, but are willing to consider new business models and even new providers to achieve system goals.

OPPORTUNITIES AND RECOMMENDATIONS

While no single solution can address all of these issues, it is critical that state Medicaid agencies take stock of the already vexing BH services environment and plan for success, even if that means making incremental changes over a longer period of time. Clearly, states will continue using managed care strategies; however, there is an opportunity for states to assess the serious implementation problems with recent carve-in rollouts and make improvements, even in states where carve-in has already occurred.

There are also opportunities for states still in the pre-implementation stages to avoid similar outcomes. The number of new states pursuing BH carve-ins may have slowed down for people with SMI, but states continue to seek more holistic approaches to address care needs of persons with SUD. Federal partners should call on states to demonstrate readiness on all fronts prior to launching such significant system changes that affect vulnerable populations already at risk of early mortality and increased comorbidity. Given the similarities between BH carve-in and managed LTSS, CMS should increase its monitoring of large-scale BH delivery system and financing reforms and hold states fully accountable for assured end to end systems testing, continuity in provider payments, access and quality.

States have access to vast information to understand BH populations, individuals' utilization history and gaps in care. States should use these resources when developing MCO procurement materials and contracts as well as understand implications for state oversight to ensure alignment between goals and implementation.

States also need to increase capacity for ensuring their own readiness to proceed with reforms. This requires more collaboration between state Medicaid and BH authorities to clearly define covered benefits and articulate service expectations, develop RFPs that reflect state goals, broaden and adopt performance metrics that reflect desired changes, develop MCO contracts and related state monitoring requirements to hold themselves accountable for plan oversight and write and continuously update clear and enforceable administrative regulations and handbooks.

State BH authorities must operate as equal partners concerning integrated care. State BH authorities should be empowered to proactively work with Medicaid agencies and exert their behavioral health leadership and expertise. BH authorities should also leverage their extensive experience with the BH provider community and ensure the active and ongoing participation of provider's clinical expertise and operational experience to weigh in on proposed reforms.

Similar to the guidance CMS issued related to managed long-term services and supports, CMS should seek input from states and other stakeholders to inform development of Medicaid BH carve-in guidelines. The guidelines should clarify CMS' expectations for how states should design and implement BH services integrated into comprehensive Medicaid managed care structures. CMS may want to include the suggestions below.

To ensure effective planning and smoother implementation of BH benefits carved-in to comprehensive Medicaid managed care organizations, states should:

1. Use existing data resources to document their understanding of the BH service system, including an analysis of population demographics, chronic health conditions, cost drivers and total cost of care of persons with SMI/SED or SUD, service utilization and trends and care gaps.
2. Assess current provider and service capacity and determine whether a sufficient network is available to attend to population health needs.
3. Describe and quantify outcomes to be achieved with carve-in, including health, quality of care, financial and member experience outcomes and have a formal pre- and post-evaluation plan for the implementation.
4. Collaborate with the state BH authority and provider networks' clinical leadership to develop a clinically informed theory about how to accomplish change and confirm which evidence-based services will support desired changes.
5. Conduct internal Medicaid agency reviews of readiness across all program phases (e.g., planning, design, pre-implementation, go-live, monitoring), particularly related to RFP development, outcomes measures identification, MCO contracting, rule promulgation and handbook development.
6. Conduct external behavioral health provider readiness reviews with respect to contract negotiation, coding, claim submission and payment reconciliation abilities and be prepared to offer technical assistance and training to behavioral health providers without prior experience in managed care contracting and billing.
7. Stage implementation based on readiness and resource constraints and establish a clear communications strategy to keep members, providers and other stakeholders informed about timeframes, progress and delays.
8. Conduct and evaluate small-scale pilots (e.g., regional rollouts) to identify implementation details that may be in need of refinement or overhaul before full implementation of reforms.
9. Ensure MCO readiness by confirming appropriate governance and staffing, provider network and services adequacy, claims processing capacity, reporting capabilities and development of internal policies and procedures.
10. Institute formal end-to-end systems testing and require MCOs to report on outcomes and document which services were not paid during testing.
11. Ensure provider readiness by assessing staffing and workforce capacity, claims submission capacity, EHRs and use of HIT/HIE.
12. Develop an oversight, monitoring and evaluation framework for program integrity and general quality improvement purposes.

