Designing integrated behavioral health services for Medicaid enrollees

An overview of integration elements and models with case studies from five major state integration efforts

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Background and overview

For decades, physical and behavioral health care—including both mental health and substance use disorder treatment—have operated in silos. Too often, this fragmented care system has meant that individuals with behavioral health needs either do not receive the care they need or receive a patchwork of care from a multitude of uncoordinated publicly and privately funded providers in systems that are difficult to navigate.[i]

A growing number of states are implementing new strategies to better integrate these services and provide holistic care—particularly for Medicaid beneficiaries—with the ultimate goals of improving care coordination and patient outcomes and, in some cases, lowering health care expenses as well.

Medicaid-covered populations are the focus of these integration efforts for a variety of reasons.

- Approximately one-quarter of all behavioral health spending nationally is by Medicaid, which is the single largest payer for behavioral health services.[ii]
- Medicaid beneficiaries with behavioral health diagnoses account for almost half (48 percent) of total Medicaid expenditures, yet represent only 20 percent of the total Medicaid population.[iii]
- Medicaid beneficiaries with behavioral health diagnoses and chronic physical comorbidities—hypertension, coronary heart disease, and diabetes—have significantly higher medical (non-behavioral health) costs than those without a behavioral health diagnosis.[iv]

Types of integration

- ***Clinical integration*** refers to care delivery and patient experience components such as co-location of services and data sharing.
- ***Systems integration***, the primary focus of this report, refers to the integration of financing and administrative structures at the policy level.

Integration in Medicaid

Approximately one-quarter of all behavioral health spending nationally is by Medicaid, which is the single largest payer for behavioral health services in the United States.[1]

While integration is a broad term used to refer to services, programs, policies, payments, and administrative structures, this report focuses on the clinical integration of behavioral and physical health services and the systems level changes put in place by states to achieve it.

This brief provides an overview of behavioral health integration strategies in state Medicaid programs, and includes case studies that explore integration in five states that have recently engaged in major Medicaid integration initiatives: Arizona, Arkansas, Michigan, New York, and North Carolina.

Clinical integration

Clinical integration occurs when physical and behavioral health care is seamlessly delivered and holistically addresses patients' care needs. While there is no single model or definitive set of components that defines integrated care, some of the major characteristics employed by providers and health care systems include:[v]

- **Co-location of services:** locating physical and behavioral health care providers within the same facility, often with a behavioral health provider located in a primary care clinic.
- **Care coordination:** using single points of contact, such as case managers, to centrally manage patient information and care.
- **Data sharing:** ensuring that all involved providers have access to patient information, ideally within a shared information technology platform.
- **Education and training:** cross-training providers to ensure that physical and behavioral health providers can communicate effectively about patient health needs and goals.
- **Partnerships:** establishing either formal or informal relationships between providers and provider organizations that make it easier to provide holistic care.
- **Screenings and referrals:** using screening tools for conditions outside of provider disciplines—e.g., a primary care provider screening for depression—to allow providers to make appropriate referrals.

Key benefits of clinical integration

- Shorter wait times for treatment
- Higher likelihoods of patients seeking and engaging in care
- Increased patient satisfaction
- Reduced long-term cost of care
- Improved mental health outcomes
- Shared learning between providers

Achieving true clinical integration is a challenging process. Institutions are often stymied by a complex web of financial, institutional, and regulatory constraints that dictate how care is structured and delivered. However, studies point to its effectiveness for both improving health outcomes and lowering costs.

- **Patient satisfaction:** primary care behavioral health integration has been shown to increase patient satisfaction while reducing the overall cost of care.[vi]
- **Quality improvements:** integrated services are associated with numerous quality improvements, including shorter wait times for treatment, higher likelihoods of engaging in care,[vii] and improved mental health outcomes for adults with serious mental illnesses, such as schizophrenia, bipolar disorder, and severe forms of depression, anxiety, post-traumatic stress disorder, and obsessive-compulsive disorder.[viii]
- **Patient experience:** many patients find it more socially acceptable to access behavioral health services in familiar physical health care settings and are more likely to seek needed care when integrated services are available.[ix]
- **Provider experience:** physical health providers who may not have the training to address complex behavioral health needs can learn from the expertise of behavioral health providers with whom they are co-located and share patients.[x]

Systems integration

Systems integration generally occurs at the policy level within state and local governments, primarily with states' mental health and Medicaid agencies. Some of its key features are:[xi]

- **Financial integration:** streamlining the financing of behavioral health services in a single system.
- **Administrative integration:** sharing organizational leadership, authority, decision-making procedures, and goals.

