



## **Making Integration Work:** Key Elements for Effective Partnerships Between Physical and Behavioral Health Organizations in Medicaid

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## IN BRIEF

A growing number of states are implementing integrated models to address problems of fragmented care and poor health outcomes for individuals with serious behavioral health needs. Many states have transitioned to contracting with managed care or accountable care organizations that are responsible for managing all physical and behavioral health services for Medicaid enrollees. These organizations commonly involve new partnerships between physical and behavioral health plans and providers that can advance the goals of integrated care. This brief, produced with support from the California Health Care Foundation, identifies key elements that contribute to successful partnerships. It synthesizes insights from organizational leaders representing Medicaid-based partnerships in Arizona, Arkansas, Colorado, and Oregon. Key elements include (1) employing joint-ownership models representing both physical and behavioral health, (2) ensuring stable system transitions for consumers and providers, (3) marrying the expertise of physical and behavioral health partners to create new and enhanced capacities, and (4) allowing adequate time for planning and implementation. These lessons are broadly applicable for health care organizations and policymakers considering how to support successful partnerships to advance physical and behavioral health integration.

## Background

Many states and regions are seeking to improve access, quality, and costs of care for Medicaid enrollees with behavioral health needs, defined as people with mental health conditions and/or substance use disorders (SUD). The relatively poor outcomes for these populations are well documented: People with behavioral health conditions have higher rates of chronic physical conditions, poor social outcomes such as homelessness and unemployment, and early mortality.<sup>1</sup> People with behavioral health needs experience fragmented care and receive less preventive care, while using more acute care.<sup>2</sup> Medicaid spending for this population is more than four times higher than for those without behavioral health conditions, largely the result of increased physical health care spending.<sup>3</sup> Informed by the growing evidence that clinical integration of physical and behavioral health can improve health outcomes and quality of life as well as reduce health care costs, many states have sought to advance integrated care for Medicaid beneficiaries with behavioral health needs.<sup>4</sup>

Separate financing and administrative structures for physical and behavioral health care in Medicaid can contribute to fragmented care. While the majority of states organize and finance physical health benefits through managed care organizations (MCOs), historically many states “carved out” the administration of specialty mental health and SUD services to separate managed behavioral health organizations (often public entities) or on a fee-for-service basis. Under such systems, with different care components managed by disparate entities, consumer access to care and care coordination can be diminished, often resulting in worse health outcomes.<sup>5</sup>

States seeking more integrated physical and behavioral health care in their Medicaid programs are pursuing a variety of approaches including integrated managed care, health homes, and accountable care organizations (ACOs).<sup>6</sup> A growing number of states have newly contracted with either integrated managed care plans or ACOs to manage all physical and behavioral health services for Medicaid enrollees. The structure of these

models — including the populations covered, phasing of implementation, and structure and responsibility of contracted entities — varies widely, as states often tailor policy approaches to address unique state and regional environments as well as existing managed care and provider capacity. As of 2019, only nine states carve out behavioral health benefits — a significant decrease over the last decade.<sup>7</sup> While there are limited data on the impact of these state integrated managed care initiatives, evaluations from Arizona and Washington have shown promising results.<sup>8</sup>

In this evolving landscape, there is much to learn from states, plans, and providers that have advanced integration efforts, both in terms of strategies to support effective implementation and impacts on care delivery and outcomes. Their experiences thus far have shown that financial integration alone is not sufficient for clinical integration — data-sharing and payment policies are critical.<sup>9</sup> But to understand the key elements for successful integration, it is also necessary to examine the partnerships between physical and behavioral health entities that undergird integration.

