Coordinating Services and Supports for Individuals with Behavioral Health Conditions Enrolled in Medicaid

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INTRODUCTION

Mental health conditions and substance use disorders are highly prevalent in the overall U.S. population. One in five adults experiences a mental health condition every year, while one in 20 lives with a serious mental illness (SMI), such as schizophrenia, bipolar disorder or major depressive disorder. Furthermore, one in 10 individuals in the United States has a substance use disorder. A smaller — though not insignificant — portion of individuals have co-occurring mental health and substance use disorders. Beyond the person experiencing a mental health condition or substance use disorder, family, friends and communities are also affected.

The service and support needs of individuals with mental health and/or substance use disorders (collectively referred to in this paper as behavioral health conditions) are not confined to behavioral health services but rather are deeply interwoven with physical health conditions and social determinants of health. Considerable research has demonstrated the degree to which individuals with behavioral health conditions (including SMI) also have chronic physical health conditions, including obesity, cardiovascular and gastrointestinal disorders, HIV, diabetes, and both chronic and acute pulmonary disease. Notably, the leading causes of premature death among individuals with SMI include medical conditions such as heart disease, stroke, cancer, diabetes and pulmonary disease. Research has found that individuals with SMI have a shorter lifespan when compared to the general population — dying, on average, 25 years sooner. There is now a growing consensus that treating individuals’ physical health, mental health and substance use disorders in silos does not yield optimal outcomes.

Individuals with behavioral health conditions also experience high rates of homelessness, social isolation and incarceration, all factors that — in conjunction with other barriers to access such as waiting lists, limited provider hours of operation, lack of transportation and social stigma — emphasize the importance of collaboration and coordination of services and supports for both behavioral and physical conditions. Such individuals are much more likely than other Medicaid beneficiaries to use hospital emergency departments as a routine source of care, and they receive much less preventive care. Increasingly, organizations involved in the provision and/or coordination of behavioral health services are becoming involved in efforts to secure appropriate long-term housing.

The current delivery system to address the needs of individuals with mental health and substance use disorders is particularly fragmented. Not only are physical health needs addressed separately from behavioral health, in many states the behavioral health benefits are administered separately — one agency has responsibility for mental health while another addresses substance use disorders. These configurations present an additional care coordination challenge for a significant subset of the population with significant behavioral health conditions.

Funding for behavioral health care is also more complicated than it is for other health conditions. Medicaid is the largest source of funding for mental health and substance use services in the United States, covering a range of benefits that includes medical services and long-term services and supports. The services and supports financed by Medicaid are generally more comprehensive than the benefits covered by other payers. Federal sources of funding also include Medicare as well as block grants to states through federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA),
the National Institute of Mental Health (NIMH), and the Health Resources and Services Administration (HRSA), which funds and administers mental health services through Federally Qualified Health Centers (FQHCs). State and local funds are also available. This complexity in funding can contribute to the fragmentation of mental health and substance use treatment services. Notwithstanding the widening acceptance of the need for integrated services and comprehensive care coordination, most individuals with behavioral health conditions who are covered by Medicaid — including individuals with SMI — are not yet receiving care in a holistic, integrated manner. States have the opportunity to improve care for these individuals by using a comprehensive, accountable and tailored managed care model to integrate and coordinate physical health, mental health and substance use services and supports.

OVERVIEW OF INDIVIDUALS WITH BEHAVIORAL HEALTH CONDITIONS

Behavioral health conditions encompass a range of conditions, and individuals’ needs and preferences for addressing their conditions vary. For instance, behavioral health conditions may range from mild depression to mild or moderate mental health conditions to substance use disorders to serious mental illness (e.g., psychosis, schizophrenia). Each of these may co-occur with physical health conditions, such as diabetes or high blood pressure — adding clinical complexity. SMI is defined as behavioral health disorders (including but not limited to substance use disorders) that, individually or in combination with one another, impacts one or more functional abilities. SMI often encompasses one or more of three condition areas: schizophrenia spectrum disorders, mood disorders (e.g., bipolar disorder) and major depressive disorders. Other diagnostic categories — such as borderline personality disorder, post-traumatic stress disorder, some anxiety disorders, obsessive compulsive disorder and agoraphobia — are included if they manifest as sufficiently interfering with or limiting functional abilities. Intellectual and developmental disabilities (ID/DD) are not mental health conditions, although many individuals with ID/DD may have a dual diagnosis of a mental health condition.

