

State Approaches to Integrating Physical and Behavioral Health Services for Medicare-Medicaid Beneficiaries: Early Insights

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Behavioral health disorders—which include mental illness and/or substance use disorders—are among the most prevalent and disabling conditions affecting individuals who are eligible for Medicare and Medicaid (also known as “dual eligibles” or Medicare-Medicaid beneficiaries).^{1,2} One in four Medicare-Medicaid beneficiaries aged 65 and older and nearly 40 percent under age 65 have a mental health disorder.³ Among Medicare beneficiaries, those with serious mental illness (SMI), such as major depression, bipolar disorder, and schizophrenia, are more than twice as likely to have three or more chronic, comorbid conditions.⁴ Substance use disorder is also more common among dually eligible individuals than among Medicare-only beneficiaries.⁵ Spending for Medicare-Medicaid beneficiaries with SMI is at least twice that of individuals without these conditions (Exhibit 1).⁶

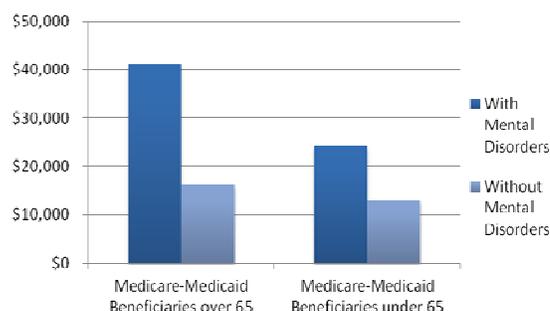
System fragmentation across Medicare and Medicaid—as well as between behavioral health services and other medical care—is particularly disruptive to people with significant behavioral health needs.⁷ Although many states are tackling the challenge of integrating Medicaid physical and behavioral health services, similar efforts that reach across both Medicare and Medicaid are an even more complex undertaking. Medicare is the primary insurer for acute and primary care, while Medicaid covers crucial “wraparound” services, rehabilitation, and home- and community-based services (HCBS) (Exhibit 2).⁸ Successful integration of Medicare and Medicaid must address not only care coordination across behavioral health services, medical care, and long-term services and supports (LTSS), but also the separate administrative and data systems, conflicting program rules, and financial misalignments between programs.

This brief, made possible through support from The Commonwealth Fund and The SCAN Foundation, describes early efforts in four states—Arizona, California, Massachusetts, and Washington—to improve integration of behavioral health services for Medicare-Medicaid beneficiaries. The Center for Health Care Strategies (CHCS) conducted interviews with state officials to learn how these four states are incorporating mental health and/or substance use disorder services within broader efforts to integrate Medicare and Medicaid. This resulting brief outlines: (1) how states are using Medicaid behavioral health system capacity to advance care coordination and establish better integration with Medicare; and (2) common elements of effective physical/ behavioral health integration strategies. While the states profiled are at early stages of implementation, initial lessons can be extracted from their experiences to inform other states.

IN BRIEF

Behavioral health disorders are among the most prevalent and disabling chronic conditions affecting Medicare-Medicaid beneficiaries. These individuals have complex needs that require closely coordinated services, but misalignments between Medicare and Medicaid often result in fragmented, poor quality care. This brief describes early efforts in four states—Arizona, California, Massachusetts, and Washington—to improve integration of behavioral health services for Medicare-Medicaid beneficiaries. It details: (1) how states are using existing Medicaid behavioral health system capacity to advance care coordination and establish better integration with Medicare; and (2) common elements of physical and behavioral health integration strategies to guide other states in developing similar programs.

Exhibit 1: Average Annual Spending on Medicare-Medicaid Beneficiaries, 2006-2009



SOURCE: R. Frank, “Mental Illness and a Duals Dilemma,” *Journal of the American Society on Aging*, 37, no.2 (2013): 47-53.

Exhibit 2: Behavioral Health Services Covered by Medicare and Medicaid⁹

Service	Medicare	Medicaid
Screening for alcohol misuse or illicit drug use	✓ ^a	✓ ^b
Screening for suicide risk		✓ ^b
Diagnostic tests, psychological testing	✓	✓
Outpatient mental health/substance abuse (MH/SA) psychotherapy	✓	✓
Inpatient MH/SA psychotherapy	✓	✓ ^c
Inpatient and outpatient detoxification	✓	✓
Pharmacological therapies and medication management	✓	✓
Opioid addiction treatment		✓
Short- and long-term MH/SA residential care		✓
Case management/intensive case management for MH/SA		✓
Crisis intervention for MH/SA		✓
Non-emergency transportation services		✓
Peer support services		✓
Family support services		✓
Home-based support services		✓

^a Covered for Medicare Screening, Brief Intervention and Referral for Treatment services.