CONCLUSION

States will continue their use of managed care strategies, particularly for segments of the Medicaid population with specialized care needs. Once states begin to evaluate the performance of MCOs against carve-in goals, contract refinements and other improvements will occur over time. However, it is up to consumers, advocates, providers and federal partners to demand more from states to avoid unnecessary disruptions in care and services.

Most importantly, it is up to federal partners to set expectations and hold states accountable for planning and implementing comprehensive, integrated managed physical and behavioral health services in the same manner that (CMS) established guidelines and clarified expectations for implementing managed long term services and supports.

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APPENDIX A

INTERVIEW GUIDE

The Transition of Behavioral Health Services into Comprehensive Medicaid Managed Care

State of Interviewee:

Name/Title/Organization of Interviewee:

Date of interview:

Lead Interviewer:

Additional Participants:

AGENDA

- Introductions
- Purpose and Overview
- Discussion of Key Questions
- Wrap-up and Next Steps

SELECTED INTERVIEW QUESTIONS

Section 1: Current Status

What does the current Medicaid MCO structure look like in your state? Are there any changes being contemplated by the state?

Section 2: Purpose of Reform

- a. What are the goals for your state's adoption of (or plan to adopt) a new managed care methodology for Medicaid behavioral health (BH) services?
- b. How were Medicaid BH services paid for and delivered prior to this reform?
- c. What were the strengths of the BH system prior to the reform? What were the key challenges in the system?

Section 3: Planning and Stakeholder Engagement

- a. Did the state engage stakeholders in the development/design of the reform?
- b. Who were the primary drivers in the development of the reform?
- c. What engagement strategies did the state use?

Section 4: Implementation and Operation

- a. What was the implementation plan? How was it executed? Was there a Readiness Assessment? How effectively did it prepare providers for implementation?
- b. What worked well? For providers? For consumers?
- c. What parts of the implement process did not go smoothly?

Section 5: Performance Measurement

- a. Has the state undertaken any specific steps to identify and track quality performance measures for populations with mental illness or substance use disorders (SUD)? Measures regarding outcomes of the integration of BH and PH services?
- b. What data, if any, is tracked, verified and made transparent through public reporting? Has data shown that the movement to managed care is achieving the state's quality strategy?

Section 6: IT

- a. Did the state create a health information technology (HIT) and health information exchange (HIE) plan to align technology capabilities with the strategic goals of the managed care transition?
- a. Did the state implement HIT project and change management steps to manage information transformation process?

Summary:

- 1. What one-to-three changes would have improved your state's experiences?
- 2. Do you see potential in a comprehensive MCO approach to improve health care outcomes for individuals with SMI/SED or SUD?

THANK YOU FOR YOUR TIME AND FOR SHARING YOUR INSIGHTS!

APPENDIX B: KEY THEMES BY INTERVIEW TOPIC

CONTENTS

Purpose of Reform	31
Current Status.....	32
Implementation and Operations.....	34
Stakeholder Engagement	36
Quality and Performance	37
HIT/HIE.....	38
Other Content.....	39
Summary and Lessons Learned.....	40

PURPOSE OF REFORM

1. Bring BH in line with national billing/coding standards
2. Enable use of value-based payment (VBP) and quality incentives
3. Update the system
4. Utilize managed care to control spending
5. Allow for a whole-person approach
6. Financial savings with carve-in but no data to support assertion
7. Promote integrated care
8. Address social determinants of health
9. Rationale for carve-out
10. Bend Medicaid cost curve
11. Build community BH network to offset psychiatric hospital downsizing
12. Protect BH capitation
13. Leverage strong county-based system to continue managing BH services
14. Ensure money flowed to providers
15. Address needs of most seriously mentally ill
16. Establish a continuum of care
17. Ensure children are served
18. Case for carve-in
19. New commissioner saying current billing systems complex
20. Current BH Choices model outdated
21. Address more social determinants of health
22. Ensure VBP
23. Address different incentives of counties
24. Bring services under one capitation
25. Allow for integrated and holistic care and remove bifurcation
26. Promote integrated care
27. Focus on BH services and access
28. Current system developed pre-parity laws
29. Address parity
30. Integrated, holistic care
31. Improve outcomes
32. Enable use of VBP
33. Easier for MCOs to come up with payment models that reward BH providers
34. Reduce barriers to integrated care
35. Promote care coordination and information sharing
36. Remove silos and barriers
37. Design system to serve the consumer
38. Improve care coordination
39. Integrate services
40. Remove county incentives for generating profits
41. Foster bi-directional care and integration