Medicaid plays a significant role serving individuals with behavioral health conditions. Medicaid is the single largest funding source for mental health services in the United States and continues to play a more prominent role in funding services for substance use disorders.12 For many individuals with behavioral health conditions, Medicaid is the sole — or at least primary — source of health coverage. Oftentimes, Medicaid may be the only payer that covers a needed service.13 Medicaid also pays for important supportive services, such as respite, transportation assistance, family support, in-home services and other services outside of the traditional medical model.14 Annually, on a per-enrollee basis, Medicaid spends 2.5 times more on adults ages 18-64 who have a behavioral health condition (i.e., $9,700) than for Medicaid beneficiaries the same age who do not have a behavioral health condition (i.e., $3,850).15

SMI, as well as other behavioral health conditions, are not a defined eligibility category in Medicaid. The prevalence of behavioral health conditions among Medicaid beneficiaries is likely due to eligibility rules that extend medical coverage to individuals with poor health status, such as medically needy and people with disabilities.16 Research has found mental health and substance use disorders to be a leading cause of disability in the United States.17 According to a recent study, more than 50 percent of Medicaid beneficiaries with disabilities have a mental illness or substance use disorder.18 Furthermore, the prevalence of behavioral health conditions tends to be higher among individuals with low incomes.19

A recent analysis published by the Government Accountability Office (GAO) examined high-expenditure Medicaid-only enrollees between 2009 and 2011. GAO defined this group as the 5 percent most costly of all Medicaid beneficiaries. GAO identified mental health conditions in more than 50 percent of this subpopulation in all three years.20 The next most prevalent conditions were substance use (19 percent), diabetes (18 percent) and asthma (14 percent).21 GAO also evaluated co-occurring conditions and found that among high-expenditure Medicaid beneficiaries with a mental health condition 27 percent also had substance use disorder, 19 percent had diabetes and 18 percent had asthma.

The interaction between physical health, mental health and substance use disorders emphasizes the importance of an integrated approach to service delivery. For example, across the broader population, recent research shows that roughly 33 percent of individuals who go to an emergency room complaining of chest pains are actually experiencing depression or a panic disorder.22 Furthermore, roughly 20 percent of individuals who have coronary heart disease and 33 percent of individuals who have congestive
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Heart failure suffer from depression but are never diagnosed. Among Medicaid beneficiaries, the interaction of physical and behavioral health conditions is even more evident. Sixty percent of Medicaid beneficiaries with a behavioral health condition also have a co-occurring chronic physical condition. Spending on these Medicaid beneficiaries is estimated to be 60-70 percent higher than for the average Medicaid beneficiary.

Finally, a critical component of any successful approach to serving individuals with behavioral health conditions is the emphasis on recovery and resiliency. Recovery, according to SAMHSA, is “... a process of change through which individuals improve their health and wellness, live self-directed lives and strive to reach their full potential [...] built on access to evidence-based clinical treatment and recovery support services.” According to SAMHSA, four dimensions support recovery: health (i.e., overcoming or managing one’s conditions or symptoms), home (i.e., having a stable and safe place to live), purpose (i.e., conducting meaningful daily activities, such as a job, school and other societal participation) and community (having relationships that provide support, friendship, love and hope). Resiliency is the ability for individuals to cope with and adapt to challenges and changes in their lives, including those caused by their behavioral health conditions. For children and adolescents in particular, resilience can be a valuable tool in coping with the responsibilities and challenges of adulthood even if they have experienced difficult circumstances; avoiding risky behaviors earlier in life (e.g., substance use, violence); and handling stress positively.