Systems integration is often driven by executive and legislative priorities and decisions, which can be competing or divergent. Non-governmental stakeholders—including payers, providers, and the behavioral health community—often work with governmental entities to influence a state's program design and delivery.

Systems integration highlights

Over the past decade, a growing number of states have integrated behavioral and physical health benefits in their Medicaid programs.

One approach employs Specialty Integration plans (SIPs) which typically focus on enrollees with complex needs—serious mental illness, children in foster care or who are medically fragile, individuals with HIV/AIDS, or those with intellectual or developmental disabilities.

State model characteristics

Medicaid beneficiaries in different states may be eligible for differing ranges of services, paid for and delivered in a variety of ways. States typically provide behavioral health services through a fee-for-service (FFS) or a managed care model, and most states use a combination of these payment approaches for specific populations or programs. Behavioral health services may be rendered through a community mental health agency, substance use disorder treatment center, the criminal and juvenile justice system, and child welfare agencies, which receive funding from multiple sources with varying requirements.[xii]

Some states allocate funds to public and private entities that provide services on the state's behalf (known as a "carve out" model). Other states allocate funds to Medicaid managed care provider contracts that centralize financing, administration, and service delivery (known as a "carve in" model). Whether states use a carve in or carve out funding model, state-covered behavioral health services are often limited to the treatment of individuals with specific conditions, such as serious mental illnesses, emotional disturbances, substance use disorders, and, in some states, individuals with intellectual and developmental disabilities (I/DD) such as autism, Down syndrome, and traumatic brain injury.

State integration trends

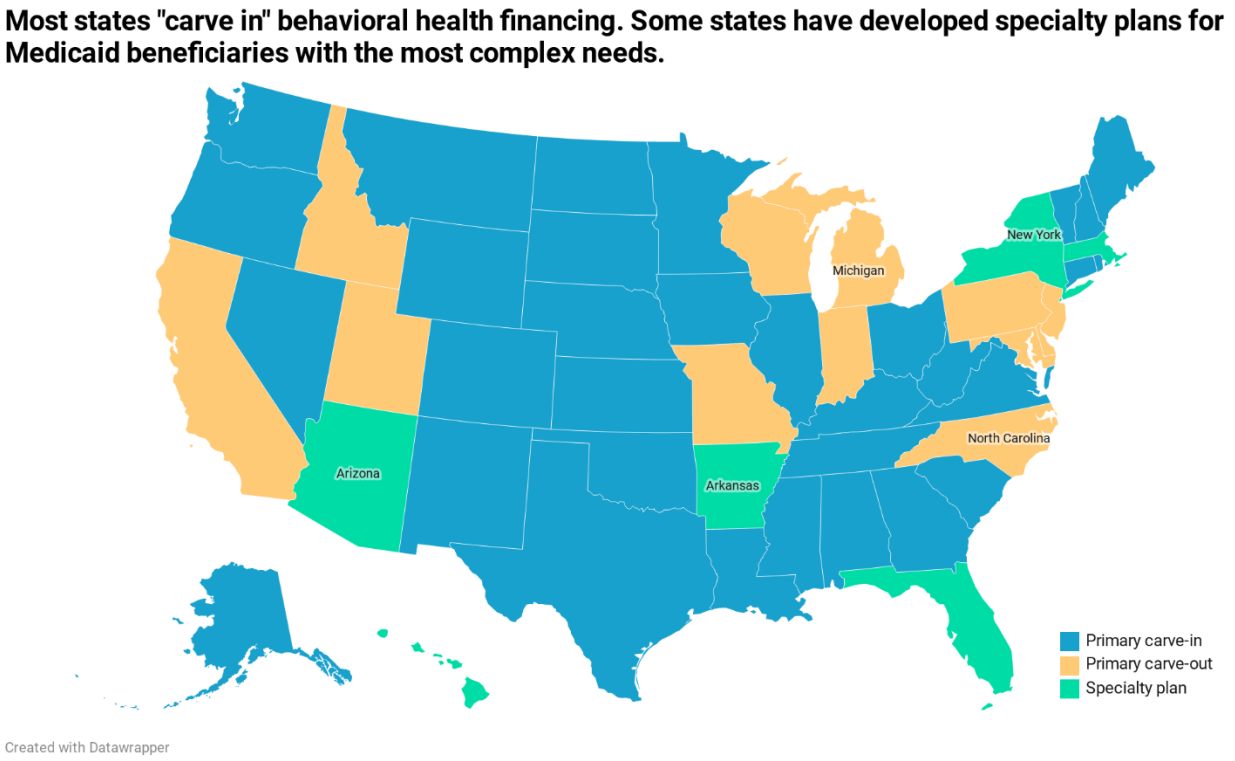
Many states are working to address both clinical and systems integration in concert with the goal of providing high quality care that improves health and social outcomes for their citizens. States are taking many approaches to financing these services and integration initiatives, including Medicaid managed care contracts, Medicaid innovation waivers, and federal grant programs.