^b Service covered for children under Medicaid's EPSDT benefit; a minority of states cover screening for adults.

^c Excludes services in an institution for mental health diseases (IMD) for those ages 21-64.

Behavioral Health Services in the Context of Medicare-Medicaid Integration

The Affordable Care Act (ACA) created new options and incentives for states to pursue integrated Medicare-Medicaid delivery systems. In 2011, the Centers for Medicare & Medicaid Services (CMS) announced the Financial Alignment Initiative, which provided states with two new demonstration models—capitated and managed fee-for-service (MFFS)—and the opportunity to partner with CMS to better integrate Medicare and Medicaid services, improve care delivery, and reduce unnecessary spending.¹⁰ Other state approaches to Medicare-Medicaid integration include contracting with Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs).¹¹

In pursuing these new approaches to improve Medicaid-Medicare integration, many states are simultaneously looking to better coordinate a range of behavioral health services for this high-need population. The following section profiles how four states—Massachusetts, California, Arizona, and Washington—are seeking to advance comprehensive strategies for integrating behavioral health care delivery for Medicare-Medicaid beneficiaries. Regardless of their designated Medicare-Medicaid integration approach, each of the profiled states are building on existing Medicaid behavioral health infrastructures as they develop more integrated models.

Massachusetts: Integrating Behavioral Health in a Capitated Demonstration

Existing Medicaid Behavioral Health Infrastructure: Massachusetts' Medicaid managed care §1115 demonstration project covers diversionary and community alternative mental health and substance abuse services for Medicaid enrollees. However, Medicare-Medicaid beneficiaries ages 21-64 are excluded from Medicaid managed care arrangements; most of

these individuals receive behavioral health services covered under the Medicaid State Plan in an unmanaged fee-for-service arrangement.¹²

Vehicle for Medicare-Medicaid Integration: Massachusetts became the first state in the nation with an active capitated Financial Alignment Initiative with its launch of One Care in October 2013. This program for Medicare-Medicaid beneficiaries, age 21 to 64, is operating in eight counties and portions of a ninth. Contracted One Care health plans receive a capitated payment to provide Medicare and Medicaid services. Diversionary and community alternative behavioral health services are included in this arrangement, extending important access to these services to Medicare-Medicaid beneficiaries age 21 to 64. Since more than two-thirds of this population in Massachusetts have a diagnosed behavioral health condition, the state believes that these services will benefit people who regularly rely on the emergency department or whose care needs escalate into crisis mode because they have nowhere to go.¹³ The Department of Mental Health will retain its current responsibility for administering targeted case management and mental health rehabilitation option services.

Approach to Integrating Behavioral Health: Several One Care plan requirements for cross-provider collaboration will improve care for all Medicare-Medicaid beneficiaries, but are particularly important for those with behavioral health conditions:

- **Interdisciplinary Care Team (ICT) support** for every One Care beneficiary, which will include a behavioral health provider for those with a behavioral health diagnosis who choose to receive those supports. Behavioral health providers participate in initial development and ongoing implementation of an interdisciplinary care plan, and consult other ICT providers about behavioral health-related care plan modifications, interventions, and transitions.
- **Independent Living-Long Term Services and Supports (IL-LTSS) coordinator oversight** of evaluations, assessments, and care plans to ensure they meet beneficiaries' needs and support recovery model principles. One Care plans must contract with independent community organizations, which may include behavioral-health focused groups, to serve as IL-LTSS coordinators. The state is working with One Care plans to expand contracts with behavioral health-focused, community-based organizations that offer self-help and peer support services, referrals, and information and training resources.
- **Connection to specialty hospital care** through contracts with each state-owned and operated psychiatric hospital.