Managed Care Is Well-Suited to Integrate Comprehensive Health and Social Services for Individuals with Behavioral Health Conditions

The quality of health and health care for individuals with behavioral health needs, including SMI and other significant behavioral health conditions, can be improved through a managed care program. A managed care approach offers the greatest promise for integrating services, enhancing access to needed services and supports, and ensuring the delivery of person-centered services that support recovery and resiliency.

Provide Coordinated and Comprehensive Services and Supports

For individuals with behavioral health conditions, it is paramount that there is a system of care with a clear point of accountability to identify each person’s health needs, ensure access to necessary services and follow-up, monitor outcomes, and measure and promote quality. States can deploy a managed care model to deliver a more holistic, integrated solution for individuals with behavioral health conditions, whether mild, moderate or severe. Given the prevalence of substance use disorders as a stand-alone condition and as a co-occurring condition among individuals with mental health needs, a comprehensive and integrated approach delivered through managed care should include coordination of services and supports for substance use disorders as part of the overall system of care.

The complexities of their conditions and the obstacles individuals face in accessing appropriate care and services make daunting the task of assessing health needs and creating care plans. Well-run managed care programs deliver an integrated, multipronged approach to identifying the health and related social circumstances of each individual, usually by deploying a specialized care team and personalized care plan. These efforts can include the critical interventions illustrated below.
• Managed care organizations (MCOs) assign suitably qualified case managers for individuals with significant behavioral health conditions to coordinate each individual’s care. MCO case managers work with clinicians and individuals to devise an individualized plan of care for each person having complex needs and to ensure the plan of care is implemented and appropriately modified as circumstances evolve.

• MCOs engage with members to understand how to best communicate with each member and, where applicable, the member’s caregiver(s). In recent years, many Medicaid MCOs have made significant progress “meeting members where they are” in terms of how, when and with whom communication occurs. One approach MCOs can implement to better engage and communicate with members is motivational interviewing. According to SAMHSA, motivational interviewing integrates principles of optimism and an individual’s capabilities to overcome mental health and substance use challenges into “… an empathic, supportive, yet directive counseling style that provides conditions under which change can occur.”

• Medicaid MCOs have effectively used peer counselors or navigators to better engage with members who have distinct needs. Peer counselors are trained laypeople working under the supervision of licensed case managers or other licensed clinicians who help the member focus on recovery and resiliency. These individuals, who themselves have faced challenges similar to those of the members they are supporting, can be effective in providing face-to-face outreach, assisting with day-to-day activities, facilitating access to providers, accompanying members on provider visits to help establish a successful patient-clinician relationship, and coaching on medication use and adherence.

• MCOs apply analytic tools to identify gaps in evidence-based care, such as individuals with SMI-level needs who are not yet receiving adequate services. A National Institutes of Health report indicates that while three-fourths of chronic mental illnesses begin by age 24, “there are long delays — sometimes decades — between the first appearance of symptoms and when people get help.” This highlights the importance of early intervention and prevention programs that MCOs can offer members. MCOs have the capabilities and expertise to leverage and bring to scale national best and promising practices in service delivery for members. For example, the programs could include early intervention programs underway nationally that engage individuals at the first onset of psychosis.

• MCOs gather information about each individual’s physical and behavioral health history from providers, public agencies, case workers, residential service providers and others. A systematic, digitized compilation of available data is needed to capture past diagnoses, the providers encountered, the medications received, social circumstances, etc. MCOs obtain and use these data — consistent with federal and state privacy rules and member consent — to inform ongoing care planning and treatment decisions internally and in collaboration with providers. An example of an MCO’s efforts to consolidate data effectively is described below.

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**Managed Care Perspectives**

**Engaging to Improve Outcomes for Individuals with Significant Behavioral Health Conditions**

A 15-year-old Medicaid member enrolled in the Amerigroup Kansas health plan had a history of several recent hospitalizations. He had been diagnosed with pervasive developmental disorder not otherwise specified, schizoaffective disorder, a mild intellectual disability and obesity.

