CLASP

Policy solutions that work for low-income people

**Memorandum**

To: Ming Wang, Program Administrator, Utah Department of Human Services
From: PATH Team at CLASP
Date: January 10, 2020
Re: Key Considerations for Transition Age Youth Physical Health-Behavioral Health Integration

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**SUMMARY**

Utah's PATH application calls for the introduction of changes to Medicaid financing that will cover clinical treatment, recovery support, prevention and promotion services for youth in transition. Utah's PATH team is currently exploring the possibility of state-level physical-behavioral health integration for transition age youth; if implemented this innovative reform approach would be the first state-level initiative in the nation to integrate physical and behavioral health with an explicit focus on transition age youth as a unique population. Although Utah's proposal is unique in the nation, the PATH team can draw from learnings, guidance, and examples of state-level integration efforts around the country.

During the November 2019 site visit, the Utah State Transition Team engaged in a series of preliminary conversations to begin to generate a blueprint for physical-behavioral health integration for Transition Age Youth in Utah. Several State Transition Team members also committed to participating in a working group focused on integration to move the integration effort forward. This memo provides an overview of key considerations, example states to learn from, decision points, and needed recommendations to guide the work of the integration subcommittee and the development of the blueprint.

**Regulatory and Financing Mechanisms**

State initiated integration efforts can be authorized and financed using several regulatory and financing mechanisms, including 1115 Medicaid Demonstration Waivers, Medicaid State Plan Amendments (SPAs), as well as newer options created by the Affordable Care Act (ACA), including Health Home and Patient Centered Medical Home SPAs. Most states that have implemented state-initiated physical-behavioral health integration have done so through SPAs. Our review of planned and submitted Medicaid Waivers developed by the Utah Office of Health, however, indicates the Utah plans to implement its Medicaid Managed Care and related integration efforts through an 1115 demonstration waiver. Unlike SPAs, these waivers allow integration initiatives that target select geographic areas or specific subpopulations and require that the initiative demonstrate cost neutrality. Because this appears to be the most likely authorizing and financing mechanism for integration in Utah, ***we recommend that the integration work group focus their learning agenda on other states that have implemented integration efforts using 1115 demonstration waivers: Arizona, Florida, Massachusetts, Minnesota, Kansas, Vermont, Tennessee, and New York.***

In addition to the Medicaid dollars associated with an 1115 waiver, the integration work group should consider the need for additional funds to initiate the integration effort and/or sustain the model. In Colorado, philanthropic investment, particularly as the integration initiative has gotten off the ground, has been critical. The Mt. Sinai Adolescent Health Center also relies on philanthropic investment for a significant proportion of its annual budget. In Vermont, pooled funding across multiple agencies/sectors has supported a broad and flexible service array, particularly to address the social determinants of health. ***We recommend that the integration work group identify potential philanthropic and or sector partners that can help to finance the TAY integration initiative.***

## Structure

Center for Medicare and Medicaid Services (CMS) has identified several options for structuring Medicaid financing for physical health/behavioral health integration, which include Managed Care Organizations (MCOs) as lead, Primary Care/Physical Health entities as lead, Behavioral Health Organizations (BHOs) as lead, and equal partnership arrangements amongst these partners.[1] Each model has strengths and weaknesses, detailed in a CMS Technical Assistance Brief linked in the resources section at the end of this memo.

### MCOs as Lead

*Arizona[2]:* The Arizona Department of Health Services, Division of Behavioral Health Services, contracts with community-based organizations known as Regional Behavioral Health Authorities (RBHAs) to administer behavioral health services. Mercy Maricopa Integrated Care (Mercy Maricopa), a not-for-profit managed care entity, is Maricopa County's RBHA and is accountable and at financial risk for the full spectrum of behavioral health and Medicaid-covered physical health services for the Medicaid population with Serious Mental Illness (SMI).

