Behavioral Health Integration and Fully Integrated Managed Care Contracting
From the Policy and Consumer Perspective

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Background:

Given the prevalence of chronic illness among people with serious mental illness or substance use disorders, as well as the relationship between mental illness and management of chronic diseases, much attention has been given to behavioral health integration (BHI) as a means to improve the health of people living with behavioral health disorders.

A review of recent medical evidence and research related to behavioral health integration published by the Milbank Memorial Fund found that overall, evidence for BHI, and specifically the collaborative care management (CCM) model, is strong. New findings are emerging regarding components of CCM associated with improved outcomes and strategies for addressing comorbid mental and medical disorders. The predominant model for BHI is the CCM model, where care or case managers systematically link patients with mental health and primary care providers. High-quality evidence from more than 90 studies involving over 25,000 individuals support that the CCM model improves symptoms from mood disorders and mental health–related quality of life. CCM components that appear to be most strongly associated with improved patient outcomes are well-trained and supported care managers who provide systematic monitoring and follow-up of patients, communicate with providers, and, in some studies, provide psychological interventions.¹

The federal government is focused on BHI, through initiatives such as the Center for Medicare and Medicaid Services’ Innovation Accelerator Program, the Affordable Care Act’s inclusion of behavioral health services in the essential health benefits package, enactment of behavioral health parity legislation and the section 2703 health home state plan option.² States have acted upon these requirements and opportunities related to BHI. In addition, a growing number of states that use Medicaid managed care contracts are moving to integrate behavioral health services into physical health

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² Hamblin, A., The Thrust to Integrate Behavioral Health Services in Medicaid (June 14, 2016) http://www.chcs.org/the-thrust-to-integrate-behavioral-health-services-in-medicaid/
MCO’s or to develop integrated MCO contracts designed specifically for people with serious mental illness.  

**Behavioral health integration (BHI) implementation issues**

If BHI is going to reach its goal of improving health and quality of life for people with behavioral health disorders, attention should be given to integration at multiple levels – in other words, integrated financing does not necessarily mean integrated care. Three key levels of integration include:

1. State policies, such as health agency licensing and provider scope of practice, Medicaid billing practices, and managed care purchasing.
2. Payer practices: Relationships and policies between behavioral health organizations (BHO’s), MCO’s and their contracted providers.
3. Clinical level: practice changes, such as coordination of care across practices, co-location of services, use of interdisciplinary care teams, integrated treatment planning or clinical information sharing.

In addition, there are key issues that arise in BHI implementation, regardless of whether behavioral health services are carved into or out of managed care contracting. Each of these issues can be looked at through a state policy, payer/managed care plan or clinical practice lens.

**Managed care contracting:**

With the passage of 2SSB 6312 in 2014, the Washington state legislature directed that behavioral health services be fully integrated into a managed health care system that provides mental health, substance use disorder services and medical care services to Medicaid clients by 2020. That same legislation authorized counties to move to full integration prior to 2020. To date, this “early adopter” model has been implemented in Clark and Skamania counties. The early adopter contract was implemented in April 2016. The discussion below reviews some of the provisions of the early adopter Fully Integrated Managed Care Contract (FIMC) related to key BHI issues.

- **Screening and identification of high risk/complex enrollees, especially those with SMI or serious SUD, for more intensive care coordination.** Once these individuals are identified, assessment for health care and social services needs, with linkage to care coordination.

  **Initial health screen:** The FIMC contract requires that the MCO perform an initial health screen (Paragraph 14.2.1) The MCO must conduct or gather information to complete an initial, brief health screen (IHS) containing behavioral, developmental, physical and oral health questions within sixty (60) calendar days of enrollment for all new enrollees including family connects and reconnects. The MCO must use evidence-based screening tools appropriate to the age of the enrollee that include but is not limited to: tobacco use assessment; housing and housing instability assessment;

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3 Id.

and adverse Childhood Events assessment (adults, children and adolescents) as part of the health history and physical exam and if appropriate, screening for depression and anxiety. The MCO must make at least three attempts to conduct the IHS. The contract also requires use of the GAIN-SS behavioral health disorder screening tool (Paragraph 14.2.2)

The MCO’s are required to report their performance on completing or gathering data from Initial Health Screens as an administrative performance measure. (Paragraph 6.10.7)

• Care Coordination:

The MCO’s must develop systems of care (SOC) for clients who need coordinated/integrated services. SOC shall provide for seamless delivery of physical, mental health (MH) and substance use disorder (SUD) services, including the delivery of social services, as needed to meet the health needs of the enrollee. The MCO must ensure that SOCs promote coordinated physical, MH and SUD services for the whole person. (Paragraph 14.1)

Paragraph 14.1.2 of the contract requires that the MCO offer all enrollees who use services in multiple systems, including those with chronic medical, substance use disorder, and/or mental health conditions or Individuals with Special Health Care Needs, one of two levels of services: Level 1 - Care Coordination Services (CCS) and Level 2 – Intensive Care Management (ICM) as follows:

Level 1 – Care coordination services – the Contractor must provide CCS to enrollees who have short-term or intermittent needs for coordination of care, either by the health plan or integrated in a health care setting such as health care clinics, skilled nursing facilities, and/or licensed community mental health agencies or substance use disorder treatment providers. (Paragraph 14.1.2.1) The contract defines care coordination as an approach to healthcare in which all of an enrollee’s needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the enrollee and the enrollee’s caregivers, and works with the enrollee to make sure that the enrollee gets the most appropriate treatment, while ensuring that health care is not duplicated. (Paragraph 1.28) CCS activities are to be provided in a culturally competent manner and include but are not limited to assistance with care transitions, coordinating authorization for needed services, ensuring access to needed behavioral health, medical or long term services and supports, providing or overseeing interventions that address the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting health and health care choices, referring and monitoring referral completion for community-based services. (Paragraph 14.3.1)

Level 2 – Intensive care management – the MCO must provide Level 2 ICM services in accordance with NCQA guidelines, or health home services using its own community-based care coordinators or through contracts with a health home Care Coordination Organization (CCO), depending on the needs of the enrollee. (Paragraph 14.1.2)

Intensive Care Management (Level 2) Intensive Care Management” is defined as a set of services designed to improve the health of enrollees. Care management includes a health assessment,
development of a care plan and monitoring of enrollee status, care coordination, ongoing reassessment and consultation and crisis intervention and case conferencing as needed to facilitate improved outcomes and appropriate use of health services, including moving the enrollee to a less intensive level of care management as warranted by enrollee improvement and stabilization. (Paragraph 1.118)

Effective care management includes the following: actively assisting enrollees to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability; utilization of evidence-based practices in screening and intervention; coordination of care across the continuum of medical, behavioral health, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals; ready access to behavioral and physical health services that are integrated as a System of Care; and use of appropriate community resources to support individual enrollees, families and caregivers in managing care.

Consistent with the state’s Section 2703 health home program, the health home coordinator is required to provide or oversee interventions that address the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting enrollee’s health and health care choices. (Paragraph 2.2). The services must be provided in a culturally competent manner, and include discussing changes in enrollee circumstances with treating/authorizing entities that serve the enrollee, work with the enrollee’s paid and unpaid caregivers, collaborate with the enrollee’s other health care providers, including medical, behavioral health and social workers, as well as nutritionist/dieticians, direct care workers, pharmacists, peer specialist, family members and housing representatives or others, to support the enrollee’s Health Activation Plan. (Paragraphs 2.3 and 2.4)

- **Health information exchange/information sharing among treating providers**

  The FIMC contract requires MCO’s to develop data exchange protocols, including consent to release before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health medical coordination including sharing of claims and pharmacy data, treatment plans or care plans and advance directives necessary to coordinate service delivery, and care management for each enrollee in accordance with applicable privacy laws, including HIPAA and 42 CFR Part 2. (Paragraph 14.5.1)

- **Building cross system relationships, via memoranda of agreement or otherwise, e.g. MH and SUD crisis systems, jails/prisons, child welfare agency**

  Within six months of Contract award, the MCO must reach agreement with External Entities (defined as organizations that serve eligible Medicaid clients and include the Department of Social and Health Services, Department of Health, local health jurisdictions, community-based service providers and HCA services/programs as defined in this Contract and develop written, HIPAA
compliant collaboration protocols with external entities for the coordination and care of individuals served by multiple systems. The MCO must facilitate a process to review/update written protocols on an annual basis. (Paragraph 14.6.3) The collaboration agreement must address, at least service system planning and assessment, information sharing, joint training, facilitating linkages with social services and criminal justice entities, supporting primary care providers, emergency department, and local emergency management (fire, police) when behavioral health emergent and urgent problems are encountered and MCO participation in relevant stakeholder planning and advocacy meetings to ensure that the MCO is aligned with state and local behavioral health initiatives.

The contract specifically addresses promotion of behavioral health-medical integration by MCO’s through education, training, financial and nonfinancial incentives and other network initiatives to promote integrated care including, but not limited to: increased screening, identification and referral for behavioral health conditions that commonly occur in primary care settings; increased access to routine physical health services by individuals with serious mental illness and substance use disorders; development of collaborative care models and co-location of primary care and behavioral health providers; development of data analytic tools to identify enrollees with behavioral health conditions who are in need of physical health care or enrollees with physical health conditions in need of behavioral health care; reductions in inappropriate ED utilization; reduction in enrollees that repeatedly use crisis services; improved care coordination consistent with requirements in Section 14 of the Contract including, but not limited to use of required screening tools and use of research- and evidence-based practices; and use of electronic records, decision support tools, client registries, data sharing, care coordination, wellness initiatives targeting high risk behavioral health populations or other similar program innovations. (Paragraph 6.1.11)