When states consider changing how behavioral health benefits are managed, often the debate centers around which entities are best positioned to manage an integrated benefit, with options commonly including physical health MCOs and public or private

behavioral health organizations. However, regardless of which option is selected, partnerships between physical and behavioral health stakeholders — including both administrators and providers — often emerge. These partnerships can take many forms, ranging from formal to more informal relationships, and may have responsibility for an entire state or a specific region. How well such partnerships function can have a significant impact on efforts to advance integrated care.<sup>10</sup>

To examine how partnerships have advanced physical and behavioral health integration — and to identify lessons for states and other stakeholders — the Center for Health Care Strategies (CHCS), with support from the California Health Care Foundation, conducted interviews with leaders of organizations that are partnering to integrate care for Medicaid enrollees. Interviewees represented both physical and behavioral health care in four states: **Colorado** and **Oregon**, which have regional Medicaid ACOs, and **Arizona** and **Arkansas**, which have integrated specialty health plans for those with serious behavioral health needs.

Through their integration efforts, the profiled states and regions experienced significant transformation in how behavioral and physical health services were managed. Details on the interviewees and their integration models are summarized in Table 1 and described in the next section.

**Table 1. Overview of Profiled Partnerships and Characteristics, by State**

	INTEGRATION MODEL	PARTNERSHIP SCOPE	ENTITY	INTERVIEWED PARTNER(S)
<b>Arizona</b>	<b>Integrated Regional Behavioral Health Authorities (RBHAs).</b> Specialty managed care plans for adults with serious mental health needs	Joint ownership between 2015 and 2018 (duration limited by design)	Health Choice Integrated Care	Steward Health Choice Arizona* (now Health Choice Arizona)
<b>Arkansas</b>	<b>Provider-Led Arkansas Shared Savings Entities (PASSEs).</b> Specialty managed care plans for adults and children with serious behavioral health needs or intellectual or developmental disabilities	Joint ownership since 2018	<ul style="list-style-type: none"> <li>▶ Empower Healthcare Solutions</li> <li>▶ Arkansas Total Care</li> </ul>	<ul style="list-style-type: none"> <li>▶ Beacon Health Options, Arkansas Healthcare Alliance</li> <li>▶ Arkansas Health &amp; Wellness (a Centene subsidiary)</li> </ul>
<b>Colorado</b>	<b>Regional Accountable Entities (RAEs).</b> Medicaid ACOs cover all adults and children	Joint ownership since 2019	Health Colorado	Beacon Health Options, Solvista Health
<b>Oregon</b>	<b>Coordinated Care Organizations (CCOs).</b> Medicaid ACOs cover all adults and children	Informal partnership	Jackson Care Connect	Jackson Care Connect, CareOregon, Jackson County Mental Health

\*After the interview was conducted, Blue Cross Blue Shield of Arizona acquired Steward Health Choice Arizona, and “Steward” was dropped from the name.

# Profiled Partnerships

## Arizona

Arizona's Medicaid agency began integrating the financing of physical and behavioral health in 2013, after having carved out specialty behavioral health benefits to Regional Behavioral Health Authorities (RBHAs) for many years. To promote integration, beginning in 2014 the state carved physical health benefits into RBHA contracts for adults with serious mental illness (SMI) and required that integrated RBHAs include a physical health plan. A single integrated RBHA in each of three regions managed care for this population.

The integrated RBHA profiled in this brief, Health Choice Integrated Care (Health Choice), was a joint venture between Steward Health Choice Arizona (Steward) and the Northern Arizona Regional Behavioral Health Authority (NARBHA). While NARBHA was a behavioral health plan, it was owned by behavioral health providers in the region and thus was closely connected to providers. Health Choice covered six counties in northern Arizona, including the cities of Flagstaff and Prescott. In 2018, as the state expanded its integration strategy to include most Medicaid enrollees, Steward assumed further responsibility as an integrated plan for the general population. At this time, it bought out NARBHA's portion of the integrated RBHA contract for the SMI population and developed a new contractual relationship allowing NARBHA to have an ongoing role advising on services for members with SMI.