*Minnesota[3]:* Minnesota operates several county-based integration efforts:

> Hennepin Health is a county-based safety-net accountable care organization in Minnesota serving Minnesota's Medicaid expansion population in Hennepin County. The goal of the partnership is to increase the use of preventive care and reduce preventable hospital admissions and emergency department (ED) visits, by integrating health care and social services for this safety-net population. Hennepin Health is a partnership of four organizations: the Hennepin County Human Services and Public Health Department; Hennepin County Medical Center (a Level 1 trauma center and medium sized public hospital and safety-net medical system); NorthPoint Health and Wellness Center (a federally qualified health center); and Metropolitan Health Plan (a non-profit, county-run health maintenance organization).
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> The Preferred Integrated Network (PIN) program is a public-private partnership between Dakota County and a Medicaid MCO to coordinate physical and mental health care services for Medicaid-eligible adults under age 65 who have serious mental illness or children with emotional disturbances, including duals. The PIN is an option for individuals in Dakota County who voluntarily enroll in Minnesota's Special Needs BasicCare (SNBC) managed care program and select Medica as their health plan.
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> Southern Prairie Community Care (SPCC) is a collaboration between 12 counties that share a similar mission: to enhance the quality of life for citizens through facilitating the integration of services and supports provided throughout their communities. SPCC is the first multi-county partnership to join Minnesota's Accountable Care Organization (ACO) demonstration in Medicaid, called the Integrated

Health Partnerships (IHP) program. Under this contract with the State of Minnesota, the SPCC's total cost of care (TCOC) for Medicaid enrollees is measured against targets for both cost and quality. Providers in SPCC's network can share in savings resulting from the program.

*Colorado*[4]*:* Through its Accountable Care Collaborative (ACC) initiative, Colorado contracts with 5 Regional Care Collaborative Organizations (RCCOs) to establish networks of Primary Care Medical Providers (PCMPs) and to provide care coordination for Medicaid enrollees at the regional level. Although behavioral health is "carved out" of the ACC and financed through capitated payments with BHOs, the integration of behavioral health and long-term care with physical health is stated as a long-term vision of the ACC initiative. RCCOs are moving toward this goal in various ways. Colorado Community Health Alliance, an RCCO serving five counties, is specifically working within its network of PCMPs to integrate behavioral health and medical services.

*New York*[5]*:* New York uses a hybrid approach in which the state is: (1) carving-in all state plan behavioral health services into its mainstream managed care plans; and (2) designating a subset of these plans as Health and Recovery Plans (HARPs) that will offer a separate product line and additional specialized services for individuals with serious behavioral health needs.

*Tennessee*[6]*:* TennCare is the state of Tennessee's Medicaid program. In operation since 1994, the program provides health services for nearly 1.2 million adults and children and at the time, was the only Medicaid program in the nation to enroll all of its members in managed care. The state began integrating behavioral health into its managed care contracts in 2007 and completed the process in 2009. All physical and behavioral health services, including addiction and substance abuse services, are covered by three MCOs; supportive housing and supported employment services are also covered for patients with SMI.

**Primary Care/Physical Health as Lead**

*Vermont*[7]*:* The Vermont Blueprint for Health is a statewide multi-payer initiative that aims to turn primary care practices into patient centered medical homes (PCMHs) that provide mental health services and to support community health teams (CHTs) offering multidisciplinary care coordination and support services. The Blueprint is increasing the capacity of the primary care system to treat mild to moderate behavioral health issues within the primary care system, as well as to collaborate with specialty mental health system for individuals with greater needs.

**Behavioral Health as Lead**

*Iowa*[8]*:* The State of Iowa contracts with a behavioral health organization, Magellan Behavioral Health Care of Iowa, to administer the state's behavioral health homes initiative (Iowa has another health home initiative for chronic health conditions). Magellan contracts with community mental health centers, designated as Integrated Health Homes (IHHs), which in turn partner with Federally Qualified Health Centers (FQHCs) as physical health providers. Both Magellan and the IHHs provide care coordination services to enrollees.