The Affordable Care Act of 2010 allows states to request Medicaid Section 1115 waivers to experiment with various innovations, including new health model arrangements. As of August 2020, 33 states had received approval from the U.S. Centers for Medicare and Medicaid Services to incorporate some type of modification to their behavioral health provisions. These states are testing a variety of changes, such as eliminating the payment exclusion for Institutions for Mental Diseases (IMD) for substance use disorder or mental health treatment, expanding eligibility criteria for services, expanding community-based benefits, and general payment and delivery system reforms.[xiii]

For individuals with the most complex needs, some states have also integrated various physical, behavioral, pharmacy, and social care services into managed care plans designed to serve narrow populations. Emerging evidence suggests that the integration of non-medical social services can improve both health outcomes and long-term costs.[xiv] These models have various names, including specialty integrated plans (SIPs), vertical carve out plans, or specialty managed care plans.[xv] These plans typically focus on enrollees with serious mental illness, children in foster care or who are medically fragile, individuals with HIV/AIDS, or individuals with intellectual and developmental disabilities.

Figure 1

Medicaid behavioral health financing models by state



Some states have innovated by fully carving in behavioral health services that are insured and delivered through Medicaid Health Plans (MHPs). Several are creating specialty health plans—managed care plans in which enrollees share a common health condition—to integrate physical and behavioral health care through a behavioral health home or other delivery method. In both full carve in and specialty health plan models, the health plan is responsible for all physical and behavioral health services, including services for those with mild to moderate behavioral health challenges as well as those with more serious conditions.

Over the past decade, a growing number of states have carved their integrated behavioral and physical health benefits into their Medicaid programs while carve out models have seen a steady decline.[xvi]

- In July 2018, Ohio moved all Medicaid behavioral health services from fee-for-service to managed care, and required behavioral health providers to contract with at least one of the state's five Managed Care Plans (MCPs).[xvii]

- In early 2020, Washington's Medicaid program fully transitioned from a traditional carve out of behavioral health services to integrated financing.[xviii]

Other carve out states, however, have seen their carve in transformation efforts stall, often as a result of stakeholder activism or disagreements among diverse groups—legislators, providers, payers, service recipients, and their families—about how the system is designed. Often individuals with SMI or I/DD have longstanding relationships with providers and fear that carving benefits into a managed care plan will limit their choice of providers or access to pharmaceuticals.

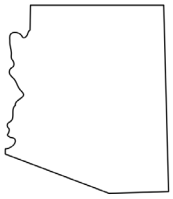
- California and Michigan have attempted regional carve in integration pilots, some of which were delayed or outright cancelled.
- In 2020, Pennsylvania stakeholders are debating whether to retain their carve out model.[xix] Supporters of the current carve out system worry that counties, which currently receive their own revenue reinvestment funds—program revenues remaining after all medical claims and other obligations are paid—will lose access to funding that has allowed locally tailored approaches to program and service delivery.