## Arkansas

Arkansas developed a unique partnership model of risk-based provider organizations that integrate specialized services for adults and children with either severe or persistent behavioral health needs, or intellectual and developmental disabilities (IDD). The state chose to focus on these high-need populations due to their rising costs of care, limited access to care, and fragmented delivery of service in the state's fee-for-service system, with the goal of developing a model to achieve savings within five years.<sup>11</sup> Arkansas pursued a

hybrid approach that merged provider leadership with the expertise of managed care organizations.<sup>12</sup>

These new entities, known as Provider-Led Arkansas Shared Savings Entities (PASSEs), cover approximately 44,000 adults and children enrolled in Medicaid with high levels of behavioral health or IDD service needs, and are now fully at risk for all enrollees after a multiphase launch.<sup>13</sup> PASSEs manage all physical and behavioral health services as well as home- and community-based long-term services and supports. Each PASSE must organize and coordinate across the full continuum of care, including development of a statewide provider network and provision of care coordination services. The program has been quickly implemented — after passage of enabling legislation in 2017, PASSEs began providing care coordination services to attributed beneficiaries in February 2018, and in March 2019 became fully at risk for all services and began receiving a global capitated payment. The state structured this phased launch to enable PASSEs to test their approaches and to use full claims data for approximately one year before becoming fully at risk.

In the PASSE model, the state requires that different providers — including a behavioral health services provider, developmental disability service provider, physician, hospital, and pharmacist — enter into a partnership with an organization that manages administrative functions, with the providers retaining majority ownership. Of three statewide PASSEs, two are profiled in this brief: Arkansas Total Care, owned by two provider groups and by Arkansas Health & Wellness (a subsidiary of Centene, a national managed care plan), and Empower Healthcare Solutions (Empower), owned by five provider groups as well as by Beacon Health Options, a national behavioral health managed care plan.

## Colorado

Colorado sought to promote integration of physical health, mental health, and SUD services while maintaining separate financing streams for physical and behavioral health. In 2011, under the first phase of Colorado's delivery system transformation, the state

focused on strengthening primary care, creating Regional Care Collaborative Organizations (RCCOs) to coordinate care across primary and specialty care on a fee-for-service basis. Meanwhile, Behavioral Health Organizations (BHOs) continued to manage a carved-out benefit as they had done previously.

In 2018, the second phase of transformation began, with a focus on advancing integration of physical and behavioral health services and making one entity accountable at the administrative level for these services to increase providers' ability to deliver whole-person care.<sup>14</sup> Regional Accountable Entities (RAEs) replaced both the RCCOs and BHOs, and became responsible for administering the capitated behavioral health benefit as well as overseeing an expanded scope of care coordination activities and increased accountability among primary care providers still operating under a fee-for-service reimbursement model. The RAEs were responsible for contracting with primary care providers to serve as medical homes, building a statewide network of behavioral health providers, coordinating care across all providers, and monitoring data and improving population health across the region. Since this phase began, RAEs are increasingly incentivized to achieve improved member outcomes across physical and behavioral health indicators, and may use value-based payments in their contracts with behavioral health and primary care providers.<sup>15</sup> Health Colorado, profiled in this brief, covers over 130,000 members across 19 counties in primarily rural and frontier south-central and southeastern regions of the state, and is jointly owned by four community mental health centers (CMHCs), a Federally Qualified Health Center (FQHC), and Beacon Health Options. One other RAE is partially owned by CMHCs and FQHCs, and the remaining RAEs have varied ownership structures, including plans as sole operators.<sup>16</sup>

## Oregon

In January 2020, Oregon implemented a significant initiative to address the fragmentation of physical and behavioral health services, with all of the state's Coordinated Care Organizations (CCOs) becoming fully accountable for behavioral health services. Some

CCOs initiated this move earlier, and the experience of the Jackson Care Connect CCO, outlined in this brief, illustrates how organizations can evolve their partnerships to navigate significant transitions in organizational responsibilities. Oregon first introduced CCOs in 2012, as locally governed regional collaboratives that included health plans, providers, county public health, and community-based organizations that administer a single global budget to serve Medicaid enrollees regionally.<sup>17</sup> While CCOs are a type of ACO — referred to by some as “ACOs on steroids” — their financing structure more closely resembles Medicaid managed care organizations.<sup>18</sup> Initially, most CCOs carved out the behavioral health benefit by passing through a portion of the global budget to local mental health agencies, with reported negative outcomes including limited access to care, delayed authorizations, and barriers to advancing clinical integration.<sup>19</sup>