42. Move from volume to value
43. Eliminate barriers
44. Ensure primary care available for individuals with BH conditions
45. Improve SUD access and infuse new resources to SUD providers
46. Remove silos
47. Improve actual management of members' care
48. Reduce hospital emergency department (ED) utilization
49. Develop a structure consistent with goals to be achieved
50. Bring all benefits into a single organization
51. Ensure budget based on population needs vs. services/providers
52. Improve accountability for BH benefit management
53. Wanted a better system that would lower costs
54. Create accountability across the entire system (PH/BH)
55. Design system that meets peoples' needs
56. Debate what system would look like and ultimately created CCOs
57. Create a balanced system that minimized cost shifting
58. Be sensitive to county politics
59. Avoid disruptions to safety net systems
60. Develop appropriate service lines
61. Bend cost curve and address unstable rate of Medicaid growth
62. Improve outcomes
63. Expand managed care as part of overall strategy
64. Better integrate care and focus on high needs SUD/BH population
65. Build recovery services into managed care
66. Ensure accountability for whole-person care
67. Achieve enhanced quality of care
68. Ensure care available at the right size and amount
69. Enable statewide improvement of BH care and benefits
70. Achieve cost containment and budget predictability
71. Ensure quality integrated care
72. Ensure network management and adequacy
73. Improve data sharing and understanding of outcomes
74. Integrated care
75. More say and voice in the system
76. More prevention services

CURRENT STATUS

1. Improvements under new state administration
2. Medicaid is working to address implementation mistakes
3. Counties have different standards and processes
4. Have not done enough to tout success of carve-out: more BH services available, increased service penetration

5. Providers able to develop unique programs in a carve-out
6. Carve-out resulted in savings to state and met or exceeded state's cost savings expectations
7. Providers like BH-focus of BH-MCOs vs. broad population focus of comprehensive plans
8. BH-MCOs have historically done work on social determinants of health (SDOH)
9. Problem is presenting and tracking SDOH
10. Carve-out structure enables focused population effort (e.g., employment, housing)
11. Multiple funding streams connected to BH-MCO with "seamless" county relationship
12. BH-MCO can choose its service delivery model and focus on what it does well
13. BH-MCOs have a limit on profits and excess reinvested in non-Medicaid services
14. Counties get state approvals before reinvestment spending
15. No financial incentives or supports for integrated care in current carve-out system
16. No data to support co-location model in current carve-out system
17. There has not been a clear Medicaid vision to get data (just know anecdotally what works)
18. Integrated care projects rely on providers leveraging their own Medicaid funding streams in carve-out state
19. Fear given last carve-in experience
20. Concerned about unique needs of people with SMI
21. Structure requires services to broad range of BH populations
22. A BH focus of carve-out has been helpful, especially pre-parity laws
23. Providers expressed need for VBP since integrated care does not work in FFS model
24. Some providers believe carve-out creates challenges for PH/MH integration
25. MCOs struggle to come up with payment models to support integration
26. State wants to figure out how to promote the best outcomes regardless of structure
27. State asked stakeholders about barriers to care, but no concrete data, just complaints
28. State wants to understand SDOH; concerned Medicaid may be paying twice since data and coordination lacking
29. BH-MCOs been in the SDOH business for 30 years
30. There is no need for a carve-in, there are opportunities in state to coordinate care
31. Believe county-based system is outdated
32. Large providers like hospitals don't have an incentive to integrate care
33. Consumers point out challenges with access and coordination
34. System is not working due to silos and lack of cohesiveness
35. Need better integration in the state
36. Need to incentivize whole person care
37. System allows for coverage of full range of services and recovery supports
38. No longer use certain BH-specific outcomes with consequences
39. Administrative structure changed and not everyone has familiarity with MH/SUD populations
40. One regional plan experienced a 40% increase in people accessing and receiving SUD treatment just by focusing on it increased access to SUD treatment
41. State wanted accountability
42. Created 12 CCOs accountable for physical and BH from beginning of carve-in in 2012
43. Before carve-in the state had a hodge-podge system where two-thirds of people were in Medicaid managed care, but for people with SMI, all benefits on MH side carved-out.
44. State in the process of moving children's services in managed care through 1915(c), I/DD, SED, etc.