Some stakeholders argue for a reformed carve in system that they believe will incentivize better coordination between providers while providing long-term cost-savings for the state. Nevertheless, simply converting to a carve in system does not guarantee clinical integration or high-quality, holistic care for individuals with complex behavioral health needs.

State models: Five case studies

The following case studies highlight several states that have recently implemented behavioral health integration within their Medicaid programs or that are in the process of transforming how behavioral health care is delivered, with learnings from each state. These states have also developed specialized integrated plans (SIPs) for individuals with the greatest behavioral health needs, i.e., individuals with serious mental illness and those with intellectual and developmental disabilities.

Case #1: Arizona



Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), historically carved out behavioral health care to Regional Behavioral Health Authorities (RBHA), regional entities that managed and provided behavioral health services. These entities were managed by a separate sub-agency beneath the AHCCCS, called the Division of Behavioral Health Services (DBHS). Beginning in 2015, the state consolidated the division within its Medicaid program and launched the process of behavioral health integration, starting with residents diagnosed with a serious mental illness, such as psychotic disorders, bipolar disorder, or major depression.

Under this new arrangement, Arizona continues to provide benefits to Medicaid beneficiaries with high behavioral health needs through the RBHAs. The model essentially adds primary care to the state's behavioral health contracts and services. Care management programs and other services are provided in behavioral health settings, rather than through health plans, which instead provide traditional insurer administrative services such as utilization reviews and claims processing. This plan is available for adults and children with serious mental illnesses and emotional disturbances, those with I/DD, and to dual eligibles through a Dual Eligible Special Needs Plan (D-SNP).

In October 2018, the Arizona Medicaid program further integrated physical and behavioral health services for all with mild to moderate behavioral health needs. These plans are known as AHCCCS Complete Care (ACC) and are structured under geographically-based service areas (central, north, and south) that correspond with the state's existing behavioral health authorities.[xx] The ACC plans are primarily led by private health plans and beneficiaries have choices depending on their location (see Appendix A: State service areas and health plans).

These changes did not affect the state's long-term care system members, its members with serious mental illness, or its children in foster care enrolled in the Comprehensive Medical and Dental Program.[xxi] American Indian members are also excluded and have the choice to receive integrated services through either a newer regional ACC plan or an existing tribal behavioral health authority if enrolled in the American Indian Health Program.[xxii]

Arizona highlights

Arizona advanced behavioral health integration through agency reform.

This not only streamlined communication and collaboration among organizations that service behavioral health needs, but also unified the culture and goals of the agency.

Importantly, the consolidation had political support through the governor's budget, as well as a state legislature that unanimously endorsed merging the state's Medicaid program and Division of Behavioral Health Services.

While the state successfully integrated systems of care, there have been issues related to provider reimbursement. For example, Arizona Complete Health was sanctioned after AHCCCS determined they wrongly denied claims, as well as incorrectly calculated reimbursement rates for nearly 2,000 providers. Providers have also noted delays related to prior authorization for residential treatment stays, which have pushed more patients in crisis to emergency rooms. Smaller providers that offer important niche services are typically more vulnerable to payment delays and have noted that they expect the Arizona behavioral health community to continue the trend of consolidation.[xxiii]

Arizona's integration was greatly encouraged by the state's Medicaid expansion, as many cross-sector players were already working together to integrate and expand services. For example, in 2013 the state had already integrated services for children with special needs, while in 2014, the existing RBHAs began pilot integration programs for individuals with serious mental illness and dual eligibles.[xxiv]

Largely, Arizona stands out as a state that advanced integration through agency reform. This not only streamlined communication and collaboration among players who touch populations with behavioral health needs, but also unified the culture and ultimate goals of the agency. Importantly, the consolidation had political support through the governor's budget, as well as Arizona's legislature which unanimously endorsed the merging of DBHS and AHCCCS.[xxv] The merger indicates that vesting the Medicaid director with responsibilities for providing a holistic range of client services can lead to a successful statewide integrated care program.[xxvi]

Case #2: New York

New York historically carved-out behavioral health services from Medicaid health plans. In 2011, Governor Andrew Cuomo called for "a fundamental restructuring of [the] Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure." To achieve these goals, his administration appointed a Medicaid Redesign Team and Behavioral Health Workgroup to create recommendations for transitioning behavioral health services into managed care.[xxvii] In October 2015, the state integrated these services into Medicaid health plans for New York City beneficiaries, and by July 2016, the program expanded integration state-wide.