Jackson Care Connect CCO had originally partnered with Jackson County Mental Health (Jackson County), the local mental health agency, which served as both the subdelegated behavioral health managed care entity for all members and as the primary provider of services for a high-need subpopulation. Both entities are located in Jackson County in southern Oregon, one of the more populous counties in the state and home to the cities of Medford and Ashland. In 2016, Jackson Care Connect opted to carve in the behavioral health benefit to address the fragmented care experienced by members with behavioral health needs, and to pare back on the services for which it contracted with the county to deliver. This partnership underwent a significant transition, with Jackson County limiting its scope to a more targeted set of services, primarily for high-need adult and youth members, including crisis and safety-net services, outpatient treatment, assertive community treatment, wraparound services, specialized services for forensics populations, and mental health court. While the scope of services that Jackson County provides is significantly narrower, the county continues to participate in the board of directors and clinical advisory panel for Jackson Care Connect, and both organizations collaborate in the development and management of a county-level behavioral health strategic plan.

# Insights: Key Elements for Successful Partnerships

Through interviews with leaders of physical and behavioral health organizations, CHCS identified a set of elements underpinning successful partnerships:

1. **Employ joint-ownership models** that include both physical and behavioral health entities.
2. **Ensure stable system transitions** for consumers and providers.
3. **Marry the expertise of physical and behavioral health partners** to create new and enhanced capacities.
4. **Allow adequate time** for planning and implementation.

These key ingredients may be broadly applicable for health care organizations and policymakers considering how to support successful partnerships as part of broader strategy to advance physical and behavioral health integration. Following is a discussion of each of these elements based on insights gleaned from the four featured states and their efforts to collectively advance integrated care across changing policy environments.

## **ELEMENT 1** Employ joint-ownership models that include both physical and behavioral health entities.

Joint ownership of integrated entities, as exists with the Arkansas PASSEs, some Colorado RAEs, and integrated RBHAs in Arizona before 2018, can create new incentives and help align different organizations around shared goals. Many of these joint-ownership models knit together different systems — such as behavioral health, physical health, and in the case of Arkansas PASSEs, home- and community-based services — through shared governance and shared ownership of the partnership entity. Notably, these arrangements arose both in states that *required* joint

ownership between physical health plans and behavioral health plans or providers, and in states that did not. For example, all Arkansas PASSEs are statutorily required to be majority-owned by providers representing a range of practice types, while Colorado has no such requirement, and only some of the Colorado RAEs, including Health Colorado, are jointly owned by plans and providers focused on physical and behavioral health. Interviewees underscored the importance of joint ownership in transforming their operations and in navigating challenges that can arise when bringing together leaders with different perspectives and business interests.

These joint-ownership models bring together plans and providers to collaborate in the design of managed care functions and require accountability for integrated care outcomes that extend beyond the measures that physical or behavioral health entities may be accustomed to assessing. While organizations may come into the partnership with divergent interests, joint ownership creates new financial stakes, and shared governance creates new pathways for making key decisions. Owners in the Empower PASSE in Arkansas shared how they codesigned strategies for medical necessity criteria, care management, and provider reimbursements with the goal of creating shared benefits among behavioral health providers, hospitals, primary care providers, IDD providers, and the health plan, even when some of the proposed changes would potentially hurt one partner. Various Empower partners characterized this process as transformative — a health plan leader called it “a natural and healthy tension in how managed care is brought to bear,” while a provider leader said, “It’s eye-opening to wear a provider hat and an insurer hat, because sometimes these things do not agree.” The provider leader shared that the experience of governing Empower fundamentally changed the perspective of all governing partners to be mindful of how reshaping the delivery of care may improve member outcomes, and to simultaneously prepare themselves to be nimble in response to potential changes in revenue. While profiled entities within and across states had different governance structures, a health plan leader said that for Empower

PASSE, equity in governance participation is “the most meaningful requirement to bring the cross-functional parts of the health care system together to manage the membership on a holistic basis.”