Massachusetts is also leveraging an existing delivery system reform effort, the Massachusetts Patient-Centered Medical Home Initiative (PCMHI), to guide One Care plan and provider coordination of physical and behavioral health services. Massachusetts referenced the PCMHI's recommendations for building an effective integrated primary and behavioral health care system in One Care plan contracts. Recommendations include guidance for cross-practice communication; use of evidence-based care; and standards for full integration of care management, treatment plans, community resource engagement, and aligned administrative processes and systems.¹⁴

California: Carving Out Behavioral Health from Capitated Demonstration Contracts

Existing Medi-Cal Behavioral Health Infrastructure: California carves out mental health and substance use disorder treatment from managed care organization (MCO) contracts in Medi-Cal, California's Medicaid program. County mental health plans and the county

departments responsible for alcohol and drug services either directly provide these services, contract with community-based organizations to deliver services, or provide some and contract for other services.¹⁵ Medi-Cal MCOs must sign a memorandum of understanding (MOU) with county mental health plans and the department responsible for alcohol and drug services to formalize policies and procedures for coordinating physical and behavioral health services for Medi-Cal members.

Vehicle for Medicare-Medicaid Integration: California is implementing Cal MediConnect, a capitated Financial Alignment Initiative, in eight counties beginning in April 2014.¹⁶ Similar to Massachusetts, contracted health plans will receive a capitated payment to provide Medicare and most Medi-Cal services to enrollees. However, to avoid destabilizing the existing county-based delivery system, Cal MediConnect will maintain the mental health and substance use disorder treatment carve-out for Medicare-Medi-Cal members. Cal MediConnect plans will provide general (often referred to as mild to moderate) behavioral health services for beneficiaries who do not meet medical necessity criteria for specialty mental health or Drug Medi-Cal services, which includes a wide range of outpatient substance use disorder services.

Approach to Integrating Behavioral Health: County entities currently do not have an official channel to access Medicare information or engage with treating Medicare providers. To remedy this, California created a new MOU for Cal MediConnect plans, county mental health plans, and departments for alcohol and drug services that will align behavioral health services for Medicare-Medi-Cal members.¹⁷ When Cal MediConnect begins in San Mateo County in April 2014, the provisions in the new MOU will begin to bridge the gaps between Medicare and the county behavioral health system. Entities may decide to use the MOU template or create an original document. In either case, the agreement must include:

- **Clear definitions of roles and responsibilities** for Cal MediConnect plans and county entities including: processes for screening and assessment; making, tracking and following-up on referrals; authorizing and reimbursing for different services; and providing verification of provider licensure.
- **Care coordination approaches** that provide seamless care at the point of contact, reduce service duplication and work with family members and other stakeholders. Regular meetings between Cal MediConnect plans and county entities are also required to review joint treatment plans and health outcomes, and identify areas for improvement.
- **Information-sharing policies and procedures** to facilitate sharing of physical and behavioral health data (e.g., referrals, the integrated care plan, provider contact information, a current medication list, and a record of services) through a secure electronic system.
- **Shared performance measures** tied to aligned financial incentives to discourage cost-shifting, assess the effectiveness of care coordination between programs, and create shared accountability for health outcomes.

Arizona: Integrating Behavioral Health through a D-SNP Platform

Existing Medicaid Behavioral Health Infrastructure: Behavioral health services are carved out of Medicaid managed care contracts in Arizona. Organizations called Regional Behavioral Health Authorities (RBHAs) contract with the Division of Behavioral Health Services (DBHS) in the Department of Health Services to manage and provide public behavioral health services in a given geographic service area through a network of providers, clinics, and other facilities. The Arizona Health Care Cost Containment System

(AHCCCS), the state's Medicaid agency, contracts with DBHS for Medicaid behavioral health services. Medicaid beneficiaries must enroll in their local RBHA to receive specialty behavioral services.

Vehicle for Medicare-Medicaid Integration: Almost all Medicaid beneficiaries are enrolled in managed care for Medicaid physical health and LTSS. Since 2006, Arizona has pursued an integrated delivery system for Medicare-Medicaid beneficiaries through a D-SNP contracting platform by encouraging individuals to enroll in the same plan for Medicare and Medicaid services. Arizona recently required participating Medicaid MCOs to qualify as a D-SNP in all the geographical areas where they have a Medicaid contract to offer the opportunity for all dually eligible beneficiaries to enroll in aligned plans for Medicare services.