New York's Health and Recovery Plans (HARPs) cover Medicaid beneficiaries with serious behavioral health needs (excluding dual eligibles) and promote a recovery-based, managed care delivery model, integrating physical and behavioral health needs. HARP eligibility is determined by an algorithm that factors service utilization, hospitalizations, diagnostic codes, and conditions. Most eligible beneficiaries are automatically enrolled in the plans, but also have the option to opt out.[xxviii] The program covers individuals 21 and older with serious mental illness or substance use disorder.[xxix] The state is working to transform the behavioral health care system for children as a separate initiative. Individuals with I/DD are covered through a separate program, Care Coordination Organization/Health Homes (CCO/HHs), launched in July 2018 as part of the redesign.[xxx]

New York highlights

New York's reform incorporated social determinants of health into its program, providing a wide range of enhanced social services to its highest-needs population.

The state has seen challenges with enrolling eligible members in services.

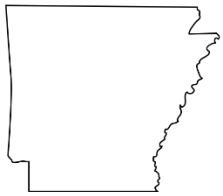
However, among those enrolled in Health Homes, the state has seen positive results related to cost savings and program outcomes.

Health plans must apply and meet particular requirements to become HARPs, which function as a separate lines of business. HARPs use Health Homes to assess member eligibility and coordinate care. HARPs contract directly with providers who deliver Behavioral Health Home and Community Based Services (BH HCBS), a package of complementary services that promote health and recovery along a spectrum.[xxxi] The services are designed to help beneficiaries overcome the cognitive and functional effects of behavioral health disorders and address a wide range of needs related to social determinants of health, including daily living and social skills, education and employment support, peer support services, family support, and crisis management.[xxxii]

In 2019, the New York Office of Mental Health reported challenges with enrolling HARP members into Health Homes,[xxxiii] including locating and engaging beneficiaries throughout a lengthy assessment and care plan process.[xxxiv] This has caused issues with the designated providers ramping up due to a low volume of referrals.[xxxv] While beneficiaries do not have to be enrolled in a Health Home to receive HCBS (services), the likelihood is increased with Health Home engagement. The state has taken several actions to address these challenges, including the use of Recovery Coordination Agencies to engage HARP members and a shortened assessment.[xxxvi]

Among enrollees, Health Homes have shown cost savings. From 2016 to 2017, the most recent year for state data, the program showed a 27 percent decrease in per member, per month inpatient costs.[xxxvii] They have also demonstrated positive member outcomes. A representative sample of Health Homes reported reductions in homelessness and incarceration rates and improvements in medication adherence, preventive screenings, and follow-up after emergency department visits.[xxxviii] CMS has approved a full evaluation of the program with a demonstration period of 2018-2021.

Case #3: Arkansas



Arkansas uses an integrated financing model across several Medicaid subprograms. In March 2019, the state launched a new specialty plan for its high need populations called the Provider-led Arkansas Shared Savings Entity (PASSE). The program consists of three statewide Medicaid health plans, known as PASSEs, that cover an estimated 43,000 beneficiaries with complex behavioral health, developmental, or intellectual disabilities.[xxxix] PASSEs are both provider-led and owned, requiring at least 51 percent provider ownership.[xl] Each PASSE acts as an insurance group that providers join to treat clients in network. Providers may join any or all PASSEs.[xli] Providers then bill individual PASSEs that pay for member health care services.