45. Incentives causing plans to quickly move VBP
46. Some things put into the design around VBP are trying to have BH metrics in these arrangements and those things have not been followed.
47. Rollout was something of a disaster.
48. Strong interest in carve-in; stakeholders fought legislative action
49. All options on the table including carve-in and putting carve-out at-risk.
50. No disruption in BH access under carve-out if changes in Medicaid eligibility
51. Leadership vacuum with ASO; consolidated market affected ASO performance
52. SUD provider outcome system no longer in use
53. MH leadership more familiar with grants management than clinical experts
54. MH agency no longer has the expertise once they lost Medicaid responsibility
55. Moved to carve-in in 2015; had a single BH MCO entity, which providers did not like.
56. Added BH to MCO contract; no re-procurement
57. Readiness process was hastened
58. State is still trying to standardize across MCOs
59. Good collaborative relationships between Medicaid and BH; BH is still viewed as the expert
60. Lots of agency cross-hiring between Medicaid and BH agencies; work in same building

IMPLEMENTATION AND OPERATIONS

1. Providers wanted to go back to state-operated billing system following full carve-in implementation
2. Unnecessary administrative burden of Medicaid documentation requirements
3. Documentation creates barriers to HIE (integrated care); documentation not aligned with industry standards
4. Fewer claims payments in 2018 (under carve-in) vs 2017; also 23% reduction in ODM BH expenditures
5. Staffing reductions, including layoffs, for clinical and administrative positions with carve-in
6. Service reductions (group counseling) and eliminations (psychiatric, MH nursing, primary care, SUD residential) with carve-in
7. Increased wait times for services under new carve-in model
8. SUD providers suffered most under carve-in
9. Rates cuts impacted services by unlicensed staff, especially group rates
10. High administrative costs
11. Even with improvements in rates, providers still behind due to administrative issues (e.g., credentialing)
12. Not enough thought about whether provider community was prepared for such a significant shift
13. Even large, sophisticated providers could not get EHRs ready in time
14. Providers were down to 60 days cash on hand and not being paid for 90 days
15. Changes occurred in midst of opioid crisis where demand for services was high; providers not sure they would be paid
16. State goals was to meet implementation timeline even if it meant the weakest providers would be left behind
17. Difficult to get physical and BH MCOs at the table together
18. State does not do enough to encourage innovation or developing innovative programs
19. State does not seem interested in Health Homes or ACOs and had a bumpy start to VBPs
20. State not interested in pilots; only carve-in
21. Inconsistent processes across BH-MCOs re authorizations, quality and payment methods

22. Limited state support for operations and implementation of innovative integrated care strategies
23. No monetary incentives for quality improvements; just general recognition of being impressed by co-location
24. There are artificial barriers in place related to differentiating PH/BH payment; leads to difficulty capitating
25. Providers still fearful about sharing data due to privacy laws
26. BH providers unable to get paid for the work they can and actually do
27. Some PH MCOs credential BH providers; others don't
28. Prior to HealthChoices, providers did not know how to deal with managed care
29. Lack of standardization across BH-MCOs,
30. Work group of BH trade association worked with BH and PH MCO leadership to streamline processes for credentialing, defining crucial incidents and now working on standard billing and coding issues
31. Work group more effective once the state was no longer at the table
32. Post-carve-in found little transparency or accountability related to contract language
33. Difficult to call for better accountability and consequences if things are not going well
34. No useful data to provider association about whether providers get paid on time
35. There is no consequence to MCOs failing to meet contractual requirements
36. Providers were not well-prepared for transition; geography specific
37. Providers submitted claims multiple times (four-to-five) before finally able to submit original claim that got approved
38. Heard that providers beefed up administrative staff
39. Want clearer expectations about people with BH diagnoses having comparable access pre/post carve-in
40. Counties have reduced ability to weigh in and provide oversight
41. CCOs interpreted requirements differently
42. Counties did not significantly benefit from PMPM
43. Ratios for intensive care coordination are challenging based on actual numbers eligible for service and available workforce
44. State readiness assessment for CCOs is due-diligence focused
45. Rural and frontier areas present work force challenges
46. MCOs contracted with solo practitioners who did not have to do PA for over a year
47. Some clients seen times a week for mild depression
48. Solo practitioners were not held accountable to Medicaid billing rules; not conduct assessments
49. No network oversight
50. In Phase 2, created CCO global budget so dollars can be spent as needed and to reduce hospital ED visits
51. CCOs can sub-capitate, which is only way VBP can work
52. State ramping up quality and access standards
53. State acting on feedback that BH was too hard to access and was not integrated with physical health
54. Short implementation ramp-up with new organizations that had no BH experience
55. Despite protections, plans viewed as taking large profits
56. Difficult to get state to enforce medical loss ratios (MLRs)
57. Plans did not understand BH service models and paid for fewer services than models call for (e.g., assertive community treatment)
58. Same procedure codes for both BH and PH resulted in claims rejections
59. State MH authority realized importance of being heavily involved to triage provider calls