Approach to Integrating Behavioral Health: In April 2014, AHCCCS is launching a new program to provide integrated behavioral health services in Maricopa County for Medicaid beneficiaries with SMI. Merging its RBHA and D-SNP platforms, the state awarded an RBHA contract to Mercy Maricopa Integrated Care (MMIC) to coordinate all behavioral and physical health services for Medicaid beneficiaries who have SMI in Maricopa County, including those enrolled in Medicare. MMIC is a D-SNP, an Arizona requirement for this procurement. Medicare-Medicaid beneficiaries may choose to enroll in MMIC for their Medicare services as well to receive all services through one, aligned organization. MMIC will be responsible for all services; it may not subcontract any key health plan operations that are critical to the integration of behavioral and physical health care, including Medicare services.

This new RBHA arrangement tested by MMIC will introduce more comprehensive requirements for care coordination to improve care for all individuals, particularly those with SMI who are eligible for Medicare and Medicaid. Requirements include:

- **Care coordination** at the system and clinical levels across physical and behavioral health providers for Medicaid and Medicare benefits to directly manage the treatment team and ensure cross-specialty collaboration and care management;
- **Processes for targeting interventions for high-risk beneficiaries**, such as identification and monitoring of the top 20 percent of high-risk/high-cost beneficiaries with SMI and new tools for risk assessments and predictive modeling;
- **Prevention strategies** that reduce the incidence and severity of serious physical and mental illness;
- **Enhanced discharge planning** and follow-up care between provider visits; and
- **Health information technology** to promote physical and behavioral health data integration, and support linked Medicare-Medicaid data and a stratified patient registry to identify the highest risk beneficiaries.¹⁸

Washington: Implementing Two Financial Alignment Demonstration Models that Target Behavioral Health Needs

Existing Medicaid Behavioral Health Infrastructure: The Washington Department of Social and Health Services (DSHS) is responsible for the provision and oversight of mental health, chemical dependency (Washington State's term for substance use disorder), developmental disability, and LTSS to individuals eligible for Medicaid. DSHS oversees Regional Support Networks (RSNs), which provide publicly funded mental health services in 11 designated regions in the state. These networks, primarily county-administered or non-profit entities, contract with licensed community mental health providers for crisis response, community support, residential, resource management, and other related services. The

Washington Health Care Authority (HCA), Washington's Medicaid agency, also covers some mental health benefits for individuals who require mental health care but do not meet acuity standards for RSN services.

Vehicle for Medicare-Medicaid Integration: The Aging and Long-Term Support Administration (AL TSA) in DSHS and HCA partnered to develop "HealthPath Washington," a two-pronged approach to promote Medicare-Medicaid integration. In July 2013, the state launched an MFFS Financial Alignment Initiative to integrate care via the Medicaid health home option (established by §2703 of the ACA). The new model is designed to coordinate all Medicare and Medicaid services, including mental health, chemical dependency, and LTSS, for high-risk Medicaid-only and dually eligible beneficiaries.¹⁹ RSNs may apply to provide the administrative and/or care coordination functions of a health home.

In addition, the state will use a capitated Financial Alignment Initiative model to contract with health plans to integrate Medicare and Medicaid services for individuals in its two most urban counties. The capitated initiative will begin in late 2014, and management of some mental health services will be transitioned from the RSNs to integrated Medicare-Medicaid health plans. RSNs will continue to cover safety net and crisis services, while the health plans will cover most Medicaid behavioral health services. The state is developing an operational agreement between the health plans and RSNs that will include procedures to set eligibility, access, and diagnostic standards; track transitions between the plans and RSNs to prevent cost-shifting between entities; and establish communication channels across programs.

Approach to Integrating Behavioral Health: Both of Washington's demonstration models have roots in earlier initiatives for high-risk individuals. The Chronic Care Management program, designed to provide self-management skills to high-risk individuals with chronic conditions, informed the state's MFFS demonstration and, more broadly, the Medicaid health home initiative.²⁰ The Washington Medicaid Integration Partnership, in which a health plan provided fully integrated care for Medicaid-only and dually eligible beneficiaries in Snohomish County, helped guide plan performance, accountability, and provider capacity requirements for the capitated model design.²¹

Elements that promote coordinated care, smooth transitions across settings, and improve provider capacity to serve high-risk Medicare-Medicaid beneficiaries, including individuals with SMI, include:

- **A web-based clinical decision support and predictive modeling tool, Predictive Risk Intelligence System (PRISM),** which combines Medicare and Medicaid data to determine eligibility for health homes or intensive care management services available for high-risk beneficiaries in the capitated model, in addition to identifying individuals at highest risk and most in need of care coordination. PRISM provides a risk score and a history of behavioral health utilization and possible gaps in care, which allows both health homes and health plans to link beneficiaries with behavioral health providers. PRISM also includes assessment data, which may identify hard-to-reach individuals who have unmet behavioral health needs.
- **Training requirements for health home care coordinators in the MFFS model** on Medicare-Medicaid integration issues, including those related to behavioral health (e.g., outreach and engagement strategies; Medicare-Medicaid service interactions and grievances and appeals; cross-systems care coordination, complex case review; PRISM use; and required elements of care transitions). Jointly developed by DSHS and HCA, training may also include "case gapping" sessions in which state staff will

convene small groups of care coordinators to discuss targeted issues for high-need populations, including behavioral health services and Medicare-Medicaid integration.²²

Common Considerations for Integrating Behavioral Health Services

The four states interviewed encountered similar issues in design and early implementation of their programs, despite the differences in their approaches to integrating care for Medicare-Medicaid beneficiaries with behavioral health conditions. The next section describes five key considerations to inform the efforts of other states pursuing integrated programs to improve care for this population.

1. Provide access to historical and real-time linked data to inform care coordination and management.

Lack of access to Medicare data is a key challenge for Medicaid programs looking to integrate services for dually eligible beneficiaries. With high rates of inpatient stays, prescription drug utilization, and comorbid chronic conditions, understanding the full spectrum of health needs for Medicare-Medicaid beneficiaries with behavioral health conditions is essential for managing their care. By linking Medicare and Medicaid data, states or health plans can target behavioral health interventions and provide real-time care coordination and transition support for these individuals. CMS has created new opportunities to help state Medicaid agencies obtain and use Medicare Parts A, B, and D data for Medicare-Medicaid care coordination, including data files with linked Medicare and Medicaid members and technical assistance for states to better understand linked data.²³

All states stressed the importance of proactively addressing concerns about data privacy while balancing the need for data availability for effective care coordination. Washington noted that states should plan to spend considerable time developing solutions to address stakeholders' privacy concerns. For instance, in Massachusetts, stakeholders were concerned that behavioral health data would be accessible to a broader array of providers and entities, instead of residing exclusively with an individual's mental health or substance use disorder provider. The state focused several provider and beneficiary stakeholder discussions on data protections to improve comfort with the new information-sharing policies.

Putting Linked Data to Work in New Ways

- **Arizona's** MMIC will be the state's first RBHA with access to linked data. MMIC will use this linked data to evaluate program processes and outcomes across populations and better target strategies for integrating the full array of Medicare and Medicaid physical and behavioral health services.
- **Massachusetts'** One Care plans use a single, centralized electronic medical record to manage communication and information flow across providers and delivery systems. Care team members (e.g., mental health and substance abuse service providers) can use the electronic record to manage referrals, transitions, and care delivered outside of their care site.
- **Washington's** PRISM provides fully integrated claims data from primary, acute, social services, behavioral health, and LTSS to health home care coordinators, a unique capability that many other Medicaid health homes programs do not yet have. The state will also use PRISM to analyze Medicare Part D data to set rates for Medicaid-covered mental health services in its capitated demonstration.²⁴ Prescription drug data available via PRISM may fill diagnostic and utilization information gaps important for risk adjustment that are not always included in other medical claims.

2. Promote shared accountability to expand care coordination across Medicare and Medicaid.

All states recognized the importance of aligned performance measures to drive shared accountability, allocate savings achieved from improvements in acute settings as well as community service expansions across programs, and reduce incentives for cost-shifting. All states will use shared performance measures to extend accountability for care coordination and health outcomes across Medicare and Medicaid. Examples of metrics that may advance behavioral health integration include evidence of written policies for coordinated care planning and information exchange, and reduction in emergency department visits for beneficiaries with SMI or substance use disorders.²⁵ States may develop a formal approach for shared financial accountability across entities through specific incentives and/or penalties linked to performance metrics for both parties. Approaches include:

- **Incentive or bonus payments** for meeting set performance measures;
- **Quality withholds** (a percentage of the capitation payment) earned back for meeting performance measures; and
- **Shared savings pools** around benchmarks for reduced service costs.

In addition, integrated arrangements may create new opportunities to improve care coordination for Medicare-Medicaid beneficiaries ages 21-64 who receive services provided in an Institution for Mental Disease (IMD). States do not receive federal Medicaid matching funds for services provided in an IMD for individuals in this age group.²⁷ Because Medicare may cover services in Medicare-certified IMDs, integrated programs may be able to cover IMD and other services for Medicare-Medicaid beneficiaries with SMI under the same program.