The program was launched as a two-phased system. Phase one assigned beneficiaries to service providers and established physical and behavioral health care coordination, while retaining a fee for service (FFS) model. Phase two transitioned away from the FFS model and PASSEs became responsible for the total management and cost of care for their beneficiaries. The state uses independent assessments, provided by Optum, to stratify beneficiaries into three tiers of behavioral health service need and two tiers of I/DD service need.[xlii] The Arkansas Department of Human Services provides the PASSE with a per member, per-month payment to cover the total cost of benefits, administration, and care coordination.[xliii]

Arkansas highlights

Arkansas uses three statewide specialty health plans, owned and led by providers, to care for members with more complex needs.

Providers have experienced challenges with complex regulations, rate cuts, and timely reimbursement.

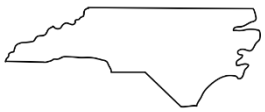
Several long-standing behavioral health facilities have merged or closed, causing difficulties with members' access to care.

Arkansas DHS encourages providers to join all PASSEs to retain their in-network status for current clients.[xliv] However, some provider groups have chosen not to enter particular PASSE contracts, which has led to some beneficiaries losing access to long-established primary care providers and pediatricians.[xlv] New state procedures ask patients to directly find and follow-up with new providers but providers note that this puts the burden on people who frequently experience serious mental illness and may have hesitancy seeking care from a new person or facility.[xlvi]

The PASSE program has also had a significant impact on the provider community. Many providers have complained that the state's new Outpatient Behavioral Health Services plan cut reimbursement rates, requires complex regulations, and is slow to pay providers.[xlvii] The program also does not reimburse providers for individual or group therapy for dual eligible members. Behavioral health agencies have struggled with staffing, many continuing to provide uncompensated care at a loss, and are worried about sustainability.[xlviii]

Some providers have also noted that competition among provider groups has increased administrative costs and they are concerned that this will lead to less money being spent on actual patient care.[xlix] Little Rock Community Mental Health Center, a longstanding service provider, closed in September 2019, attributing the closure to unstainable administrative costs brought on by the state's behavioral health integration changes.[l] Perspective Behavioral Health Management also closed in December 2019 due to current and projected state cuts.[li] Other providers have chosen to consolidate; four of the state's 12 community mental health centers announced that they would merge to create a financially sustainable organization.[lii]

Case #4: North Carolina



North Carolina is in the process of transitioning from a fee-for-service, behavioral health care carve out model to a financially integrated managed care system for both physical and behavioral health services. In 2015, the state passed legislation to contract with insurance companies to provide holistic services to Medicaid beneficiaries within six geographic managed care regions at a state-negotiated, per person rate, with an implementation goal of February 2020.[liii] [liv]

North Carolina highlights

North Carolina designed regional tailored plans with enhanced behavioral health benefits to care for members with more complex needs.

The new system has yet to be launched because of political gridlock related to Medicaid expansion.

In 2017, CMS approved the state's amended Section 1115 Medicaid Demonstration waiver, which included the integration of physical, behavioral, and pharmacy benefits into two types of Medicaid health plans: standard plans and tailored plans.[lv]

Standard plans will cover the majority of beneficiaries who may have mild to moderate behavioral health needs, while tailored plans are specifically designed for beneficiaries with a serious mental illness, serious emotional disturbance, substance use disorder, I/DD, or traumatic brain injury and include a more intensive set of benefits.[lvi]

Five contracts were awarded to Medicaid health plans to operate standard plans, available to beneficiaries in all six regions. Seven existing local management entities that historically provided behavioral health services as managed care organizations are scheduled to participate in a readiness review in 2021 before launching tailored plans, though contracts have not been officially awarded and final catchment areas are still undefined.[lvii]

North Carolina's integration program was scheduled to begin in early 2020 with the launch of standard plans, before the launch of tailored plans in 2021. However, in November 2019 implementation was officially delayed due to an impasse between the state's Republican legislative leaders and Democratic Governor Roy Cooper after he vetoed a new state budget largely due to the absence of funding to expand Medicaid eligibility.[lviii]

North Carolina is among 13 states that have not expanded their state Medicaid program, and the issue has remained unpopular among congressional Republicans. The state will continue to provide Medicaid services under its existing model and expects the new programs to be implemented as originally planned once an agreement is reached.[lix]

Case #5: Michigan

Since the mid-1990s, Michigan has carved out Medicaid coverage of behavioral health services from physical health services. There are two basic types of organizations that manage and administer the publicly funded mental health system: Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health (CMH) agencies.

