



Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:

Integrating Benefits and Care

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EXECUTIVE SUMMARY

One in five Medicaid beneficiaries has a mental health condition and/or substance use disorder,¹ and 60 percent of those individuals also have co-occurring, chronic physical health conditions.²

To successfully improve these individuals' health outcomes and well-being, it is well recognized that physical health and mental health conditions and/or substance use disorders (MH/SUD) must be addressed in an integrated and coordinated manner.³ Yet too often, owing to the typically siloed nature of health care delivery and payment systems for physical health and MH/SUD, these conditions have been addressed apart from one another, leading to poor outcomes and high costs.

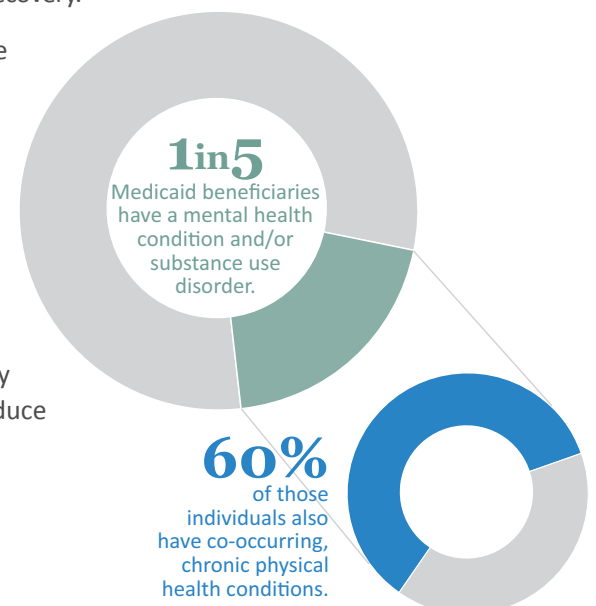
The need to address these siloes and move toward integration of physical health and MH/SUD care is particularly acute in Medicaid. As illustrated above, the program routinely serves individuals with a variety of MH/SUD, from depression associated with onset of chronic disease to serious mental illness (SMI). Individuals with MH/SUD experience poorer health outcomes, lower life expectancy, and higher costs compared to those without MH/SUD, reinforcing the importance of addressing all health care needs in an integrated manner.⁴ The importance of integration only increased following the implementation of the Affordable Care Act (ACA) as more adults with MH/SUD enrolled in Medicaid.⁵

Managed care can offer state and federal policymakers a range of options for fully integrating physical health, MH/SUD, and pharmacy benefits and care—along with other benefits such as vision, dental, and social services and supports. Many states are experimenting with a wide range of integration approaches in partnership with managed care organizations (MCOs). While many integration efforts are still in their early stages—and the impact of these efforts is yet to be fully measured—analyses of longer standing Medicaid managed care programs generally demonstrate program savings and improved health outcomes.

Anthem's affiliated health plans use a range of strategies to manage and better integrate benefits and care for their members. In many states, they serve as a key partner, linking critical services to build a system of care that meets the full range of members' needs. Leveraging existing data and infrastructure as well as care coordination tools, these health plans have been able to reach at-risk members with MH/SUD and assist them connecting with providers who can address their physical and mental health needs, locate housing and other critical supports, and move toward stability and recovery.

Across the country, Anthem's affiliated health plans are promoting a system of care for all of their members, with the goal of delivering a fully integrated care experience that provides seamless care and support across the continuum of benefits to address the full range of members' needs. Medicaid MCOs are structured to drive accountability for access, quality of care, health outcomes, and spending, and they are uniquely positioned to support the delivery of integrated, person-centered care. MCOs can serve as the locus of coordinated care for beneficiaries by working with state Medicaid programs, mental health agencies, providers, members and their families, as well as social service agencies that coordinate housing and other needs. Early examinations of programs that fully integrate benefits and care show that health outcomes can be improved and reduce total costs of care.⁶

Physical health and mental health conditions and/or substance use disorders must be addressed in an integrated and coordinated manner to successfully improve individuals' health outcomes and well-being.



INTRODUCTION

It is well recognized that improving health outcomes and successfully improving individuals' well-being requires addressing both physical health and mental health and/or substance use disorders in concert with one another, rather than separately.⁷ Too often, these needs have been addressed apart from one another, owing to the typically siloed nature of health care delivery and payment systems for physical health and MH/SUD.

