

INNOVATIONS IN HEALTH CARE | A TOOLKIT FOR STATE LEGISLATORS

### Overview

As the largest payer of behavioral health services in the United States, Medicaid plays an important role in covering and paying for a broad array of services to address mental illness and substance use disorders. One in five Medicaid enrollees has a behavioral health diagnosis and, when combined with physical health care services, this population accounts for about half of total Medicaid expenditures (see right).<sup>1</sup> Total Medicaid spending for enrollees with a behavioral health diagnosis is nearly four times higher than that for individuals without a diagnosis. This reflects the array of physical conditions, such as asthma or diabetes, that often accompany a behavioral health diagnosis.<sup>2</sup>

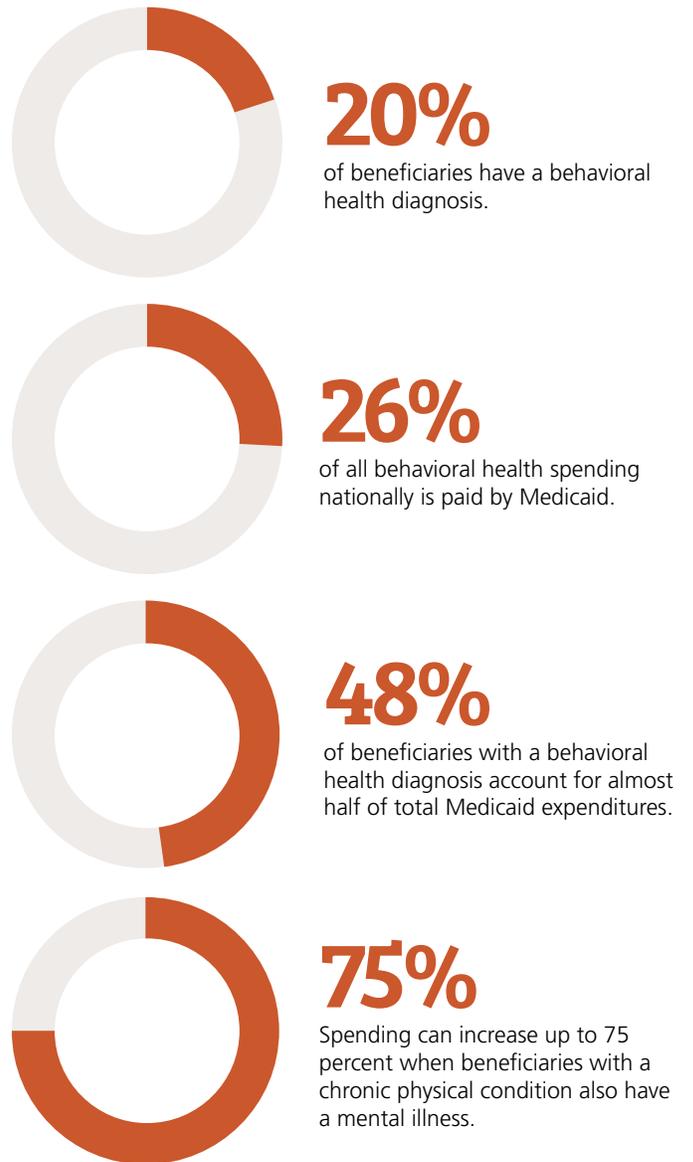
As policymakers consider how to control Medicaid costs and improve health outcomes for the 9 million enrollees with a behavioral health diagnosis and the 3 million with a substance use disorder,<sup>3</sup> many are taking steps to integrate primary and behavioral health care. States have adopted various strategies to address the traditionally fragmented system of care and to integrate behavioral and physical health, including through comprehensive managed care, health homes and accountable care organizations (ACOs).<sup>4</sup>

### How Integration Helps Address Barriers, Improve Care and Reduce Costs

Historically, the health care system has dealt with a person’s physical needs separately from his or her behavioral needs, using different payment structures for each. When care is fragmented and physical needs are treated separately from behavioral ones, it ultimately leads to higher costs and less effective results.<sup>5</sup> An estimated 60 to 70 percent of patients with behavioral health conditions who seek care in emergency rooms or primary care clinics leave without receiving treatment for their mental health or substance abuse needs. This increases the chances that they will have difficulty recovering from those conditions.<sup>6,7</sup> Moreover, a 2017 report by the Milbank Memorial Fund found that only 15 to 25 percent of children with psychiatric disorders receive needed care.<sup>8</sup>