60. Some providers did not realize until it was too late that they were in financial trouble
61. Trainings were not as effective compared to funds spent for trainings
62. Providers believe they are stuck with an insufficient rate
63. Providers delivering integrated care struggled with payment rates
64. Lack of meaningful reporting
65. Plans were not ready at time of go-live and could not pay claims
66. Plans received little guidance and standardization from state
67. State viewed as deferential to plans and not willing to enforce contractual requirements
68. SUD providers were less ready and more negatively affected by carve-in (couldn't get paid)
69. MCOs did not have a good grasp of BH providers services and credentialed outside of the traditional specialty BH network
70. MCOs had to work hard to shore up UM and quality management teams once they better understood the system
71. MCOs needed to establish familiarity with local culture and system to be effective.

STAKEHOLDER ENGAGEMENT

1. Multiple meetings and feedback sought, but not ever implemented
2. State seemed more interested in communicating the number of stakeholder meetings
3. Engaged stakeholders and did town meetings around the state
4. Extensive stakeholdering done by Medicaid
5. Process enabled people to get together who had never spoken to each other before
6. State considered recommendations and principles were incorporated
7. Extensive stakeholder engagement, including six months spent gathering information about "what's working with the CCO structure?"
8. Multiple methods of engaging stakeholders including emails, webinars and town halls
9. Process informed stakeholders about what to expect with CCO 2.0 applications
10. CCOs are also required to do a "roadshow"
11. One-and-a-half year stakeholder process, including lots of town halls
12. Large workgroup met weekly on different topics such as integrated care, financing, equality, etc.
13. Work group focused on pieces that became an implementation plan that went back to legislature and passed
14. Very public stakeholder process though some participants were lost in understanding intricacies of the system
15. Specific team focused on BH
16. Process helped achieve agreement that if BH dollars fall out of premium they could be reinvested for BH
17. Two-year Medicaid redesign team
18. Stakeholders spent many hours putting together a plan for carve-in and then a plan for kids (took seven years)
19. Hard to object in same room with powerful people and have peers really hear you.
20. Despite stakeholder process, the state contract process with CMS was viewed as "secretive"
21. Three-year extensive weekly stakeholder process that included BH focus groups
22. SUD providers were not well-represented at the time
23. Despite stakeholder process, implementation described as an "immediate disaster"
24. Provider organization fought original carve-out but state said important to do stakeholder process to engage people in reform
25. Open stakeholder process

- 26. Lots of stakeholder engagement through community forums and well-facilitated sessions
- 27. State conducted year-long engagement almost to the detriment of leaving out MCOs
- 28. State continues stakeholder engagement and calls with MCOs to work out issues and challenges