For the owners of Health Colorado RAE, which include community-based physical and behavioral health providers as well as Beacon Health Options, the diversity of perspectives among partners is both the biggest challenge and the greatest catalyst for change. Partners are forced to think beyond their individual organizational interests, sharing the responsibility and risk of managing care for Medicaid enrollees across the region. “The entire design of this new system is based on improving coordination around the health care supply chain,” a behavioral health provider leader in Health Colorado said. “Partnering without being contentious takes communication, patience, compromise, and culture change, which is a big shift in health care.” This leader described how the partnership creates a reason for physical and behavioral health providers to work together even when their financial interests may seem to differ. For example, to promote greater clinical integration, Colorado recently added a Medicaid benefit for a limited number of behavioral health visits within primary care settings to be billed under the physical health fee-for-service system. In regions of the state served by other RAEs, this new benefit may have had the unintended consequence of incentivizing physical health providers to limit their collaborations with external behavioral health providers, instead limiting integration efforts to those services that they can provide and bill for in-house. By contrast, Health Colorado focused on leveraging this new benefit to create a more integrated model between physical and behavioral health services, through better referral pathways and opportunities for co-location and integration. The structure of the Health Colorado RAE, with shared ownership between physical and behavioral health providers, creates a clear business rationale for these providers to work together and avoid turf battles for resources.

When behavioral health entities have a seat at the table to shape how integrated services are managed and delivered, they can also help prioritize a system

design that is financially sustainable for providers delivering behavioral health services to high-need members. For providers facing dramatic changes related to physical-behavioral health integration, participating in a joint-ownership partnership can support providers to, as a plan leader said, “define their own destiny rather than have someone else define it for you.” Many behavioral health providers lack the financial capital to manage financial risk across physical and behavioral health care, and are reliant on volume-based services based on specific behavioral health funding streams. Joint-ownership models may enable providers to move toward value-based, coordinated care that advances integration. As a health plan leader in the Arkansas Total Care PASSE said, “Providers want and deserve to play a more active role in population health management and value-based purchasing.” Being a part of an organization like this PASSE gives providers, from the perspective of this plan leader, “more stake in the game and more control in the delivery system and model of care.” A provider leader in a PASSE observed that participating in a joint-ownership model allows behavioral health providers to shape system changes to strengthen their work and potentially avoid provider closures that could reduce access to care.

Ultimately, as a Beacon Health Options interviewee working with both the Arkansas PASSE and Colorado RAE models said, integrating care for those with the most severe needs remains a persistent challenge across the country, with no easy solutions. However, this plan interviewee suggested that “there is no way to advance the ball without engaging providers directly to realign the organizational and financing structures to the clinical redesign needed to drive improved outcomes at the local, community level.” As a plan interviewee in Arkansas Total Care explained, the shared ownership model of the PASSE will help “force innovation and bring creativity to the front” to structure provider reimbursements based on agreed-upon quality measures and incentives that foster the most desirable outcomes. With the evolution of PASSE and other joint-ownership models, their experiences in designing new value-based payment approaches are likely to provide additional valuable insights.



## ELEMENT 2 Ensure stable system transitions for consumers and providers.

Transitioning to new models for financing, delivering, and reimbursing behavioral health services can be disruptive for consumers as well as providers. Successful partnerships, however, can optimize the unique strengths of individual organizations to focus on consumer and community needs and to mitigate transition challenges. Partnerships are well positioned to lead robust stakeholder engagement inclusive of providers, advocates, and consumers. A partnership structure can also create new models for sustainability for behavioral health organizations transitioning to redefined responsibilities.

Partnerships that use consumer and provider input to tailor the transition approach to integrated care can engender greater buy-in among stakeholders. Community-based behavioral health organizations are particularly well positioned to engage consumers and providers to facilitate smoother transitions to integrated care. A behavioral health provider partner in the Health Colorado RAE noted that local behavioral health providers represent the needs of and are accountable to their communities, which fundamentally strengthens their ability to design systems that improve community outcomes. Through its community-based focus, Health Colorado could also more successfully engage cross-sector entities, including schools and criminal justice agencies, to partner with RAE and collaborate on community-wide approaches. While Arkansas Total Care does not include a locally based behavioral health provider among its joint owners, the PASSE did engage advocacy groups, provider associations, and consumers early in its development. A plan partner in the Arkansas Total Care PASSE described the importance of early and frequent conversations with stakeholders to understand their experiences and challenges under the previous system. When the PASSEs transitioned to a full-risk model in 2018 and became responsible for many new services, from this interviewee's perspective "you don't just turn that on, you have to understand the way to

turn it on" — with sustained stakeholder engagement essential to achieving that understanding.