Integrating services can help address these challenges. According to the Centers for Medicare & Medicaid Services (CMS), “Given the prevalence of mental health conditions in the Medicaid population, the high level of Medicaid spending on behavioral health care, and the adverse impact that uncoordinated care can have on people’s health, initiatives to integrate physical and mental health are

### Key Reasons to Integrate Physical and Behavioral Health Services in Medicaid



Sources: Report to Congress on Medicaid and CHIP, Medicaid and CHIP Payment and Access Commission, June 2015; Clarifying Multimorbidity Patterns to Improve Targeting and Delivery on Clinical Services for Medicaid Populations, Center for Health Care Strategies, December 2010.

a top priority for Medicaid agencies.”<sup>9</sup> Effective, integrated care offers better access to individualized treatments, increased collaboration among providers, a decrease in unnecessary emergency services, greater adherence to treatment and increased mental and physical health.<sup>10</sup> The American Psychiatric Association found that integrated behavioral health care can save between 9 percent and 16 percent of the additional costs incurred by patients with behavioral health issues.<sup>11</sup>

## State Examples

States, the federal government and health care providers have made significant investments and enacted a wide range of strategies to integrate physical and behavioral services.<sup>12</sup> Examples of state actions and evidence of their effectiveness follow.

### INTEGRATE BEHAVIORAL HEALTH IN THE PRIMARY CARE SETTING

Primary care settings “have become a gateway for many individuals with behavioral health and primary care needs,” finds the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). To address patients’ needs, primary care providers are integrating behavioral health care services through care managers, behavioral health consultants or consultation models.

States are adopting various strategies to support integration within the primary care setting. For example, in 2015, **Iowa** lawmakers passed [legislation](#) to establish patient-centered medical homes, accountable care organizations and other integrated care models to improve quality and health while reducing health care costs. Legislators required the Department of Public Health to collaborate with Iowa Medicaid and child health specialty clinics to integrate the “1st Five” initiative. It supports health providers in efforts to detect social-emotional and developmental delays in children from birth to age 5, and coordinates referrals, interventions and follow-up. While its long-term effects are not yet available, a 2016 provider survey shows progress toward the initiative’s goal of expanding and supporting the universal use of screening and surveillance tools in health practices. The percent of 1st Five health practices using a high-quality screening tool increased from 40 percent in 2013 to 64 percent in 2016. Almost 90 percent of providers reported that the program helped reduce barriers to implementing surveillance and screening.<sup>13</sup>

### INTEGRATE CARE THROUGH HEALTH HOMES

Some states are integrating physical and mental health care under Medicaid’s primary care health home model. Using an evidence-based collaborative care approach, primary care providers, care managers and psychiatric consultants work together to provide care and monitor patients’ progress. These programs have been shown to be both clinically effective and cost-effective for a variety of mental health conditions, such as anxiety and depression. Community mental health centers are among the providers designated as health homes for Medicaid beneficiaries with serious mental illnesses.

CMS in 2011 approved **Missouri’s** State Plan Amendment to create Community Mental Health Center (CMHC) Healthcare Homes (HCH) for enrollees with serious mental illness. The homes provide care coordination and disease management for chronic conditions. A [2016 analysis](#) found that the program achieved disease management goals, such as improved cholesterol and blood glucose levels for diabetic patients, as well as cost savings of \$20.7 million for all enrollees for the first year of services.<sup>14</sup>

### ADOPT REIMBURSEMENT AND LICENSURE POLICIES TO REMOVE PRACTICE BARRIERS

Several states have enacted reimbursement and portable licensure policies to remove barriers for health care practitioners who provide telehealth services. For example, lawmakers in **Alaska** passed [legislation](#) in 2016 to remove disciplinary sanctions for certain providers, such as psychologists and professional counselors, who practice via telehealth. The law also requires Medicaid to expand the use of telehealth for primary care, behavioral health and urgent care, and establishes demonstration projects to improve the state’s behavioral health system for Medicaid recipients. **Mississippi** and **New Mexico** use statewide telehealth programs to build provider capacity and increase access for both behavioral and physical health services. Early evidence indicates that these programs result in equal or better care when compared to traditional in-person services and may result in cost savings.<sup>15</sup>

### CONSOLIDATE BEHAVIORAL HEALTH AND MEDICAID ADMINISTRATION

Recognizing that separate agencies and funding streams can perpetuate fragmentation, some states have taken steps to consolidate or improve coordination among state agencies responsible for administering Medicaid, social services and behavioral health. For example:

- **Arizona’s** 2015 consolidation of physical and behavioral health under its Medicaid agency led to increased attention to behavioral health integration. It also resulted in more strategic purchasing of health care services for Medicaid enrollees and improved sharing of patients’ health information among providers, along with other positive results, according to a 2017 analysis.<sup>16</sup>
- **Washington** state lawmakers passed legislation in 2018 to transfer oversight of behavioral health programs from the Department of Social and Health Services to the Washington State Health Care Authority, the agency responsible for administering Medicaid. According to [HB 1388](#), “The legislature therefore intends to consolidate state behavioral health care purchasing and oversight within the health care authority, positioning the state to use its full purchasing power to get the greatest value for its investment.” In addition, the law consolidates behavioral health licensing and certification functions within the Department of Health, a move that will “streamline processes leading to improved patient safety outcomes.”

## FACILITATE INTEGRATION THROUGH SECTION 1115 WAIVERS

States design and improve their Medicaid programs within the flexibility allowed under existing federal law, using long-standing tools such as Section 1115 waivers to best meet their state's unique needs. Legislators play important roles by enacting legislation related to Medicaid waivers and engaging with federal partners during waiver development, implementation and oversight.

According to [tracking](#) by the Kaiser Family Foundation, as of August 2018, 23 states were using Section 1115 Medicaid waivers to provide enhanced behavioral health services to targeted groups. They also used the waivers to expand Medicaid eligibility to additional populations with behavioral health needs, fund physical and behavioral health integration and make other delivery system reforms. Sixteen states had pending waiver proposals that included behavioral health provisions. For example:

- **Arizona's Health Care Cost Containment System Section 1115 waiver** provides health care services through a statewide, capitated managed care delivery system for both mandatory and optional Medicaid groups. Federal law [requires](#) state Medicaid programs to cover certain [mandatory](#) populations, such as low-income infants and children who qualify for Medicaid and/or the Children's Health Insurance Program (CHIP) based on income or other guidelines. States are also allowed the option of covering others, such as low-income adults who would not otherwise qualify for coverage. CMS approved Arizona's waiver in September 2016 to integrate physical and behavioral health through regional behavioral health authorities and children's rehabilitative services plans. In January 2017, CMS approved an amendment to establish the [Targeted Investments Program](#), which provides incentive payments to Medicaid providers for increasing physical and behavioral health integration.
- **Delaware's Section 1115 waiver** implemented the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE), a voluntary program that provides enhanced behavioral health services and supports for targeted Medicaid beneficiaries. PROMISE enrollees have severe and persistent mental illnesses and/or a substance use disorders and require home- and community-based services to live and

### Behavioral Health Integration: State Policy Options and Considerations

- Explore policy options for integrated care models that address physical and behavioral health in primary care settings. Examine existing reimbursement policies to identify barriers or options. States may want to examine existing mental health coverage laws to assess whether they create barriers to coverage or access.
- Ensure that state investments in programs aimed at populations with mental health and substance abuse disorders support evidence-based practices. Resources, such as "The Guide to Evidence-Based Practices" by the Substance Abuse and Mental Health Services Administration (SAMSA), identify best practices for treating and preventing mental and substance use disorders.<sup>17</sup>
- Consider using federal Section 1115 waivers to enhance behavioral health services for targeted groups, expand Medicaid eligibility to additional populations with behavioral health needs, fund physical and behavioral health integration, and make other delivery system reforms.
- Adopt reimbursement and portable licensure policies to remove practice barriers for health care providers who provide telehealth services.
- Consider opportunities to facilitate integration at the state level through consolidation or coordination among behavioral health and Medicaid agencies.

work in integrated settings. A 2018 [interim evaluation](#) found that while still in its early stages, PROMISE has started to expand access to behavioral health services.

- **Massachusetts' Section 1115 waiver** implemented a statewide Accountable Care Organization (ACO) aimed at improving integration of care and coordination among providers, reducing the rate of growth in spending and avoidable use of services, and maintaining access and quality.<sup>18</sup>

## Notes

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NCSL Contact:

**Emily Blanford**

Program Principal, NCSL Health Program

303-856-1448

[Emily.Blanford@ncsl.org](mailto:Emily.Blanford@ncsl.org)

*Kristine Goodwin contributed to this report.*

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**William T. Pound, Executive Director**

7700 East First Place, Denver, Colorado 80230, 303-364-7700 | 444 North Capitol Street, N.W., Suite 515, Washington, D.C. 20001, 202-624-5400

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