Although he was engaged with a community mental health center, he was also eligible for other services that he was not receiving. His Amerigroup Kansas care coordinator identified the additional services for which he was eligible and coordinated with the community mental health center and the state agency to ensure he could choose from the services that would be most beneficial for his recovery. His Amerigroup Kansas care coordinator also established a relationship with his mother by answering her questions and helping her navigate the system to best meet her son’s needs. He is now attending an alternative school half-day, five days a week and spends five hours a day each weekday with his respite worker participating in community and recreational activities of his choice — playing games and engaging in outdoor activities. He has been able to remain at home without further hospitalizations and is building a life for himself in the community.

Source: Program information from the Amerigroup Kansas health plan.
Advancing Access to Information Sharing

Anthem’s affiliated health plan Medicaid MCOs are advancing providers’ access to member health care information and further supporting the development of member-centered medical homes via an integrated care management platform, Member360. Consistent with federal and state privacy guidelines, Member360 combines member information from various sources into a single record to reveal a holistic picture of the member’s health services utilization, including pharmacy, care management services and gaps in care. Member360 includes information, such as member health risk assessments, care plans, longitudinal member health records and clinical data. Through the provider-facing Member360 tools, providers who have members attributed to them can see the member record via the provider portal, giving them simple, easy-to-access information to assist them in engaging the member in their health and well-being.

- MCOs can use claims and encounter data, along with care coordinator reports, to identify proactive, preventive care or enhanced interventions for those members who are predicted to be at greatest risk of experiencing significant, and perhaps avoidable (e.g., emergency department visits) utilization of services. While many individuals with behavioral health conditions have significant needs for behavioral health and physical health care, this information can be used to identify early warning signs and intervene effectively to prevent an individual’s condition or status from worsening. For example, medication refills can be tracked in real time and an apparent missed refill can prompt action, such as phone calls to the member, prescriber and/or pharmacy.

- Adherence to medication regimens can be challenging but is very important for individuals prescribed psychotropic medications. MCOs can provide enhanced support to members to promote medication adherence, including strengthening the dialogue between members and prescribers and promoting shared decision-making with respect to prescribed medications. These efforts often yield clinical improvements for members and help avoid the costly consequences of medication nonadherence or adverse drug interactions. Recent research demonstrated the impact of medication adherence on hospitalization rates among individuals with schizophrenia: Only 14 percent of fully adherent individuals were hospitalized compared to 24 percent and 35 percent of individuals who were partially adherent or nonadherent, respectively.

- Many Medicaid MCOs furnish and collaborate with providers to implement an array of medication adherence supports to their members who are on complex drug regimens, including telephonic and/or text messaging outreach, mail-delivered prescriptions to reduce the challenges of getting to the pharmacy, and other approaches. For example, the use of Medicine-On-Time options can be effective interventions to ensure better adherence to medication, especially for individuals with multiple comorbidities.

Overall, better coordination through MCOs can show positive results in key areas for individuals with significant behavioral health conditions. For example, the Amerigroup Tennessee health plan operates a comprehensive care coordination program to better integrate primary care and behavioral health providers. A member is assigned to a behavioral health case manager who collaborates with behavioral health and medical providers, as well as the member, to ensure care is closely coordinated. The case manager also supports the member in receiving health screenings, behavioral health services and follow-up services. Recent data indicate this program has increased behavioral health visits by 116 percent while reducing inpatient admissions and emergency department visits by 15 percent and 59 percent, respectively, for members with SMI and diabetes.

Integrate Behavioral Health and Physical Health Services and Supports

Coordinated care programs for individuals with any type of significant health care needs, including significant behavioral health conditions, are rapidly evolving toward a holistic, integrated model. Under this system of care, the key underlying health problems are effectively treated, but therapies are also integrated with care of the other conditions the individual may have.

It is becoming well understood that treatment of either behavioral health or physical health conditions without consideration of the linkage between the two will lead to less than optimal outcomes. “Studies of different models of integration across widely varying delivery systems demonstrate with great consistency that integrated care improves depression and anxiety outcomes. […] Furthermore, integrated care improves patient quality of life and satisfaction with care.”
Effective integration of physical and behavioral health services is also valuable in placing behavioral health conditions and care on par with physical health conditions. This is important in reducing the stigma surrounding behavioral health conditions that too often becomes a significant barrier to accessing needed care.