As a result, stakeholders are pushing for and supporting the delivery of physical and MH/SUD services in an integrated fashion. Examples include grants and resource centers sponsored by federal agencies, such as the Substance Abuse and Mental Health Services Administration's (SAMHSA) Primary and Behavioral Health Care Integration Program, which offers support to communities to provide integrated care and establish Behavioral Health Homes. In addition, SAMHSA and the Health Resources and Services Administration (HRSA) jointly fund the Center for Integrated Health Solutions, which supports development of integrated primary care and MH/SUD services.⁸ Private foundations such as the Commonwealth Fund have also supported integration, including through efforts to establish quality metrics for integration.⁹ Additionally, professional associations and patient groups such as the National Council for Behavioral Health, continue to advocate for integration.¹⁰ These efforts complement an overall shift in health care to "value-based" care and payment, which holds providers and payers accountable to improve quality, health outcomes, and costs—thus necessitating a focus on the "whole person."

At the same time, a growing number of individuals are newly accessing the health care system and seeking treatment for MH/SUD. This change is largely the result of the ACA's expansion of Medicaid benefits, the inclusion of MH/SUD benefits in the essential health benefits (EHB), and requirements for mental health parity. It is estimated that approximately 30 percent of formerly uninsured individuals who, based on income, are or would be eligible for Medicaid under the ACA expansion have either a mental illness, substance use disorder, or both.¹¹

Anthem's affiliated health plans, partnering with state Medicaid agencies, advocates, and providers, have been developing and advancing integrated care for their members—well before recent policy changes and trends brought a renewed focus on integration.

THE CASE FOR INTEGRATED CARE

The need for better integration of care is particularly evident in Medicaid. Medicaid beneficiaries with MH/SUD range from children in need of screening, referral, and treatment to adults with SMI who require ongoing inpatient and outpatient health services and social supports to address a mental health condition as well as underlying socioeconomic issues such as unemployment, poverty, or homelessness. In 2011, 20 percent of Medicaid beneficiaries—or 9 million people—had a diagnosis of one or more mental health conditions and/or substance use disorders. Yet, this group accounted for nearly 50 percent of total Medicaid expenditures—over \$131 billion.^{12,13}

At the same time, approximately 60 percent of Medicaid beneficiaries with MH/SUD have co-occurring, chronic physical health conditions.¹⁴ These beneficiaries are more likely to have a medical condition such as cancer, cardiac disease, hypertension, or kidney disease compared to those without MH/SUD.^{15,16} Likewise, individuals with chronic physical health conditions have higher rates of depression and anxiety.¹⁷ Costs are also higher for beneficiaries with comorbid conditions. One study found that costs are 60 to 75 percent higher for Medicaid fee-for-service (FFS) beneficiaries with a mental illness and one or more chronic physical conditions, and two to three times higher when a drug or alcohol condition is also present.¹⁸

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Poor health outcomes and high costs result from both the complexity of beneficiaries' needs, as well as fragmented delivery systems and benefit structures. Administrative and operational barriers in many states have hindered the development of fully integrated systems of care that could address the full range of a beneficiary's needs. Further complicating effective care delivery, Medicaid beneficiaries also often lack transportation, stable housing, and caregiver supports—factors which are increasingly linked to health outcomes.¹⁹

MCO INTEGRATED BENEFITS CAN IMPROVE HEALTH OUTCOMES

Providers, payers, and policymakers have been testing approaches to improve payment and care delivery for almost 30 years, including pilots and programs to test the integration of MH/SUD and physical health services dating back to the 1990s.²⁰ Yet, full integration of both benefits and care delivery, from the MCO to the provider level, has only recently become a more widely adopted goal in Medicaid.