QUALITY AND PERFORMANCE

- 1. Lack of transparency on quality or outcome measures
- 2. Providers unsure of data being tracked by MCOs
- 3. Increased services and savings for state during carve-out
- 4. Providers like focus on BH and fearful of traditional MCOs
- 5. No analysis been done on possible savings with carve-in
- 6. Physical health MCOs shown lack of interest in joint ventures
- 7. Performance based on quality measures tied into BH contracts
- 8. Population focused efforts based on regional needs
- 9. Cost savings demonstrated at \$5 billion over 10 year mark if states remained in FFS
- 10. Incorporated reinvestment dollars into contracts
- 11. Capped profits at 3%
- 12. BH provider interest in tracking outcomes/data of integrated model
- 13. Whole person approach to integrated care
- 14. Admitted lack of focus on BH outcomes
- 15. VBP approach began at same time for BH/PH plans
- 16. Interested in outcomes beyond HEDIS (Child and Adolescent Needs and Strengths/Adult Needs and Strengths Assessment (CANS/ANSA))
- 17. Focus on long-term outcomes
- 18. Wants to improve BH/PH plan communications/engagement
- 19. Services successfully transitioned from carve-out to carve-in
- 20. No consequences currently tied to outcomes for MCOs
- 21. HEDIS focus
- 22. Performance measures focused on MH successful
- 23. CCO must earn payments withholds that are tied to measures
- 24. Measures reported through claims/encounter data
- 25. Contract section dedicated to BH performance requirements/tracking/monitoring
- 26. New measures developed each year
- 27. Lack of nationally accepted BH metrics outside of HEDIS
- 28. Fear of value-based environment leading to lack of quality care because of incentives to keep people out of hospitals/ER over all else
- 29. Initial struggles with payment for integrated care
- 30. Metrics focused on SUD more used by providers than MH side
- 31. Forecast of more VBP based on outcomes
- 32. ASO model allows more focus on innovation in outcome measures
- 33. Solid outpatient measurement system for MH
- 34. Use of DLA-20
- 35. Issues with EHR purchases, implementation

- 36. Issues with data system linkages, leads to issues with outcome data
- 37. State monitors some outcomes not tied into contracts
- 38. ER data is slightly down from when state was carve-out

HIT/HIE

- 1. Burdensome credentialing processes adopted by MCOs at outset of carve-in
- 2. No consistency or standard with provider credentialing across five MCOs
- 3. Centralized credentialing now handled by state Medicaid department
- 4. Providers seeking return to single entity (MITS) for claims submissions
- 5. HIT touted at outset of redesign, was never actualized
- 6. Challenges for both MH/SUD providers on EHR adoption and clearinghouses
- 7. Two-phased implementation alleviated some burdens with regards to codes and rates
- 8. EHR vendors could not deliver on state deadlines
- 9. Increased cost of admin. across the board for BH providers
- 10. Providers seeking return to single entity (MITS) for claims submissions
- 11. Not enough use of HIT to support data exchange
- 12. Claims standardized, but individual plans have different authorization/quality/payment
- 13. Lack of oversight on IT, despite providers liking relationships with individual counties
- 14. Lack of universal data systems and support for exchange
- 15. Data exchange weak at county level, but has helped with care coordination for children, justice-involved youth, etc.
- 16. State dragged feet on HIE efforts
- 17. Drive for carve-in based off one provider telling Sec. Miller about complicated billing with BHChoices and HealthChoices, not a sentiment shared across vast majority of providers
- 18. Some counties have strong use of HIT
- 19. Not a lot of data to support co-located/integrated model
- 20. EHR vendors been apprehensive about building out systems to support integrated care
- 21. Data exchange remains a big challenge
- 22. Major questions on confidentiality rules stymie innovation efforts
- 23. Privacy laws are a major challenge on SUD side, stringent state regulations
- 24. Many EHRs not connected to state health exchange
- 25. Unsure of redundancy on care coordination efforts on BH/PH sides
- 26. Seeking data around social determinants
- 27. Major success was creating standardized provider credentialing form
- 28. Critical incident reporting unable to be standardized in form because of county differences
- 29. Discussion of DRM-20 at potential tool across plans
- 30. Pushback from MCOs who are worried data will be used against them
- 31. Historic issues in PA of IT projects going over budget, driving fears
- 32. Because of intersection of six MCOs and BH ASO, along with core billing requirements, created complexities for providers
- 33. Providers who operate across regions spending a lot on admin. costs
- 34. EHR vendors not being willing and able to do the work to link into state information exchange systems