Successful partnerships can support behavioral health providers navigating potentially disruptive transitions and collaboratively solve problems. For behavioral health providers transitioning from billing the state fee-for-service or on a contract basis to billing multiple managed care entities, as in Arkansas's PASSE transition, submitting claims and receiving payment could create major problems for providers operating with narrow margins. Partnerships that actively engage providers may be better positioned to identify these problems early and develop solutions quickly, especially during a transition to new billing systems. A plan interviewee of the Arkansas Total Care PASSE said that "being provider-sponsored caused us to have a higher sensitivity to provider challenges," especially during the transition to becoming fully at risk for all services. In the experience of this plan partner, the dynamic of this partnership model changes how both the plan and providers (including equity partners and other providers) participate. Providers in the Arkansas Total Care PASSE model have been much more engaged in policies and procedures, addressing questions such as how to best ensure that claims are filed and paid. Often these conversations were driven by an immediate operational issue but evolved into a broader conversation about the best strategy to improve providers' ability to deliver care that can improve consumer outcomes.

Additionally, behavioral health provider partners are well positioned to identify and share transition-related problems that consumers experience, which can help partnerships mitigate these issues. When Arkansas providers reported to the Empower PASSE that some members were being placed in the wrong level of services due to statewide challenges in completion of an independent assessment, Empower sought to identify members at risk of incomplete assessments and develop a strategy to complete them. An interviewee at one of Empower's provider partners said that having providers in this leadership role enabled Empower to quickly pivot to develop solutions that better serve consumers and providers. In Oregon, when Jackson

Care Connect CCO shifted the management of the behavioral health benefit and the provision of many specialty mental health services away from Jackson County in 2016, the two organizations collaborated to transition consumers with behavioral health needs to new providers. Jackson County said that partnering with Jackson Care Connect led to a well-designed process that put the needs of vulnerable consumers first, which “helped to minimize the impact” with the goal of “making it as seamless as possible for clientele.”

Finally, as systems continue to evolve, partnerships may create new pathways for sustainability for individual organizations. After transitioning the behavioral health benefit and many services away from Jackson County, Jackson Care Connect CCO in Oregon focused on working with the county to stabilize and explore different ways of maintaining the county’s role as a service provider. Jackson Care Connect began contracting with Jackson County to provide additional services for specific populations, finding that the county brought unique strengths in working with high-need groups, such as young people experiencing early symptoms of psychosis and justice-involved populations. In interviews, both partners described now having shared ownership of the behavioral health system in the county, with greater transparency about their responsibilities and roles. Notably, Jackson County wrote a letter of support for Jackson Care Connect’s 2019 CCO application, which noted “since [Jackson Care Connect] began managing the behavioral health system directly, [their] partnership has grown to even deeper levels.”<sup>20</sup> This testimonial to the strength of their partnership is especially noteworthy given these organizations’ history, with Jackson County experiencing significant organizational disruption and layoffs three years earlier. As another example of new partnership opportunities, when the shared contract to manage the integrated plan for SMI ended in Arizona in 2018, Steward (the health plan that began managing an integrated benefit) developed a new contractual arrangement with NARBHA, the prior regional behavioral health plan, to continue their partnership toward improving care for this population.