Michigan's PIHPs are behavioral health managed care organizations that administer capitated funds, bear risk for Medicaid patients, and ensure the management of behavioral health care services.[lx] Medicaid funds are allocated to PIHPs based on the number of Medicaid beneficiaries in the associated service area and PIHPs pay providers (including CMHs) directly.[lxi] CMHs provide direct care or contract with other community providers to deliver local behavioral health and I/DD services.[lxii]

In 2016, boilerplate language in Governor Rick Snyder's executive budget called for carving in the state's $2.4 billion behavioral health care system and directly funding Medicaid Health Plans (MHPs) to manage both the physical and behavioral health needs of beneficiaries.[lxiii]

In response, Michigan's legislature directed the Michigan Department of Health and Human Services (MDHHS) to launch three pilot programs to test the financial integration of Medicaid physical and behavioral health services under a single contract. The pilots were complicated by numerous delays and disagreements between the participating pilot agencies, accompanied by concern from the mental health community with private, risk-averse companies managing behavioral health services.[lxiv]

Governor Gretchen Whitmer ultimately vetoed the funding for the pilots in the 2019-2020 budget, but MDHHS officials stated a firm commitment to transform the state's behavioral health system.

Michigan highlights

Michigan launched pilots to test the financial integration of Medicaid physical and behavioral health services; however, disagreements between the participating agencies led to their cancellation.

MDHHS has stated a firm commitment to transform the state's behavioral health system and has proposed using a specialty integrated plan model.

Integration work has notably grown through several CCBHC expansions.

In December 2019, the MDHHS laid out a vision for an integrated system with the broad goals of increased access to quality care, improving coordination, and increasing behavioral health investment alongside financial stability. Individuals with significant behavioral health needs would be enrolled in a Specialty Integrated Plan (SIP) that would be responsible for delivering and financing physical and behavioral health needs. These SIPs appear to be similar to other specialty managed care models (such as Arizona's RBHAs and North Carolina's tailored plans), with lead organizations providing holistic services and care coordination, and receiving capitated payments.

MDHHS describes SIPs as "qualified managed care entities, which will maintain provider networks, manage claims, conduct utilization management, and [provide] individual care coordination," similar to Michigan's current PIHPs and CMHs.[lxv] The state has expressed flexibility about who may serve as the lead plan entity (e.g., CMHs, MHPs, providers, or other organizational partnerships).

Michigan's work toward SIPs has slowed considerably in the face of the coronavirus pandemic. However, other integration efforts are ongoing, particularly the effort to expand the use of Certified Community Behavioral Health Clinics (CCBHCs). CCBHCs are a U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) demonstration program established under the Protecting Access to Medicare Act (PAMA) of 2014. They are designed to provide comprehensive, integrated services to individuals with complex behavioral health needs.[lxvi]

In 2018, the CCBHC program expanded beyond its original eight states and awarded grants to a number of Michigan sites. In 2020, CCBHC expansion was further sparked by $250 million in funding under the CARES Act, with Michigan receiving 18 new CCBHC expansion grants, many designated to new sites.[lxvii] Accordingly, the state may consider supporting the CCBHC model in its delivery system transformation.

Recommendations for states

1) When developing an integrated care model, states should consider the unique characteristics and needs of their Medicaid beneficiaries; however, they should also take note of lessons learned from others states' reform efforts.

- Agency reform can act as a positive catalyst for integration by merging cultures and creating a shared set of common goals.
- Political agreement and compromise among legislators should be considered throughout the process, from design to implementation, and carefully managed to avoid unnecessary conflict and obstructions.
- States should take advantage of federal grants, programs, and matching dollars for building integration partnerships and capacity.

2) Involving many voices from the behavioral health community enriches the integration design process and improves the likelihood of success.