Managed care models facilitate access to needed services and avert duplicative or conflicting interventions by deploying an array of measures, such as the following:

- Link each enrollee to a health home and offer incentives to achieve desired physical health and behavioral health outcomes. For many individuals with behavioral health conditions, the health home will be a behavioral health provider, but it could be a primary care provider (PCP). Ideally, the health home will be composed of an interdisciplinary care team that integrates both physical and behavioral care. The federal government has endorsed the health home concept for people with chronic illnesses and behavioral health conditions, including SMI. For example, at the state level, Georgia’s recent Medicaid MCO procurement asked how each health plan would establish and maintain a behavioral health home for individuals with mental health conditions.40

- Invest in systems and staff to help members obtain needed health care services. For example, Medicaid MCO helplines can connect members to services after hours to their case manager and to other services.

- Forge a more comprehensive system of care for individuals with behavioral health conditions by coordinating with the other agencies including Medicaid, the Department of Mental Health, the criminal justice system and schools. In the same manner that optimal clinical care for individuals with behavioral health conditions cannot occur by viewing the person through only a mental health care lens, it is important the care coordination efforts extend beyond a Medicaid silo. For example, identifying housing supports, employment or job-training options, transportation, and other social supports is pivotal to promoting recovery and social inclusion. While the degree to which MCOs can directly pay for these types of supports (e.g., housing) is often limited by Medicaid’s available funding and by Medicaid’s benefits package, effective MCOs will connect their members to all appropriate community resources. In some states, MCOs also provide specific value-added benefits to help address some of these social determinants of health.

- Co-locate primary care and behavioral services to help individuals get needed physical and behavioral health services. Co-location can occur in either direction — by placing a behavioral health practitioner at a primary care site or by placing a primary care practitioner inside a behavioral health practice, such as a community mental health center. For instance, the Amerigroup Tennessee health plan sponsored and supported a community mental health center to place a primary care clinic within its building.41 The PCP shares data and records, sits in team meetings with the behavioral health staff, and fosters a coordinated approach to managing physical and behavioral health conditions. Where actual co-location is not feasible, MCOs can facilitate a collaborative connection between physical health and behavioral health providers, such as by fostering telephonic case conferences and psychiatric consultations among an individualized care team or directly with the PCP.42

These approaches help with quicker identification of emerging behavioral health and/or physical health conditions and facilitate appropriate holistic, integrated treatment. Furthermore, working with PCPs to develop stronger linkages with behavioral health specialists can provide PCPs with the support needed to enroll members in medical homes when co-location or behavioral health supports at the PCP site do not exist.
Co-location of Primary Care and Behavioral Health Care

Primary care integrated screening, identification, treatment and evaluation (PC-INSITE) of depression and substance use disorders is based on the evidence-based IMPACT model developed by psychiatrists at the University of Washington. In Sacramento, Calif., Anthem Blue Cross of California has collaborated with WellSpace, a large federally qualified health center (FQHC) with clinics in the urban center and rural locations, to implement PC-INSITE. Funding supported hiring a licensed behavioral health professional as a behavioral health consultant co-located in their medical clinics. This is WellSpace’s story of how their clinic model evolved:

WellSpace Health began implementing the PC-INSITE model six months ago. At the time, the Integrated Behavioral Health team struggled to gain acceptance from the primary care providers and others in the clinic. Today, the entire situation at WellSpace has turned around for the better. There were several key factors, including the vocal support of our CEO, COO and chief medical officer. The doctors and nurses were trained on the IMPACT model, and the behavioral health director created protocols for consultations that made the process simple. The concreteness of the program (offer consult at 10 or above on the patient health questionnaire-9) took a lot of the guesswork out of the hands of primary care and gave the providers more opportunities to see the benefits of immediate consultations and interventions. This was both an exciting and challenging time for the staff, and some of those who did not buy in eventually left the clinic. This has afforded us the opportunity to hire new clinicians and medical providers who “get it.”