### **ELEMENT 3 Marry the expertise of physical and behavioral health partners to create new and enhanced capacities.**

Physical and behavioral health organizations — including both plans and providers — have distinct areas of expertise shaped by the history, culture, and practice of their traditionally independent systems. Successful partnerships to advance integrated care create shared new capacities, expertise, and culture forged by collaboration between partners, providing value greater than the sum of their parts. As a result, these partnerships can leverage their combined expertise to design and implement administrative and clinical processes, and innovations in service delivery, to effectively meet community needs and to improve member health outcomes. In particular, where physical health plans have a leadership role in managing integrated care, such as in Arizona and in Oregon’s Jackson Care Connect CCO, partnerships with behavioral health stakeholders can help the plans to change the culture and underlying capacities of their plans.

Interviewed health plan leaders in both Arizona and Oregon agreed that culture shifts were among the biggest challenges for their organizations in implementing financial integration. In the words of a Jackson Care Connect interviewee from Oregon, it is important “not to underestimate what it takes to change a physical health plan to a global health plan.” Partnerships with behavioral health entities enabled these plans to develop new capacities to manage integrated care, with improved member outcomes. Plan interviewees said that prior to 2016, when Jackson Care Connect delegated the behavioral health benefit to Jackson County, its staff held the entrenched belief that behavioral health would be too different and complex to manage within a traditional physical health plan. When the benefit was carved in, Jackson Care Connect turned to Jackson County for its expertise and adopted county processes to inform Jackson Care Connect’s approach to managing an integrated benefit. Jackson Care Connect’s efforts included (1) conducting comprehensive staff education, (2) incorporating behavioral health processes and providers

into the existing system, and (3) pursuing internal integration of staff and programmatic approaches, including hiring many more social workers to lead teams and drive care coordination, a substantially different model than it previously employed. As a result, Jackson Care Connect reported improved access to mental health services and reduced costs among its members, with the penetration rate for mental health services increasing from approximately 12% to 19%, and an over 9% reduction in the cost per member served.<sup>21</sup>

In Arizona, Steward and NARBHA partnered to codevelop a new integrated care management strategy while preparing their bid for the integrated contract. Based on a member survey that identified flaws in the existing care management strategy for adults with SMI, the partners decided to pursue an integrated approach, leveraging health homes based in community mental health settings. To implement this model and to support physical and behavioral health providers in working together, Health Choice hired new care management staff to be the “glue” between these different provider systems, as many providers did not have staff trained to coordinate across these different services. Among the highest-need tier of members with SMI served in this program, Steward reported overall cost savings of 7% to 8% as a result of major decreases in inpatient spending along with moderate increases in physical and behavioral health outpatient spending.<sup>22</sup> Interviewed plans also reported steady or slightly improved outcomes related to member and provider satisfaction and quality of care.

Partner collaboration may also lead to the design of improved clinical services, such as better referral and coordination pathways between primary care and behavioral health providers. In Arkansas, Empower partners (who manage physical and behavioral health as well as home- and community-based services) are working together to develop a mobile crisis system for individuals with developmental disabilities and behavioral health needs to ensure access to highly responsive services in times of greatest need.<sup>23</sup> By leveraging partners with expertise in acute care as well as community-based behavioral health and IDD

services, Empower is working to develop solutions to complex issues such as addressing ambulance funding for transportation to non-emergency room settings. Empower is also looking to expand telehealth utilization and to implement other innovations to better coordinate care for those with serious physical and/or behavioral health needs.

Similarly, Jackson Care Connect and Jackson County in Oregon are continuously codeveloping new initiatives to serve members with complex health and social needs. For example, the two organizations have collaborated to increase access to medication-assisted treatment, link individuals with co-occurring SUD and physical or mental health needs with other providers, and expand mobile crisis response. Additionally, the partners have collaborated on jail-diversion activities and on developing an outpatient behavioral health forensics team. Jackson Care Connect and Jackson County have worked with other agencies, including the Jackson County Sheriff's Office, to open a Community Justice Resource Center to help members leaving jail or prison to access needed resources. These initiatives demonstrate how a partnership approach may, in the words of a Jackson Care Connect interviewee, “allow for optimizing the strengths of each organization,” and lead to new opportunities for public behavioral health plans to take on a new role, such as focusing on cross-sector collaboration to address key unmet community and member needs.