**Equal Partnership/Bi-directional Integration**

*Florida*[9]*:* Florida's Medicaid managed care program includes a specialty plan designed exclusively for beneficiaries diagnosed with or in treatment for severe mental illness (SMI). The specialty plan is offered by Connecticut-based Magellan Complete Care a contracted Administrative Services Organization (ASO) and aims to better coordinate physical and mental health care for high-cost beneficiaries.

*Massachusetts*[10]*:* In 2012, the Commonwealth of Massachusetts signed a five-year contract with the Massachusetts Behavioral Health Partnership (MBHP), a ValueOptions company, to provide integrated physical and behavioral health programs, management support services, and behavioral health specialty

services to people enrolled in MassHealth's Primary Care Clinician (PCC) Plan. Individuals enrolled in MassHealth's PCC plan receive behavioral health services through the state's contract with ValueOptions and medical services from PCCs on a fee-for-service basis.

*Kansas*[11]*:* Kansas contracts with three KanCare managed care organizations (MCOs) to serve as "lead entities (LEs)" to administer its health home initiative. LEs contract with community providers called "health home partners (HHPs)" to provide some of the six core health homes services. Many different types of community providers can qualify as HHPs. Current HHPs include each of the state's 26 community mental health centers, several county health departments, and many of the state's larger safety net clinics.

Typically, when state-level integration efforts focus on populations with serious mental illness (SMI) or children with serious emotional disturbance (SED), integration is structured with behavioral health organizations as lead. When integration efforts target broader populations of Medicaid recipients, the other structures are more typical; MCOs as lead is the most common structure, with fewer examples of integrating behavioral health into primary care and equal partnership arrangements. To date, the State Transition Team has indicated a desire to focus on transition age youth broadly, and an inclination that an MCO lead integration effort to support transition age youth seems to make the most sense. There were limited examples of this structure in Utah. **We encourage the integration subgroup to learn more about MCO-lead integration models, and to develop a recommendation for structuring Physical-Behavioral Health Integration for TAY in Utah.**

## Cornerstones

CMS has identified 5 cornerstones of effective behavioral/physical health integration:[12]

1. Aligned financial incentives across physical and behavioral health systems
2. Real time information sharing across systems to ensure that relevant information is available to all members of a care team
3. Multidisciplinary care teams that are accountable for coordinating the full range of medical, behavioral, and long-term supports and services as needed
4. Competent provider networks
5. Mechanisms for assessing and rewarding high quality care

Below are summarized some key lessons learned and considerations in relation to each of these cornerstones based on the experience of state-initiated physical-behavioral health integration in other states:

**Aligned financial incentives across physical and behavioral health systems**

Historically, one of the biggest barriers to effective physical-behavioral health integration has been payment.[13] These challenges include prohibitions on billing for multiple services in one day, inequities in reimbursement rates for behavioral health providers, fifteen minute increment billing, an inability to bill for case management and care coordination, and medical necessity requirements for a formal diagnosis to bill for behavioral health services. Aligning financial incentives across physical and behavioral health systems is critical to comprehensive integration. States have adopted a number of approaches to improve financial alignment, including carving-in behavioral health in the context of managed care (where the same managed care entity is responsible, either directly or through contracts, for physical and behavioral health), per member per month capitated payments instead of fee for service (FFS) (sometimes with a risk adjustment/enhanced payment for individuals with serious mental illness), parity enforcement, and same-day billing policies. During the site visit, the State Transition team identified this

cornerstone as an area where Utah currently demonstrates fewer strengths. ***We recommend that the integration working group learn more about the strategies already in place in the state to align financial incentives and develop recommendations for the implementation of additional strategies.***

**Real time information sharing across systems to ensure that relevant information is available to all members of a care team**

Many states have identified the collection of data and the use of information systems as critical components of their integration efforts.[14] During the site visit, the State Transition team identified real time information sharing as a relative strength in Utah, but also an area where substantial challenges exist in the state. Stakeholders in Vermont identified implementing data systems as by far the biggest challenge to fulfilling the vision of their "Blueprint." On the other hand, Tennessee had a managed care model in place long before behavioral health integration and did not require any new information systems.[15] One of the key considerations for integration implementation is whether to build on existing data-sharing capacity in the state, or to build an entirely new system. During the site visit, the team indicated that building a new data system from scratch is likely time and cost prohibitive. ***We recommend that the integration working group identify existing state-level data systems that the initiative could build on to facilitate real time information sharing for TAY.***