In most states responsibility for mental health, substance use, and physical health has been delegated to different entities. In 2010, separate agencies oversaw Medicaid MH/SUD benefits in 48 states.²¹ In 2014, only 9 of the 35 states and DC with Medicaid managed care programs integrated physical health and MH/SUD benefits under MCOs. The remaining 26 states carved out some or all MH/SUD services—ranging from all MH/SUD care to specialty services to certain classes of drugs.²² The division of responsibility across multiple agencies, providers, MCOs, vendors, and payers has led to fragmented care with poor outcomes and high costs, especially for individuals with MH/SUD.²³

However, states' interests in carving in benefits—or integrating physical health and MH/SUD benefits under the same managed care plan—has grown over the past several years, especially for high-cost, complex patients.²⁴ Increasingly states with Medicaid MCOs are moving towards carve-in models. At least eight states—Alabama, Colorado, Iowa, Louisiana, Nebraska, New York, Washington, and West Virginia,—are planning to or have recently carved in MH/SUD benefits, including administrative and financial responsibility for those services.²⁵ Additionally, a number of states have contracted with MCOs to offer products designed to meet the needs of specific populations.²⁶

Many states are experimenting with a wide range of integration approaches in partnership with MCOs. While many integration efforts are still in their early stages—and the impact of these efforts is yet to be fully measured—analyses of longer standing Medicaid managed care programs generally demonstrate program savings and improved health outcomes. A 2009 analysis of the research on the benefits of Medicaid managed care showed that while the level of financial results varied across studies, all identified some savings. Lower rates of inpatient utilization and pharmacy spending drove savings and were most significant for the Supplemental Security Income (SSI) population, which includes low-income aged, blind, and disabled individuals.²⁷ For example, Tennessee's Medicaid managed care program, which fully integrated MH/SUD and physical health services as well as long-term services and supports (LTSS) into MCOs, showed a reduction in inpatient utilization and emergency department visits, as well as improvements in care and lower costs.²⁸

Examples of States Moving to Carve-in MH/SUD Benefits

Washington currently carves MH/SUD benefits and care out of Medicaid MCO contracts in most counties and instead contracts with regional behavioral health organizations (BHOs). The BHOs are paid a capitated rate to manage MH/SUD benefits and services. The state plans to transition to a carved-in approach with MCOs being at risk for fully integrated MH/SUD and physical health benefits by 2020.²⁹

New York, as part of its Section 1115 waiver, is carving in MH/SUD benefits into its MCO contracts statewide. Traditional MCOs were required to offer fully integrated benefits effective October 2015. The state and MCOs worked together to introduce specialty MCO products for adult Medicaid beneficiaries with SMI (known as Health and Recovery Plans (HARP)) in 2016, and will carve in children's behavioral health benefits into MCOs by 2017. Historically, the state carved out MH/SUD benefits and services from its Medicaid MCO contracts and managed them through the FFS system.³⁰

Anthem’s affiliated plans have long supported state integration efforts using a system of care approach that integrates physical health, MH/SUD, and pharmacy benefits and care, including connecting members to social supports. Their goal is to deliver more individualized, person-centered care to achieve better health outcomes. A look at the efforts of Anthem’s affiliated plans in four states illustrates the range of strategies being employed by MCOs to promote integration of physical health and MH/SUD benefits and care. The figure below depicts the various strategies Anthem’s affiliated plans have developed to address states’ desire for more integration and to enhance members’ outcomes. A system of care has the greatest potential to improve outcomes and reduce costs when both MH/SUD and physical health benefits and care delivery are integrated from the MCO down to the practice level, and there is broad stakeholder engagement. However, this requires strong partnerships among states, payers, providers, and members and their families or caregivers.

Models for Moving to a Fully Integrated System of Care	
MCO Carve-In	MCO has financial and administrative responsibility for physical health (PH), pharmacy, and MH/SUD benefits but manages them separately.
Integration of MCO Operations	MCO adds designated internal plan team to manage PH, pharmacy & MH/SUD benefits and care for members with co-occurring conditions.
Dedicated Care Management	MCO adds dedicated MH/SUD case management function to help members navigate PH, pharmacy, & MH/SUD care and helps coordinate info sharing and care across providers.
Integrated Providers in Network	MCO invests in and drives provider/delivery system integration (e.g., through supporting co-location or on-site MH/SUD providers at primary care providers)
Provider Accountability for Integrated Care	MCO extends accountability to providers for cost and quality for “whole person,” creating strong incentives for integrating PH, pharmacy, & MH/SUD care delivery, for preventing inappropriate use of acute services, and for connecting to community-based services and supports to meet full range of member needs.

Anthem’s affiliated plans integrate physical health and MH/SUD benefits in Medicaid in many states. The examples below highlight some of the elements necessary for integration of physical health, MH/SUD, and pharmacy benefits as well as other services and supports.