Now, consultations in primary care are routine. At the midway point of the first year, we have screened 75 percent of the target goal of 800 patients. We meet with the providers twice a day during huddles where we review the appointments for the day and identify both potential and repeat patients. We now have begun bringing in graduate students to assist with the volume of consults and follow-ups, and we anticipate implementing this program at several of our other locations next year with continuation of the partnership with Anthem Blue Cross of California.

Analysis of member outcomes pre- and post-integration of physical and behavioral health care supports MCOs’ efforts to integrate care. For instance, Tennessee moved from a behavioral health carve-out model, in which care was not integrated, to an integrated approach combining physical and behavioral care under one umbrella. The Amerigroup Tennessee health plan served the TennCare population throughout this transition and compared service utilization for enrollees with both SMI and diabetes under the non-integrated model and the strongly-integrated model it implemented under the carve-in. They found favorable results including:

- 22 percent reduction in hospital emergency department visits
- 11 percent reduction in inpatient admissions
- 65 percent increase in outpatient behavioral health visits to a physician
- 12 percent increase in outpatient visits to a general practitioner

Analysis of member outcomes pre- and post-integration of physical and behavioral health care supports MCOs’ efforts to integrate care.
Support Individuals and Their Families in Their Homes and Communities

The fee-for-service (FFS) setting offers little or no incentive or accountability to help individuals overcome barriers to integrated services and supports. Partnerships between states and MCOs, however, systematically work to provide members, their families and their caregivers, as applicable, with timely access to recovery-oriented and integrated services and supports.

MCOs can play an important role in helping individuals with behavioral health conditions achieve all four dimensions of recovery (i.e., health, home, purpose and community); promote resiliency; and foster hope. Through an integrated, collaborative and coordinated approach, MCOs put structures in place and make available resources and supports for individuals with behavioral health conditions to live independently, direct their own care and services, and achieve recovery with the needed services and supports, including social supports. MCOs convey focused educational information to members and caregivers regarding management of the behavioral health and physical health conditions each individual is facing. Some Medicaid MCOs furnish tailored support to caregivers, including respite services, informational materials, phone conferences, webinars and face-to-face support group meetings.

MCOs collaborate with providers to support members in setting and attaining their own realistic and achievable goals. Goals may be specific to health care (e.g., attend all scheduled therapy appointments during the next three months) but will often involve quality of life and wellness issues that are tangential to health (e.g., lose a certain amount of weight by a target date) or even issues not closely tied to health or health care (e.g., obtain or renew a driver’s license). This process is important for individuals with behavioral health conditions to create a positive cycle of motivation, hope, resilience and achievement.

An important focus of a managed care program is to support individuals with behavioral health conditions to work and participate in other community activities. An MCO can coordinate across all the resources individuals might access and use, including publicly-funded services or supports, such as transportation; supportive housing; supported employment; as well as faith-based and social supports, which are integral to community participation, social inclusion and achieving recovery. Managed care plans also support members by connecting them to housing resources and coordinating with businesses and vocational/educational programs operated by other state and nonprofit agencies.

Some individuals with behavioral health conditions, including SMI, reside in institutional care settings such as state psychiatric facilities, nursing facilities and assisted living facilities. For example, out of an estimated 9.6 million adults with SMI in 2012,
For those individuals who can be transitioned safely to living in the community, these moves yield significant quality of life improvements and cost efficiencies.

For example, in its initial Medicaid managed care contracts, Tennessee required MCOs to reduce the long-term, chronic, subacute population in the state hospitals by 10 percent. The Amerigroup Tennessee health plan reduced by roughly 75 percent the number of members residing in one particular facility by finding alternatives with adequate and individually tailored community supports. Many of these members then transitioned to independent living or chose to return to their families. In one instance, two members who had been in the state hospital for more than 20 years moved to a supported housing environment with intensive case management. As a result of the members’ successful recovery and resiliency to date, they recently moved to a more independent housing arrangement.

Enhance Provider Collaboration and Access to Services

Individuals face many challenges in accessing behavioral health services. Barriers include a shortage of behavioral health clinicians and/or a reluctance of clinicians to serve Medicaid beneficiaries. For any given individual there may also be cultural barriers to seeking care (e.g., stigmatization) and poverty-related challenges, such as a lack of transportation. MCOs undertake numerous approaches to pointedly improve access to providers through collaboration, innovations and value-based payment relationships.