Creating Shared Financial Incentives for Improved Outcomes

- **California** will require Cal MediConnect plans to formalize a process by which funds earned back through quality withhold metrics tied to coordination between mental health and/or substance use disorder services will be shared with the county mental health plans and county departments for alcohol and drug services.²⁶
- **Massachusetts'** expansion of behavioral health diversionary services to younger Medicare-Medicaid beneficiaries may reduce inpatient and other acute care service use, and provide an opportunity for the state to access any shared savings.

3. Embed person-centered and recovery-based principles into behavioral health care model plan and provider requirements.

Any integrated program for high-need beneficiaries should be person-centered, and this is particularly important for individuals with significant behavioral health needs. In contrast to traditional medical models in which providers or institutions direct treatment decisions, person-centered, recovery-based care models encourage individuals to establish personal recovery goals based on their needs, strengths, preferences, capacities, and desired health and quality of life outcomes.²⁸ Other principles underlying a recovery-based model include a holistic focus on an individual's mind, body, spirit and community; peer support; beneficiary responsibility in meeting treatment plan goals, and the belief that people can and do overcome obstacles.²⁹ Several states commented on the importance of an individualized, self-directed framework that allows individuals to determine their path to recovery in these programs.

Encouraging Recovery

- **Arizona** requires that MMIC incorporate recovery-based principles across contract requirements. For example, members provide input in developing individualized treatment goals, wellness plans, and services. Family involvement, community integration, and a safe affordable place to live are noted in contract language as integral components of a member's recovery.³⁰
- **Massachusetts** empowers individuals to drive the design of their care plan. Individuals are encouraged, with guidance from their care team, to decide how and when to tackle behavioral health, medical, or social issues in a manner that feels appropriate to them.
- **Washington** asks individuals who qualify for health home or intensive care management services in the capitated model to work with their care managers to develop a Health Action Plan that outlines their treatment goals and priorities, the actions they will take to achieve their goal(s), and the actions that their providers will take to support them.

4. Address administrative challenges that may impede the development of integrated behavioral health provider networks.

Relationships with community providers, neighborhood organizations, and other local behavioral health supports are often a critical element in treatment and recovery for individuals with significant behavioral health needs. The preservation of these relationships is an important consideration in the development of an integrated care program. However, administrative policies and procedures such as licensure and credentialing requirements or billing systems may be a barrier to participation for some types of providers.

Eliminating Administrative Barriers

- **Arizona** revised administrative rules to expand the types of settings in which Medicaid behavioral health services may be reimbursed to facilitate a team-based approach to service delivery across providers.
- **California** is reviewing options to reconcile different licensure and credentialing requirements under Medicare and Medi-Cal for some mental health providers in community-based organizations under Medi-Cal to maintain current levels of access and continuity of care.
- **Washington** is working with health home providers to better understand Medicare and Medicaid billing practices for different services provided to the same individuals. Washington will also work with health plans to help build mental health networks in capitated model counties. King County manages RSN services, and the county is interested in subcontracting with the health plans to keep these providers in place. In Snohomish County, the same health plans will build new networks of mental health providers.

5. Encourage stakeholder engagement to strengthen program design and implementation.

Robust stakeholder engagement, outreach, and communication—across individuals, families, and providers, and internally with sister agencies—is critical to the design and implementation of integrated care programs. Beneficiary input should drive the design of recovery-focused behavioral health models. Similarly, provider buy-in is essential to the design and implementation of effective programs. Different types of providers are likely to have various concerns about Medicare-Medicaid behavioral health integration, requiring distinct approaches to engagement and education. For example, traditional medical providers may need more education about recovery-based care models, while Medicaid or locally-

funded community behavioral health providers may benefit from training on Medicare and/or managed care. In many states, some or all public behavioral health services are delivered outside of the Medicaid agency, requiring new mechanisms for collaboration across agencies. In addition, state health and social service agencies, which often provide important services for individuals who have mental health or substance use disorders, may have limited, if any, exposure to Medicare program policies. Medicaid agencies may need to fill some knowledge gaps.