- **Florida: Integration of MCO Operations.** Florida shifted to a carve-in model in 2014. Anthem’s affiliated health plan uses regional interdisciplinary teams to address members’ physical health, MH/SUD, and social support needs. It then uses local MCO staff to engage providers. The model relies on strong partnerships; staff from the MCO, state, and providers meet regularly to identify best practices and lessons learned. The MCO shares performance data—including readmission rates, length of stay and utilization data of various behavioral health codes—to show providers how their performance compares to their peers. The performance feedback helps to incentivize better provider practice and improved care.

- **Texas: Dedicated Case Management.** Texas shifted from a carve-out to a carve-in model in 2014. An integrated team of licensed mental health professionals, medical clinicians, and case managers situated within the MCO provides telephonic care management and deploys clinicians and community-based providers to deliver care and link members to local resources. The MCO leverages telemedicine and other health IT capabilities to reach members regardless of their location.

The internal integrated MCO team coordinates care with an array of physical health and MH/SUD providers from primary care practices, to community mental health centers, to peer support specialists. The MCO also has an integrated High Intensity Team (HIT) that regularly meets face-to-face regarding complex cases to address members’ needs in an individualized manner.

- **Tennessee: Integrated Providers in Networks.** Tennessee began integrating benefits within its Medicaid MCOs nearly a decade ago, including MH/SUD, physical health and LTSS. Initially providers and stakeholders were hesitant to engage, but they now work closely with Anthem’s affiliated plan and other MCOs through a Behavioral Health Advisory Committee among other avenues. Anthem’s affiliated plan has also created a performance feedback loop with providers via regular meetings and scorecards.

Anthem's affiliated plan's multi-pronged model includes an integrated team within the MCO, ongoing coordination via meetings with providers and regional health advisory committees that include members, and face-to-face case management and supportive services. Wellness coordinators identify and link members to needed social services, such as supported employment and supported housing. The model includes mechanisms for gathering and integrating member feedback into care delivery and management.

This high level of engagement with stakeholders, members, and providers as well as TennCare, the state Medicaid agency, has led to an integrated system of care that has improved members' outcomes. Anthem's affiliated plan's care coordination program increased MH/SUD visits by 116 percent and reduced inpatient admissions and emergency room (ER) visits by 15 percent and 59 percent, respectively, for members with SMI and diabetes during the first year of transition from carve out model of care to an integrated carve in.³¹

- **Kansas: Provider Accountability for Integrated Care.** Kansas implemented fully integrated physical health, MH/SUD, LTSS and pharmacy benefits in 2013. Anthem's affiliated health plan's approach is led by an MCO clinical leadership team comprised of a psychiatrist, internist, and other clinical professionals that oversee integration and coordination of member's care as well as linkages to social support services. Case managers engage individuals telephonically and in the community depending on their needs. The MCO also works closely with providers and other stakeholders to help identify gaps in care as well as strengths.

In addition, Anthem's affiliated plan has implemented pay-for-performance for both physical health and MH/SUD providers. Pay-for-performance is a step toward value-based payment and incentivizes providers to improve member outcomes and lower costs. The health plan has begun to see a decrease in hospitalizations and ER use and higher rates of outpatient care as a result of the change to a carve-in model with integrated benefits and operations.

Promoting Integrated Care through Co-Location of Primary Care and MH/SUD Providers

Anthem's affiliated health plans in California, Maryland, Tennessee, and Texas have implemented Anthem's primary care integrated screening, identification, treatment and evaluation (PC-INSITE) model in select cities. Under this model—which was designed based on the evidence-based IMPACT model in Washington state—MCOs collaborate with local federally qualified health centers (FQHCs) to implement co-location of primary care and MH/SUD services with the goal of improving screening, detection, diagnosis, and treatment of MH/SUD conditions. Since the program began in 2013, over 4,200 members have been screened across the four sites, with 29 percent screening positive for depression and 9 percent for a substance use disorder. Sixty percent of individuals in the clinical range for depression had at least one follow-up and 50 percent experienced a reduction in symptom severity.³²

HOW POLICYMAKERS CAN SUPPORT INTEGRATION

Integration of physical health, pharmacy, and MH/SUD benefits for individuals with mental health and/or substance use disorders is an important step in providing person-centered care, improving outcomes, and lowering total cost-of-care for Medicaid beneficiaries. Policymakers can look to managed care for a range of options to drive greater integration, starting with carving in MH/SUD into MCO contracts along with physical health benefits and moving all the way to holding payers and providers accountable for costs and outcomes.