- 35. Updating provider directories has been difficult
- 36. State uses ER system called EDDY. Allows providers (BH/PH) to put flags on person arriving to ER
- 37. Most hospitals use EPIC
- 38. Specialty BH data systems 10 years behind PH
- 39. Larger specialty BH systems having successes connecting EHRs to hospital systems
- 40. Various mentions on data sharing and confidentiality legal issues
- 41. CCOs had to create EHR use roadmap in 2016. Succeeded in achieving performance metric in that area, measure was sunsetted
- 42. Mentions of EDDY ER alert system in place for high users
- 43. Five HIEs in the state, with 1 operating in 2/3 of state
- 44. Beginning to look at transitions from HIEs to community health exchanges
- 45. BH still fragmented with EHR adoption
- 46. State reinvesting funds to support BH IT initiatives, but will not last forever
- 47. Leading up to carve-in, influx of dollars to support HIT development, but BH providers had trouble drawing on this
- 48. Small agencies hit hardest with EHR adoption (under \$10 million annual agencies)
- 49. RIOs developed around the state, but providers fear growing expenses to connect
- 50. State using CRISP as HIE for the state
- 51. ASO has not been involved at systems level, mostly been provider to hospital
- 52. Providers cannot keep up with funding required for EHR adoption
- 53. State psych hospital doesn't even have EHR
- 54. State created grant funding to help BH providers connect EHRs to Chesapeake Regional Information System for our Patients CRISP, but EHRs asked for too much money and initiative fell flat
- 55. State BH agency not forceful enough in taking role in CRISP discussions
- 56. MCOs having trouble tracking providers because of EHR systems not connecting
- 57. In carve-out, Magellan had free EHR that providers hated
- 58. In carve-in, providers clamoring for Magellan EHR back
- 59. BH providers less sophisticated, most had never used an EHR prior to carve-in

OTHER CONTENT

- 1. State association interest in provider-led care managed care or coordination entities
- 2. State did not take network adequacy seriously enough
- 3. Only focused on total numbers of providers but not access to a range of services
- 4. Expectation that state BH authority would be the expert but lack of strength resulted in unaddressed problems
- 5. Providers do not understand whether/how new initiatives (e.g., 1115 SUD waivers) relate to carve-in
- 6. If carve-out benefits go to private plans, county jobs would disappear
- 7. State did not define integrated care
- 8. BH system has long been in the business of SDOH
- 9. Strong focus on HEDIS but other SDOH data is available to identify quality outcomes
- 10. People have jumped to the conclusion that carve-out does not foster integrated care
- 11. No clear definition of integrated care
- 12. No investment in co-location models

- 13. No clear vision on gathering data and not a lot of data to support co-located/integrated care
- 14. See a lot of incentives for offering quality care but no monetary incentives from the state
- 15. A clear definition of integrated care would be helpful
- 16. Good things can happen in a carve-out environment
- 17. There are artificial payment barriers that differentiate physical/behavioral health care
- 18. Carve-out was never about creating distance between physical and BH care but to preserve dollars for BH care
- 19. State saw an integrated model in action where all practitioners in same room helping person get care but hard for model to work in FFS environment
- 20. MCOs and integrated care provider were unable to come up with a viable payment model
- 21. State just wants to figure out how to pay providers to deliver the kind of care that will have the best outcomes
- 22. State spend almost two years understanding barriers to access care but no concrete data available
- 23. Some MCOs put BH providers in their networks
- 24. State has not focused on BH outcomes as much as they should have in the past

SUMMARY AND LESSONS LEARNED

- 1. When providers say they are not ready and the state still moves forward, there will be a problem
- 2. The two-phased implementation regarding new codes and then reimbursement rates was smart, but providers needed a longer runway (one year vs. six months)
- 3. There was a much higher learning curve among providers than anticipated
- 4. Thinks of MCO benefits in managing utilization and transportation and can have a positive influence on consumers staying in recovery longer
- 5. No evidence of carve-in improving lives of people with BH and PH conditions
- 6. No evidence of a financially integrated model
- 7. Whole person care should be front and center
- 8. Key is holding plans accountable, tracking money more easily and developing an infrastructure for the most vulnerable
- 9. Good things can happen in a carve-in environment but there have been stories about disasters in other states
- 10. In the long-run, carve-out is the way to go
- 11. Pennsylvania is unique
- 12. Administering an MCO at state level would not work because of diversity of the state; believes it is better for structure to be at the county level

APPENDIX C

State-Specific Goals from MCO Procurement Materials and Contracts

These are state-specific descriptions of the overarching goals identified by the states included in this review that have adopted comprehensive managed care arrangements. While implementation strategies and experiences varied across states, the stated goals of behavioral health integration into comprehensive managed care arrangements were very similar in nature.