MCOs often broaden access by expanding the field of providers who serve people with behavioral health conditions, including SMI. This broadening of access is of vital importance given the dwindling number of mental health providers serving Medicaid enrollees and that many PCPs face significant challenges getting access to or communicating with mental health specialists, including psychiatrists. MCOs’ efforts strive to facilitate access to all types of behavioral health providers. Increasingly, these efforts include making optimal use of telehealth in addition to facilitating access to traditional face-to-face visits and peer-to-peer consultations.

MCOs that assume full financial risk for their enrollees’ care can leverage their role as payer both to attract providers and to better motivate desired outcomes than those that occur in the FFS setting, where payments are tied only to the volume and mix of services rendered. Managed care plans have the latitude...
to incentivize providers with bonuses that reward attainment of favorable clinical outcomes and quality metrics, for example, or to help the provider care for individuals with behavioral health conditions, such as by assisting with appointment scheduling and supporting medication adherence efforts.

GUIDING PRINCIPLES FOR A SUCCESSFUL MANAGED CARE PROGRAM

Managed care can greatly improve the services and supports, including social supports, delivered to people with behavioral health conditions. MCOs can promote recovery and resiliency for individuals while also partnering with the state to build a sustainable delivery system that meets specific state needs. As more states move in the direction of fully integrated managed care for all services and supports for individuals with behavioral health conditions — especially those with significant behavioral health needs, such as SMI — the following recommendations can guide their efforts.

Integrate All Individuals with Behavioral Health Conditions and All Covered Services into Comprehensive Managed Care Programs

Notwithstanding the pressing need for better service coordination, states have hesitated to use a full-service, full-risk managed care model to coordinate care for individuals with behavioral health conditions, especially those with significant behavioral health needs — either excluding these Medicaid beneficiaries from the coordinated care program or “carving out” behavioral health services. Thanks both to the managed care field’s advances in serving these individuals and to enhancements in state capabilities for oversight and quality measurement, there are numerous benefits associated with including this high-need population in comprehensive managed care or eliminating carve-outs of behavioral health services from MCO contracts. In particular, MCOs’ investment in behavioral health services has created a focus on behavioral health within managed care that meets or exceeds that of specialty carve-out programs. MCOs build and engage provider networks that include the capacity and subspecialties needed to meet the needs of individuals with behavioral health conditions.

Furthermore, MCOs are effectively integrating health services and supports. First and foremost, MCOs integrate physical health and behavioral health services, forging collaborations between physical health and behavioral health providers and ensuring services aren’t provided in silos. MCOs also link individuals to community supports and peer navigators to support the recovery process. Additionally, MCOs can promote healthier lifestyles (e.g., offering smoking cessation or weight loss support) and help meet social needs such as housing, employment and transportation. With what is known today about the value of integrating physical and behavioral health care, states should partner with MCOs to coordinate services and supports on a whole-person basis and avoid carve-outs to the greatest possible extent.

Utilize an MCO Model to Improve Quality

Though relevant metrics have long existed, requirements for measuring and monitoring quality in the behavioral health services arena have lagged behind medical and administrative quality measurement. However, stakeholders in the Medicaid program have expressed a strong interest in this area, and significant progress is being made. For instance, several measures from the Healthcare Effectiveness Data and Information Set (HEDIS) are currently available to help assess services rendered to people with SMI:

- Follow-up after hospitalization for a mental illness post-discharge
- Diabetes monitoring for people with schizophrenia or bipolar disorder who are using anti-psychotic medications
- Cardiovascular monitoring for people with cardiovascular disease and schizophrenia
- Adherence to anti-psychotic medications for individuals with schizophrenia
The managed care structure provides the necessary accountability for measuring and reporting on a set of behavioral health quality measures. MCOs have the expertise and capabilities to implement and support a variety of important quality improvement efforts, including many currently of interest to states:

- Achievement of accreditation from NCQA or other accrediting body
- Preparation and submission to the state an annual quality improvement plan that addresses physical and behavioral health outcomes and implementation of various performance improvement plans
- Incorporation of quality measures into MCO payments through withholds, bonus payments or both
- Assignment of higher percentages of new enrollees — those who do not affirmatively choose a health plan on their own — by states to Medicaid MCOs that score highest on quality ratings
- Publication of health plans’ HEDIS scores and overall quality rankings, which enrollees can use as a guide for selecting MCOs and which can more broadly affect each organization’s reputation
- Convening of advisory groups that include advocates for people with a mental illness to give input to the design of the coordinated care program prior to its implementation and to air issues and ideas throughout its operation

Medicaid MCOs typically dedicate entire departments to quality measurement and improvement. In addition, health plans collaborate with their network providers to monitor quality performance, share data to drive performance and motivate improvements through financial incentives.

Collaborate to Achieve Broad Community Engagement in Serving Individuals with Behavioral Health Conditions, Including SMI and Other Significant Conditions

The needs of individuals with behavioral health conditions, including SMI, can be served most effectively by a tailored approach to collaborative and coordinated care. A managed care model in which MCOs partner and collaborate with the state to engage a range of community supports can best help individuals manage their conditions, realize improved quality of life and make strides toward recovery. A successful approach to tailoring services and supports needs the following components:

- Dedicated resources to coordinate care for members with behavioral health conditions and to provide family and social supports
- Holistic, integrated care coordination for individuals who have a complex array of conditions spanning physical and behavioral health, including peer supports, supported housing and employment, social and community inclusion, wellness strategies, and other supportive services
- Coordination with providers to adopt recovery-oriented models and training on evidence-based practices
- Comprehensive needs assessments for each individual, follow-through with a thorough plan of care that includes the member and their family, and appropriate modifications as circumstances evolve
- Processes to work effectively with all relevant public agencies, including those in the housing, vocational rehabilitation and justice systems
- Access to preventive and treatment-related services and processes to work with all involved parties to address identified gaps in care
- Analytics, practice-based evidence, and best and promising practices to continuously improve access to services and supports and increase the quality of care
- Financial models that establish effective integration and achieve efficiencies in health benefit administration while not rewarding cost-shifting to other benefit sources
CONCLUSION

States are in the early stages of fully integrating the total physical health, behavioral health care and social support needs of individuals with mental health conditions and substance use disorders. This comprehensive and integrated approach is crucial to improving individuals’ health statuses and quality of care and services while emphasizing recovery, resiliency and independence. This approach also facilitates the level of provider engagement necessary to drive further improvements in quality and access.

For individuals with behavioral health conditions who need an array of services and supports, an MCO serves as a the single point of accountability for ensuring the member receives all needed services and supports in an integrated and collaborative fashion. MCOs work with their members and network providers to develop holistic, recovery-oriented plans that support members’ physical health, behavioral health, functional and social support needs. The result is greater independence for the individual, reduction in service gaps, attainment of individual goals, improved health outcomes and better quality of life. MCOs have made significant investments in their approach to behavioral health to ensure members receive holistic, integrated services and supports that promote recovery and resiliency.

MCOs work with their members and network providers to develop holistic, recovery-oriented plans that support members’ physical health, behavioral health, functional and support needs.

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ENDNOTES


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41. Program information from the Amerigroup Tennessee health plan, (August 7, 2015).
43. Program information from the Amerigroup Tennessee health plan, (August 7, 2015).
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About the Anthem Public Policy Institute
The Anthem Public Policy Institute was established to share data and insights to inform public policy and shape the health care programs of the future. The Public Policy Institute strives to be an objective and credible contributor to health care innovation and transformation through publication of policy-relevant data analysis, timely research, and insights from Anthem’s innovative programs.

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Anthem is working to transform health care with trusted and caring solutions. Our health plan companies deliver quality products and services that give their members access to the care they need. With over 74 million people served by its affiliated companies, including more than 40 million enrolled in its family of health plans, Anthem is one of the nation’s leading health benefits companies. For more information about Anthem’s family of companies, please visit www.antheminc.com/companies.