To bolster the activities above, the contract requires MCO’s to develop and deliver ongoing training for network providers on key issues related to meeting the medical and behavioral health needs of enrollees. The training objective is to strengthen the knowledge, skill and expertise of all parties to improve integrated care delivery as it relates to outreach and engagement, screening and assessment, appropriate referral and delivery of person-centered, recovery-oriented care. (Paragraph 9.12.2)

Performance and quality measures:

Behavioral health performance measures, and measures related specifically to BHI lag behind medical care measures. MCO’s must report all HEDIS Medicaid measures. (Paragraph 7.3.1)

As provided in SB 5732/HB 1519, DSHS and HCA are moving forward on development and implementation of cross-system performance measures. The 2016 early adopter contract, as well as BHO and MCO contracts in non-early adopter counties, include performance measures related to:

- Alcohol or drug treatment penetration
- Substance use disorder treatment initiation and engagement
- Mental Health treatment penetration
• Psychiatric hospitalization readmission rate (Paragraph 7.3.4)

The measures related to alcohol or drug treatment penetration and mental health treatment penetration are notable because they reach beyond assessing the care provided to people who take the initiative to seek behavioral health services. Instead, they create an expectation that more individuals with behavioral health treatment needs will be identified and engaged effectively in care to support their recovery. In addition, DSHS will collect and analyze data to determine the proportion of person-months receiving long-term services and supports (LTSS) associated with receipt of in home-and community-based settings during the measurement year.

The MCO’s, in collaboration with their peer MCO’s, are required to disaggregate data on at least one preventive care measure and examine the data for racial/ethnic disparities and in collaboration with peer MCO’s, target interventions with known disparities in preventive care utilization and measure the impact of the interventions on future preventive care utilization patterns. (Paragraph 7.3.11)

Additional process measures related to the degree of behavioral health/primary care integration, such as co-location of providers, use of interdisciplinary care teams, and health information sharing across BH and PC providers should be considered for development.

Given the commitment to movement toward value-based purchasing strategies in the Healthier Washington State Innovation Model Plan and the Medicaid 1115 demonstration waiver that has received approval in principle, advocates may want to take the opportunity to promote value based payment strategies that are designed to incentivize BHI at the payer and clinical level.

The recently adopted federal Medicaid managed care regulations specify that withhold arrangements be actuarially sound and that they take a plan’s operating needs into account given the size and characteristics of the plan and its enrollment, as well as capital reserve requirements. Given this restriction, an MCO’s rate must be actuarially sound if the MCO does not earn back any portion of the withhold. Withholds are an opportunity to incentivize improved performance on contractual performance measures. If the Legislature sets rates at the lowest boundary of actuarial soundness, without sufficient cushion to use withholds, the Health Care Authority’s ability to use financial incentives to improve performance could be severely limited, if not eliminated.

Monitoring and compliance:

Washington state’s commitment to incorporating substantial BHI requirements in its MCO contracts is laudable. The capacity to aggressively monitor and oversee MCO performance and to provide consultation to MCO’s who want to meaningfully engage in improving the services they provide is equally important. Client advocates can raise this issue, expressing support for

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sufficient Health Care Authority and Department of Social and Health Services staffing and infrastructure to appropriately monitor MCO performance.

**Practice transformation support:**

Beyond managed care contracting requirements, both primary care and behavioral health providers may benefit from practice transformation supports to implement clinical BHI practices into their day to day operations and clinical models. These supports could include:

- Using integrated/interdisciplinary care teams;
- Training, such as motivational interviewing/patient engagement, and understanding each other’s “language” for purposes of whole person care planning;
- Support for implementation and sustainability of evidence-based practices;
- Integrated patient-centered care planning;
- Collaborative care model training; and
- Training/resources related to health information data sharing among treating providers through:
  - Development and use of standardized patient consent forms;
  - Offering provider training related to health information sharing opportunities under HIPAA and 42 CFR Part 2.

Washington State’s State Innovation Model test grant from CMMI includes a practice transformation support hub. Washington State Department of Health oversees the Practice Transformation Support Hub. The intent of the Hub is to build upon the support already available in many areas throughout Washington by coordinating practice transformation efforts and sharing resources where possible. The goal of the Hub is to help providers integrate physical and behavioral health, move from volume to value-based care and improve population health through clinical community linkages.  

The Hub will convene a web-Based Resource Portal for primary and behavioral health care providers. Regional Health Connectors will serve as brokers of practice transformation activities. The Connectors will assess needs, provide technical assistance, and coordinate referrals to coaching, facilitation and training services that will address practices’ learning priorities. Practice coaching, facilitation and training services will advance whole-person care, improve population health, and lower health care costs.

**State regulatory policies:** Several areas of provider agency or individual health provider credentialing are worthy of examination in achieving clinical BHI. These include:

- BH and primary care clinic/agency licensing standards, including opportunities for consolidated licensing or streamlining licensure for agencies that want to provide multiple services.

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• Health practitioner licensure rules to determine whether licensing requirements/provisions are an impediment to integrated BHI, including scope of practice, permissible sites of practice, encouraging cross-credentialing for health care providers who already have related training and peer support counselor certification and supervision by licensed health professionals.