Building Relationships through Stakeholder Engagement

- **Arizona** discussed MMIC’s efforts to engage stakeholders actively, early, and often during the initial procurement stages. The plan met with provider and peer organizations in the community to obtain their feedback before submitting its proposal. MMIC also worked with behavioral health service providers to promote open dialogue and address concerns, especially those related to billing, transitions, and data sharing. AHCCCS and DBHS held regular internal meetings to address concerns and draft the RFP for the new integrated RBHA contract.
- **California** holds monthly meetings with Cal MediConnect plans, county mental health plans, and county departments for alcohol and drug services. The state also realized the importance of directly engaging with community-based behavioral health providers early on—in addition to health plans—to ensure transfer of program information to providers.³¹
- **Massachusetts** credited Medicare-Medicaid beneficiaries and their families for providing valuable feedback to inform the design of the state’s recovery-based philosophy, how to implement One Care person-centered requirements, and areas for provider training, such as guiding beneficiaries’ ability to self-direct their care³². In addition, the Medicaid agency has regular meetings with staff from One Care and the state behavioral health agency to keep all involved parties informed and engaged. If beneficiaries work with case managers from the Department of Mental Health, One Care interdisciplinary care teams include those individuals in care planning to foster information sharing across programs.
- **Washington** recognized the importance of extensive collaboration between DSHS and HCA to develop a structure for shared governance of the demonstrations and new strategies to improve health care, services, and supports. The state also noted that its collaborative culture encourages participating providers to work together to successfully transition to new models of care.

Conclusion

Medicare-Medicaid beneficiaries with behavioral health conditions are among the nation’s most vulnerable high-need, high-cost populations. These individuals must navigate fragmented delivery systems for behavioral and physical health services, as well as separate coverage, administrative and financial rules for Medicaid and Medicare. States are taking advantage of innovative opportunities to address long-standing, systemic misalignments for Medicare-Medicaid beneficiaries generally and individuals with behavioral health conditions specifically. State capacity for developing these programs relies in part on their existing behavioral health foundation and broader efforts to pursue Medicare-Medicaid integration. The different paths of the four states profiled in this brief illustrate wide-ranging state approaches and individual program elements that may inform other state initiatives to advance behavioral health integration and improve care for a high-need population.

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About the Center for Health Care Strategies

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

Endnotes

- ¹ “Behavioral health” encompasses both mental health and substance use disorders diagnoses and services. Some information presented in this issue brief is specific to mental health and/or serious mental illness (SMI) diagnoses and services, and is noted specifically with that terminology.
- ² Substance Abuse and Mental Health Services Administration (SAMHSA). *Behavioral Health, United States, 2012*. 2013. Available at: <http://www.samhsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf>.
- ³ Congressional Budget Office (CBO). *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies*. Washington, DC: CBO, 2013.
- ⁴ The SCAN Foundation. DataBrief no. 35: *Prevalence of Chronic Conditions Among Seniors with Severe Mental Illness*. February 2013. Available at: http://thescanfoundation.org/sites/thescanfoundation.org/files/1pgdatabrief_no35_prevalence_of_chronic_conditions_among_seniors_with_severe_mental_illness.pdf.
- ⁵ W. Lin, J. Zhang, G. Leung, and R. Clark, “Twelve-Month Diagnosed Prevalence of Behavioral Health Disorders Among Elderly Medicare and Medicaid Members.” *American Journal of Geriatric Psychiatry*, no. 11 (2011): 970-9. As cited in Published Ahead-of-Print November 25, 2010. As cited in A. Hamblin, J. Verdier, and M. Au. *State Options for Integrating Physical and Behavioral Health Care*. Center for Health Care Strategies. October 2011. Available at: http://www.chcs.org/usr_doc/ICRC_BH_Brief_Final.pdf.
- ⁶ Ibid.
- ⁷ A. Hamblin, et al., op cit.
- ⁸ When both Medicare and Medicaid cover a service, Medicare is the primary payer; Medicaid may pay for all or some of remaining out-of-pocket costs, co-insurance/co-payments, and premiums following a Medicare payment.
- ⁹ Kaiser Family Foundation. “Mental Health Financing in the United States: A Primer.” 2011. Available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8182.pdf>.
- ¹⁰ Center for Medicaid, CHIP and Survey & Certification and Medicare-Medicaid Coordination Office. Financial models to support state efforts to integrate care for Medicare and Medicaid enrollees. State Medicaid Director Letter (SMDL) #11-0008. July 11, 2011. Available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/financial_models_supporting_integrated_care_smd.pdf.
- ¹¹ Dual Eligible Special Needs Plans (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid). D-SNPs may combine benefits available through Medicare and Medicaid.
- ¹² Senior Care Options (SCO) covers all of the services reimbursable under Medicare and MassHealth through a senior care organization and its network of providers. The SCO program was created to offer seniors aged 65 or older the opportunity to receive quality health care that combines health services with social support services. By coordinating care and specialized geriatric support services, along with respite care for families and caregivers, SCO offers an important advantage for eligible members over traditional fee-for-service care.
- ¹³ Interview with MassHealth officials, December 6, 2013.
- ¹⁴ Three Way Contract for Capitated Model: Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The Commonwealth of Massachusetts and One Care Plan. Issued July 11, 2013. Available at: <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/contract-for-one-care-plans.pdf>.
- ¹⁵ Specialty behavioral health services include 24-hour, seven day a week access to emergency, hospital and post stabilization care.
- ¹⁶ Implementation will be phased in along county-specific timelines as plans demonstrate readiness.
- ¹⁷ Template Language for Memorandum of Understanding between Duals Demonstration Health Plans and County Behavioral Health Department(s) Revised February 28, 2013. Available at: <http://www.calduals.org/wp-content/uploads/2013/02/Local-BH-MOU-Template-02-15-13.pdf>.
- ¹⁸ Arizona Mercy Maricopa Integrated Care: Scope of Work. ADHS Regional Behavioral Health Authority. GSA 6 Solicitation No: ADHS13-00002257. 10/04/2012. Available at: <https://procure.az.gov/external/bidDetail.sdo?docId=ADHS13-00002257&external=true&parentUrl=bid>.
- ¹⁹ Health homes are a new option for state Medicaid programs to provide care coordination services for enrollees with chronic conditions. The option, established under Section 2703 of the Affordable Care Act, took effect on Jan. 1, 2011. Health homes are designed to facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care and long-term community-based services and supports.