Support integrated administration and financing of MH/SUD, pharmacy, and physical health benefits at the MCO level.

- MH/SUD benefits and services should be integrated at the most basic level. These benefits and services should be carved into MCO contracts allowing plans to coordinate benefits and care that meets the full range of a beneficiary's needs.
- Carving in MH/SUD benefits forms the foundation for benefits integration at the plan level, as well coordination and partnership with providers, social supports, community-based organizations, and state/local agencies.

- MCO contracts should include requirements that encourage coordination and collaboration between plans and providers and with community-based organizations that provide social supports and other services. These requirements can help ensure that not only are the physical health, pharmacy, and MH/SUD needs of members addressed, but also the intermediate and long-term socioeconomic needs that can derail treatment, long-term stability, and recovery such as lack of stable housing or employment.
- Upfront broad stakeholder engagement and support (e.g., plans, providers, social services, advocates, and consumers) are important for successful plan and program design and implementation as well as to produce positive member outcomes and reduce costs.

Encourage MCOs to implement integrated physical health and MH/SUD operations—such as case management and other tools—to help members navigate the full range of care and facilitate communication across providers.

- Integrated care teams at the MCO level help identify members with complex health needs and ensure members get necessary screening, diagnosis, referrals, and individualized care plans.
- States should partner with MCOs that have a broad range of capabilities—such as community-based care managers and telephonic case management—to help members coordinate and navigate care across settings and providers as well as access other social and community-based services and supports.
- Coordination of benefits and operations at the MCO level creates opportunity for better sharing of information with and among providers, increasing the ability for plans and providers to work collaboratively along the continuum of care to meet members' needs holistically.
- Contractual requirements—such as requiring that all new members with diagnoses of MH/SUD receive an individualized needs assessment—can incentivize MCOs to provide person-centered, holistic care and services. Needs assessments, and other tools such as screenings, can help case managers develop care plans that ensure individuals are connected to providers and resources that can address their needs.

Promote the creation of integrated networks where accountability for costs and outcomes is shared across health plans and providers.

- Fully-integrating benefits administration and care from the plan to the provider level—for example, through innovations such as co-location of MH/SUD and physical health case managers and providers or on-site MH/SUD providers within primary care practices or clinics—promotes accountability from the plan to the provider level.
- Coordination and shared accountability between MCO and provider teams creates opportunity for sharing best practices that can continually improve care management processes and delivery.
- Integrated networks facilitate performance measurement, regular feedback, and partnerships along the full continuum of providers (including LTSS and community-based services and supports), which are necessary to identify promising practices and improve care management and delivery.
- States should encourage MCOs to incorporate MH/SUD into quality improvement projects to help promote full integration of benefits.
- MCOs should incorporate value-based payments into contracts with high-volume MH/SUD providers (e.g., community mental health centers) or other providers (e.g. primary care providers) to incentivize proper screening, referrals, and treatment for members with MH/SUD.

CONCLUSION

As Medicaid programs respond to new imperatives to improve care while controlling costs, there is an increasing focus on individuals with complex needs, especially beneficiaries with co-occurring MH/SUD and physical health needs. Policymakers and other stakeholders are recognizing the potential of integrating MH/SUD and physical health benefits and care to improve outcomes and reduce costs in the Medicaid program.

However, successful integration requires strong partnerships among states, payers, providers, community-based organizations, and members and their families or caregivers. Medicaid MCOs can lead these integration efforts in partnership with states because they are uniquely positioned to support the delivery of integrated, person-centered care while driving accountability for improving quality, outcomes and controlling costs. Early experiences from Anthem's affiliated plans illustrate the range of strategies that are being employed by MCOs to promote integration of physical health and MH/SUD benefits and care—ranging from simply carving-in MH/SUD alongside physical health benefits to fully integrating care in a way that holds payers and providers accountable for costs and outcomes

This paper is one of several issue briefs focused on integrating care for physical health and mental health and substance use disorders; the others are available at <http://anthempublicpolicyinstitute.com>. The Anthem Public Policy Institute gratefully acknowledges the support of CapView Strategies in the research and writing of this paper.

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About the Anthem Public Policy Institute

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