#### **ELEMENT 4 Allow adequate time for planning and implementation.**

Partnerships benefit from strong alignment between partners related to long-term goals and strategy, but rapidly paced timelines for standing up new integrated care models, as well as unexpected policy shifts, can be particularly destabilizing for these arrangements. Many states have implemented financial integration as part of a multiphase process, but with considerable variation in both in implementation timelines and in transparency about the overall direction of policy change. While interviewed partners described their efforts to adapt to these issues, including through leveraging preexisting relationships, they

also identified adequate time and planning as critically important for stakeholders and policymakers interested in setting up partnerships to succeed.

When a physical and behavioral health partnership model must be achieved on a short timeline, organizations struggle to develop new processes. Partners from different worlds have a lot to learn, and rushed decisions can lead to long-term tensions that hamper collaboration. As a plan interviewee observed, in these models it can be “difficult to reconcile the pace with which government wants to move with the reality of how long it takes to operationalize those challenges.... We need to both have aspirational state regulations and the necessary time to implement them on the ground.” A plan interviewee at one PASSE, Arkansas Total Care, identified one of the most important considerations for state policymakers interested in ensuring access to integrated care as taking the necessary time to “let the model work” and being mindful that “transformational work takes time.” In another Arkansas PASSE, Empower, plan and provider partners both identified the difficulties of adapting to ongoing regulatory changes and described how frequent changes can leave partners as well as the broader provider community struggling to remain focused on big-picture goals.

These challenges can be particularly pronounced for local behavioral health plans and providers that are often smaller than larger physical health partners. Behavioral health providers said that it is hard to commit limited resources to developing new models when policy, regulatory, and contractual requirements can quickly change. As a Health Colorado provider interviewee said, provider partners of the RAE must “shift how they allocate resources to ensure that they are on top of not only what is currently required, but in anticipation of what the state may want them to do in the future.” The uncertainty can lead to inefficiencies and ineffectiveness. This interviewee offered that partners can better work together in models that are “iterative without being unpredictable.” Thus, models should enable innovation while also supporting longer-term investments in system transformation.

Arizona emphasized a transparent integration-rollout process with a multiyear plan for how populations would be phased into an integrated benefit, which may have better positioned partners to navigate challenges. Arizona’s purpose in designing the integrated specialty plan model for physical and behavioral health plans as it did was to *begin* learning how to manage integrated benefits, with the understanding that the initial plans were a transitional product that would be incorporated for the general population at a later date. As an interviewee at Steward described, this approach helped to “ease organizations into the transition toward integration” by phasing in different populations. While the model created some challenges, including for providers navigating new claims and payment policies as well as for partners who had to negotiate new contracts twice in a three-year period, from the perspective of the plan the partnership succeeded in its goal to be “a vehicle to help guide the transition to integration.”

Across different state processes — and especially in those with fast timelines to implement new models — organizations benefit from partnering with established organizational relationships. Multiple interviewees characterized their relationships with partners as going back decades, and said that these preexisting relationships facilitated the development of a new organization. Because partners need to quickly develop bids, governing agreements, and plans, these preexisting relationships can help to accelerate their work. A plan interviewee shared that working with longstanding partners “fundamentally changes the learning curve and relative capabilities of the [participating] organizations.” Whether or not partners have longstanding relationships, strong working relationships are essential. In the words of a behavioral health provider partner, integrated care in Medicaid requires “finding a group of people that can collaborate to create a better system.” As states prepare for major system transitions, they should consider opportunities to seed or otherwise support the development of partnerships that can provide important foundations for long-range strategic goals.

# Looking Ahead

Successful physical-behavioral integration approaches often bring together physical and behavioral health organizations as partners in designing and implementing new models of care. States interested in advancing physical-behavioral health integration in Medicaid, including through developing or refining integrated managed care or ACO models, may benefit from applying the lessons of partnerships that have emerged and matured in other states. Leaders in partnering organizations interviewed for this brief identified key ingredients that can best position these partnerships to succeed in designing, implementing, and improving system changes to meet the comprehensive health needs of members and communities. These lessons reflect the importance of designing an overall policy approach, timeline, and requirements that best position key stakeholders to innovate and achieve more integrated care.

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