- The provider community must be included so that financial incentives do not create or exacerbate issues with access, capacity and solvency. Medicaid Innovation Accelerator Program (IAP) participants have noted there is no success when providers have difficulty getting paid.[lxviii] States must be prepared to reimburse providers adequately and quickly to ensure that they can effectively serve their clients.
- Many community health agencies have already integrated aspects of patient care; program administrators and frontline staff have a wealth of knowledge related to successes as well as persistent challenges.
- Medicaid clients and their caregivers, users who understand the system's intricacies, strengths, and weaknesses from lived experience, should also have opportunities to give input on how an ideal system would work.

3) To fully meet the holistic needs of Medicaid beneficiaries, states should consider integrating not only behavioral health services, but also wraparound services that address social determinants of health—such as housing, nutrition, and employment—as increased investment in these factors is linked to both improved health outcomes and cost savings.[lxix]

4) States should consider seeking to achieve a full spectrum of integration by incorporating changes at multiple levels—clinical, financial, administrative, and regulatory—to ensure that they are sufficiently integrating the entire system of patient care.

Conclusion

Many states have moved to integrate physical and behavioral health care systems for Medicaid beneficiaries, streamlining both financing and care coordination. While integration is widely seen as an effective strategy for delivering higher-quality, holistic care, there is still little evidence on which specific integration models and arrangements work best. Nonetheless, integrated managed care models have shown multiple positive outcomes related to patient satisfaction, mental health outcomes, physical health comorbidities, as well as general cost savings from better coordinated care, and there is a growing trend, based on research and evidence, toward integration as the standard for care delivery.

Appendix A. State service areas and health plans

Arizona ACC and RBHA Service Areas and Health Plans

Provider	Population	Service Area	Health Plans
ACC	AHCCCS members with mild to moderate behavioral health needs	North	• Care1st • Steward Health Choice Arizona
		Central	• Banner University Family Care • Care1st • Steward Health Choice Arizona • Arizona Complete Health • Magellan Complete Care • Mercy Care • UnitedHealthcare Community Plan
		South	• Banner University Family Care • Arizona Complete Health • UnitedHealthcare Community Plan (Pima County)
RBHA	Individuals with SMI, DES/DDD, foster children	North	• Health Choice Arizona
		Central	• Mercy Care
		South	• Arizona Complete Health

New York HARP Service Areas and Health Plans

Service Area	Health Plans
Statewide	• Fidelis Care • UnitedHealthcare of New York
New York City	• Metro Plus
Brooklyn, the Bronx, Manhattan, Putnam, Queens, or Staten Island County	• HealthPlus, LLC (BCBSA)
Southern New York State (excluding NYC and Long Island)	• Affinity Health Plan • HealthFirst PHSP, Inc. • Health Insurance Plan of Greater New York (Emblem Health) • Capital District Physicians' Health Plan, Inc.
Eastern and parts of Western New York State	• MVP Health Care
Central New York State	• Molina Healthcare
Western New York State	• Excellus Health Plan, Inc. (BCBSA)
Allegany, Cattaraugus, Chautauqua, Erie, Monroe, Ontario and Wyoming Counties	• YourCare Health Plan
Erie County	• Independent Health Insurance Association

Arkansas PASSE Service Areas and Health Plans

Service Area	Health Plans
Statewide	• Arkansas Total Care • Empower Healthcare Solutions • Summit Community Care

North Carolina: Comparison of Standard and Tailored Health Plans[lxx]

Plan type	Population	Service Area	Available Health Plans*
Standard Plan	Covers all benefits for the general Medicaid population Physical health, behavioral health, and pharmaceutical services	Statewide across six defined geographic regions	• AmeriHealth Caritas North Carolina • BlueCross BlueShield of North Carolina • Carolina Complete Health • UnitedHealthcare • WellCare
Tailored Plan	Covers benefits for high-need individuals requiring specialty care Physical health, behavioral health, pharmaceutical services, and specialty services	Catchment areas for specific counties (to be defined)	• Alliance Health • Cardinal Innovations Healthcare • Eastpointe • Partners • Sandhills Center • Trillium Health Resources • Vaya Health

*Two standard plan regions will have the additional choice of a regional health plan

Endnotes

[i] "Report to Congress on Medicaid and CHIP." MACPAC. Medicaid and CHIP Payment and Access Commission, March 2016. https://www.macpac.gov/wp-content/uploads/2016/03/March-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf

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