**Multidisciplinary care teams that are accountable for coordinating the full range of medical, behavioral, and long-term supports and services as needed**

A consistent theme amongst states with established integration efforts is the importance of peer support, care managers, and navigators. Several states (Arizona, Florida, Iowa) explicitly built peer support into the integrated service array to address wellness, recovery, and prevention goals. Vermont has also structured their Blueprint to incorporate community-based social service providers into their care teams. ***We recommend that the integration working group develop a set of guiding principles for the role of Peer Support Specialists and community-based social service providers in an integrated model for TAY.***

**Competent provider networks**

States with existing integration initiatives have emphasized the importance of allowing time to develop a comprehensive oversight system. Kansas' comprehensive oversight methodology requires on-site reviews, internal systems validation and survey work, performance improvement plan monitoring, and review of submitted reports. Texas requires monthly reports from health plans on the number of network providers for mental health rehabilitative and targeted case management services to help ensure adequacy of the provider network. ***We recommend that the integration working group develop recommendations for how to assess the adequacy of the TAY provider network and criteria for on-going oversight and monitoring in support of Utah's integration effort.***

**Mechanisms for assessing and rewarding high quality care**

States that have established physical-behavioral health integration initiatives typically identify a set of outcome measures across physical and behavioral health domains to track health outcomes, behavior changes, and costs. Some of the commonly tracked outcomes, such as emergency room visits, Body Mass Index (BMI), and outpatient visits are highly relevant for transition age youth. Others, such as high blood pressure and chronic condition hospital admissions may be less relevant for youth and young adults. The team will need to identify outcome assessments with relevance to TAY. In Iowa, the state documented demonstrated improvements in the Quality Caregiver Survey (QCS), which tracks medical,

school, family, economic, psychological, and legal issues.[16] Kansas has used selected metrics from the National Outcomes Measurement System (NOMS) to assess certain social determinants of health, such as employment status and housing.[17] During the site visit, the state transition team identified this cornerstone as an area of relative weakness in Utah. ***We recommend that the integration working group develop recommendations for TAY specific performance and outcomes metrics to support physical-behavioral health integration for this population.***

**Implementation Considerations**

In addition to the structure and cornerstone decision points outlined above, there are additional decision points and considerations for implementation of TAY physical-behavioral health integration within an MCO framework. To maximize the strengths of this model and address potential challenges, these considerations include:

*SMI/SED vs. TAY Broadly*: A key decision point faced by states is whether to develop a single integrated system or multiple, specialized systems of care for subsets of beneficiaries.[18] Although many MCO-lead integration efforts focus on SMI/SED, Hennepin County in Minnesota, Massachusetts, Tennessee, and New York serve broad populations of Medicaid beneficiaries. Everything that we have heard from the State Transition Team to date suggests that the team wants the integration effort to focus on TAY broadly, as opposed to only those with Serious Mental Illness or Serious Emotional Disturbance. ***The team should be sure to articulate this commitment clearly in the Blueprint and in conversations with Medicaid Stakeholders.***

*Full integration vs. phase-in across the integration continuum*: Some states have phased-in integration efforts focusing on increasing care coordination or co-location of services as a first step before implementing full-integration. ***Because Utah already has several integrated programs and pilots in place, the team should consider focusing its Blueprint on full integration rather than a slower phase in.***

*Statewide implementation vs. select regions*: Larger states and those with larger populations (New York, Arizona, Texas) often have started their integration efforts in select regions, expanding statewide over time. Other states with smaller populations (Kansas) or a longer history of managed care (Tennessee) have gone straight to statewide implementation. Utah already has several integrated programs and pilots in place in select regions, including urban, rural, and tribal communities***. We recommend that the integration working group explore the feasibility of statewide implementation that adequately meets the needs of different types of communities across the state.***