²⁰For more information on Chronic Care Management, see Washington State Health Care Authority website, available at: <http://www.hca.wa.gov/medicaid/healthyoptions/pages/ccm.aspx>.

²¹D. Mancuso, et al. Medicaid Integration Partnership: Medical Care, Behavioral Health, Criminal Justice and Mortality: Outcomes for Disabled Clients Enrolled in Managed Care." Washington Department of Social and Health Services; Planning, Performance and Accountability; Research and Data Analysis Division. RDA Report number 9.100, December 2010. Available at <http://www.dshs.wa.gov/pdf/ms/rda/research/9/100.pdf>.

²²Interview with Washington state officials, December 19, 2013.

²³For more information see the State Data Resource Center website at: <http://www.statedataresourcecenter.com/>.

²⁴Medicare Part D, also called the Medicare prescription drug benefit, is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Modernization Act of 2003 and went into effect on January 1, 2006.

²⁵Appendix 2 Framework for Shared Accountability: Coordination and Alignment Strategies for Integrated Delivery of Behavioral Health Services. CA revised proposal to CMS, May 31, 2012. Available at: <http://www.calduals.org/implementation/workgroup/bh-integration/>.

²⁶Behavioral Health Coordination Standards. California Coordinated Care Initiative (CCI). Updated February 15, 2013. Available at: <http://www.calduals.org/wp-content/uploads/2013/02/BH-Coordination-standards-02-15-13.pdf>.

²⁷A facility is an IMD if it has over 16 beds, is primarily engaged in providing diagnosis, treatment or care of persons with mental disorders, including medical attention, nursing care, and related services. A facility's license type is not a defining characteristic of an IMD, Title 42, CFR, § 435.1009.

²⁸Definition of "person-centeredness" taken from: Centers for Medicare & Medicaid Services. Accessed January 2014.

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing-Real-Choice-Systems-Change-Grant-Program-RCSC/Person-Centered-Planning-Grants.html>.

²⁹Recovery Principles. American Psychological Association. January 2012. Available at: <http://www.apa.org/monitor/2012/01/recovery-principles.aspx>.

³⁰Arizona Mercy Maricopa Integrated Care: Scope of Work. ADHS Regional Behavioral Health Authority. GSA 6 SOLICITATION NO: ADHS13-00002257. 10/04/2012. Available at: <https://procure.az.gov/bso/external/bidDetail.sdo?docId=ADHS13-00002257&external=true&parentUrl=bid>

³¹Interview with California officials, December 9, 2013.

³²Interview with MassHealth officials, December 6, 2013.