MATHEMATICA Policy Research

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Integrating Care for People with Behavioral Health Needs

Mathematica's case studies of physical and behavioral health programs in Louisiana, North Carolina, Pennsylvania, Tennessee, and Vermont highlight key features of each program. These studies can offer insights for other states and communities seeking to integrate care.

In response to concerns over the poor quality of care for individuals with mental health and substance use disorders, more states and communities are working to better integrate and coordinate care for people with behavioral health conditions. Several strategies are being used to improve care coordination. One approach is to integrate behavioral and physical health benefits within Medicaid managed care arrangements. Another is to take advantage of enhanced primary care case management (PCCM) programs; these programs offer financial incentives for primary care providers to coordinate care and function as medical homes. Some communities are also reorganizing delivery systems to place physical health providers in behavioral health care settings. States and communities may draw lessons from or adapt aspects of each of these approaches based on their own financing and delivery systems.

The Office of the Assistant Secretary for Planning and Evaluation engaged Mathematica Policy Research to conduct case studies of four programs in Louisiana, North Carolina, Tennessee, and Vermont. Each program had distinct strategies to improve the integration and coordination of care for adults with behavioral health conditions. Mathematica also conducted a case study of Behavioral Health Home Plus, a pilot program that trained behavioral health staff and integrated nurses to provide wellness services in two behavioral health agencies in rural Pennsylvania.

STRATEGIES FOR INTEGRATING CARE

The five programs used two main approaches to integrate physical and behavioral health care, although each program used different funding streams and strategies to organize and deliver care. Some states, including Louisiana and Tennessee, have made substantial changes in their Medicaid managed care arrangements to improve care coordination.

- **Louisiana.** One managed care organization oversees the delivery of specialty mental health and substance abuse services for Medicaid and non-Medicaid populations.
- **Tennessee.** The state requires that all Medicaid managed care organizations take responsibility for physical and behavioral health benefits. It also recently integrated long-term care services into its managed care contracts.

Other states, including North Carolina, Vermont, and Pennsylvania, have adopted strategies to transform primary care practices or behavioral health agencies into comprehensive service providers.

- **North Carolina.** The state uses enhanced PCCM to coordinate services for Medicaid beneficiaries and to help primary care providers function as medical homes for people with behavioral health conditions.

Common Features Across States Integrating Care:

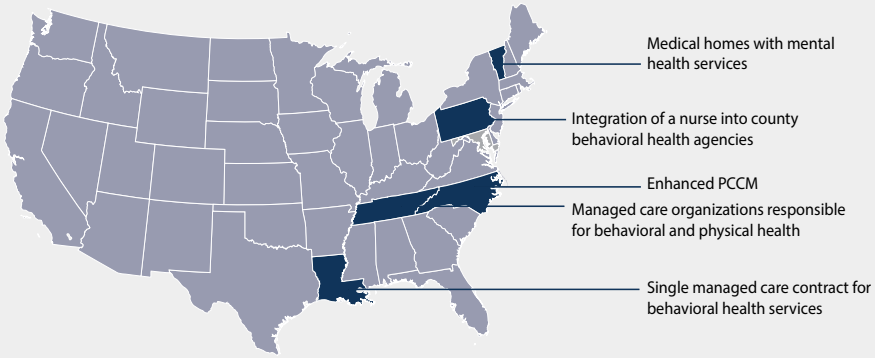
Financing services creatively

Broadening services and supports

Using information systems

Monitoring quality and improvement

Strategies for Integrating Care in Five States



- **Vermont.** As part of a statewide multipayer initiative, Vermont is working to transform primary care practices into medical homes that provide basic mental health services and support community health teams.
- **Pennsylvania.** One of the Medicaid behavioral health managed care organizations pays an enhanced case management rate to county behavioral health agencies to hire a nurse, conduct training in wellness coaching, and use a web-based portal for tracking health behaviors.

COMMON FEATURES

The five programs share some similar features that may be useful for other states and communities to consider, including:

- **Financing services creatively.** The states use a range of funding mechanisms to better coordinate and integrate physical and behavioral health care. For example, some states pool funding across state agencies or health care payers. Other states rely exclusively on federal waivers for Medicaid to fund services. States have also relied on state, federal, and private grants to get their program off the ground or to fund certain initiatives.
- **Broadening available services and supports.** Each program seeks to connect people with an array of state- and community-funded social services such as housing and employment assistance. For example, both Louisiana and Tennessee are adding supportive housing services to their managed care arrangements.
- **Using information systems.** Several programs are either providing an electronic health record (EHR) platform or encouraging providers to use EHRs and other information technologies, such as web portals and registries, to share patient information, coordinate care, and inform clinical decision making.
- **Monitoring quality and improvement.** Several programs have used a variety of quality-improvement strategies to help meet program goals. The collection of data and the use of information systems are critical components of the programs. Several of the programs encourage, but do not require, the use of EHRs and are drawing on data from these and other systems to monitor the quality of care. This ongoing monitoring makes it possible to better evaluate the impact of financing and delivery system changes on care quality and costs.

For details on the programs, please see the full reports:

http://aspe.hhs.gov/daltcp/reports/2014/4CaseStudes.shtml

http://aspe.hhs.gov/daltcp/reports/2014/ruralPAes.shtml

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