*Prescriptive vs. flexible program requirements:* States have indicated that initial program requirements should clearly reflect the state's policy goals, allow plans the space to develop innovative approaches, and be very prescriptive in a few key areas. These key areas include continuity of care requirements to safeguard beneficiaries during program transitions, clear requirements for sub-contracting BHOs that foster coordination, and requirements for care coordination and administrative data collection. ***We recommend that the integration working group, in collaboration with key stakeholders, clearly articulate the goals of TAY integration and how they align with state policy goals as an initial step in this process.***

*Stakeholder Buy In:* States and health plans have noted that they often underestimated how much work it would take to create buy-in for a program paradigm shift that merges two systems into one. They recommend that states develop a comprehensive, overarching approach to stakeholder engagement

and focus targeted engagement efforts on specific providers as needed during the program design and early implementation phases.[19] As noted at the site visit, on-going and deep engagement with a broad range of stakeholders including young people, health, behavioral health, and community-based providers will be crucial to the success of the initiative. ***We recommend that the integration work group develop a comprehensive approach to stakeholder engagement that targets adult and child-serving providers and identifies specific stakeholders in need of targeted engagement.***

*Infrastructure and technical assistance:* Providers in different systems can have widely varying levels of familiarity with Medicaid billing, electronic health records, and shared data systems. Other states have noted that they have sometimes underestimated the learning curve for providers, particularly community based and social services providers.[20] ***We recommend that the integration work group develop a strategy to assess the readiness of the existing provider network for integration, and use this information to inform on-going planning and technical assistance***.

**TAY Physical Health-Behavioral Health Integration: Key Takeaways and Next Steps**

- We recommend that the integration work group meet regularly to systematically tackle the suggested integration learning agenda, deliberate key decisions, and develop needed recommendations
- We also recommend that the integration work group invite additional members, consider developing subcommittees, and consult with state and national experts to develop the many needed decisions and recommendations.
- We also recommend that the integration work group regularly report out to the State Transition Team, UTAC, Providers, and other key stakeholders
- The integration work group, in collaboration with the CLASP team, will finalize the blueprint for presentation to Medicaid stakeholders and potential philanthropic partners.

**Resources**

State Initiated Physical-Behavioral Health Integration

Overview
Arizona
Colorado
Florida
Iowa
Kansas
Massachusetts
Minnesota (Hennepin, Southern Prairie Community Care, Preferred Integrated Network)
New York
Tennessee
Texas
Vermont

Transition Age Youth Physical-Behavioral Health Integration

Mt. Sinai Adolescent Health Center

CMS Technical Assistance Brief

Integration Continuum Summary Chart

Endnotes

[1] https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/bh-briefing-document-1006.pdf
[2] https://www.macpac.gov/wp-content/uploads/2015/09/Catalog-of-Behavioral-and-Physical-Health-Integration-Initiatives.pdf
[3] Ibid
[4] Ibid
[5] https://www.chcs.org/media/BH-Integration-Brief_041316.pdf
[6] https://aspe.hhs.gov/system/files/pdf/76991/4CaseStud.pdf
[7] https://www.macpac.gov/wp-content/uploads/2015/09/Catalog-of-Behavioral-and-Physical-Health-Integration-Initiatives.pdf
[8] Ibid
[9] Ibid
[10] Ibid
[11] Ibid
[12] https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/bh-briefing-document-1006.pdf
[13] https://aspe.hhs.gov/system/files/pdf/76991/4CaseStud.pdf
[14] Ibid
[15] Ibid
[16] https://www.macpac.gov/wp-content/uploads/2015/09/Catalog-of-Behavioral-and-Physical-Health-Integration-Initiatives.pdf
[17] https://www.chcs.org/media/BH-Integration-Brief_041316.pdf
[18] Ibid
[19] Ibid
[20] https://aspe.hhs.gov/system/files/pdf/76991/4CaseStud.pdf