Arizona: Arizona's move to integrate behavioral health within managed care organizations was seen as a step toward improving individual health outcomes, enhancing care coordination and increasing member satisfaction for Medicaid enrollees across the state, particularly for those determined to be SMI. Under the integrated primary and behavioral health care managed care structure, the state expected to achieve improved access to primary care services, increased prevention and early identification and intervention to reduce the incidence of serious physical illnesses, including chronic diseases. The Arizona Health Care Cost Containment System's AHCCCS Complete Care (ACC) health plans provide physical and behavioral health services for Medicaid enrollees across the state. Regional Behavioral Health Authorities in Arizona operate in three geographic service regions and provide crisis, grant funded and state-only funded services.ⁱ

Kansas: As key goals of behavioral health managed care implementation, the State of Kansas determined that contracting with multiple MCOs would result in provision of efficient and effective health care services to the populations currently covered by Medicaid and Children's Health Insurance Program (CHIP) in the state. In addition, Kansas looked to use the effort to ensure coordination of care and integration of physical and behavioral health services with each other and with home and community-based services. The state contracts with three national managed health plans through its KanCare program.ⁱⁱ

Louisiana: The state's overarching goals for its Medicaid managed care delivery system are to improve the health of populations served, enhance the experience of care for individuals and effectively manage Medicaid per capita care costs. Through the Louisiana Department of Health's effort to integrate specialized behavioral health services into managed care in 2015, the goal was to improve care coordination for enrollees, provide more opportunities for seamless and real-time case management of health services and use resources more efficiently. In addition, the state hoped that integration would enhance management of behavioral health across the state as a result of integrated claims data, improved access to information and financial responsibility residing with MCOs.ⁱⁱⁱ

New York: The state's goals for behavioral health integration into a managed care structure centered on improving health outcomes and recovery, reducing unnecessary emergency and inpatient care and increasing network capacity to deliver community-based, recovery-oriented services. In terms of Medicaid member-related goals, New York wanted to deliver person-centered care management for all members, support the integration of physical and behavioral health services, bolster consumer choice and address the unique needs of children, families and older adults. New York also sought to tie payments to outcomes, track physical and behavioral health spending separately, reinvest savings to improve services for behavioral health populations and ensure adequate and comprehensive provider networks.^{iv}

Ohio: The State of Ohio's Behavioral Health Redesign initiative was aimed at rebuilding Ohio's community behavioral health system capacity and supporting integration of behavioral and physical care. The state wanted to use behavioral health integration into managed care by developing new benefits for individuals

with high intensity service and support needs and targeting improved health outcomes through better care coordination across physical and behavioral health care. The effort also included a re-coding of all Medicaid behavioral health services to help the state achieve alignment with national coding standards.^v

Oregon: As part of efforts to develop and implement a health care delivery model that integrated mental health, addiction treatment, dental health and physical health interventions, Oregon launched a new managed care model that relied on risk-bearing, locally-governed provider networks called coordinated care organizations, or CCOs. These CCOs were contracted to develop, implement and participate in activities that would support mental health and substance use disorder treatment through an integrated, person-centered care model that would also coordinate physical health services. As part of the behavioral health transformation, the state wanted to specifically address the needs of individuals with SMI.^{vi}

Tennessee: By bringing management of physical and behavioral health services into one contract and "under one roof," with a behavioral health carve-in, Tennessee hoped to encourage coordination of physical and behavioral health services at both the state administrative and MCO levels. The state aimed to ensure access and quality care for enrollees, as well as integrate behavioral and physical health services at a cost that would not exceed what would have been spent in a Medicaid fee-for-service program. The state encouraged MCOs to integrate data systems in a way that would allow staff to access and make decisions based on both physical and behavioral health information, as well as provide case management services for high service utilizers and those with complex health needs.^{vii}

Washington: The State of Washington looked to use behavioral health integration into managed care as a way to ensure that state funds were being effectively used to purchase high-quality care at the best price. Through this carve-in effort, the state wanted to adopt a whole-person approach to care, as well as address physical and behavioral health needs in one system through an integrated network of providers. In addition, a major goal was to offer better coordinated care for patients and more seamless access to the services. Washington used the term "bi-directional integration" to describe the key aim of integrating behavioral health services into primary care settings and integrating primary care services into behavioral health settings.^{viii}

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