“Behavioral health integration initiatives in state Medicaid for children with special health care needs”

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This dashboard includes information on state Medicaid programs that cover children with special health care needs (CSHCN).

These maps focus on Medicaid because nearly half of the CSHCN in the U.S. are publicly insured through Medicaid. And many states use Medicaid programs as a first step to initiate change in publicly and privately insured CSHCN. Because eligibility expansions for CSHCN are optional, the number of CSHCN covered by Medicaid varies by state. Using state plan amendments or Medicaid waivers, states have the flexibility to advance behavioral health integration by revising policies and reforming payment arrangements within their managed care plans.

Successful delivery of behavioral health services requires that underlying policies support behavioral health integration. As state Medicaid programs shift towards managed care delivery systems to serve CSHCN, it is critical that appropriate strategies are in place to combat barriers to integration.

Many states rely on their Medicaid managed care as the foundation for care provision initiatives. Given the increased need for behavioral health care, it is necessary that state Medicaid managed care programs make behavioral health services accessible for CSHCN. Alternative payment models, performance measurement, information sharing, and specific integration mechanisms are used by state Medicaid managed care programs to encourage integration of behavioral health into pediatric patient-centered medical homes.

The following maps highlight Medicaid managed care policies that support behavioral health integration. States have a varying number of strategies in place to support behavioral health integration in CSHCN. Three states do not use any of these strategies and only cover CHSCN under fee-for-service (FFS) programs.

Best practices to encourage behavioral health integration fall under four categories: payment, measurement, information sharing, and coordination.

1) **Payment:** Medical and behavioral benefits should be combined into one payment pool (Kathol *et al*., 2010; Baird *et al*., 2014) and behavioral health carve-outs should be eliminated (Ader *et al*., 2015; Soper, 2016). Pay-for-performance methods should be introduced, individual payments should be adjusted for care complexity, and payment should be tiered to reward practices with a higher degree of behavioral health integration (Asarnow *et al*., 2017; Bao *et al*., 2013; Knutson and Rajkumar, 2020).

2) **Measurement:** Desired population-based health outcomes should be defined, measured, and consistently reviewed (Kathol *et al*., 2014). Systematic tracking of outcomes should be used to continuously improve the care delivery system (Asarnow *et al*., 2017). These measurements should also facilitate performance-based payment models.

3) **Information sharing:** Medical records should enable streamlined information sharing between all members of the care team (Baird *et al*., 2013). Regulatory and legal barriers should be addressed, and procedures should be put in place to ensure seamless access to behavioral health services for all patients (Kessler *et al*., 2009). Medical and behavioral electronic health records (EHRs), registries, and claims data should be combined and used to identify patients with more complex behavioral health care needs (Kathol *et al*., 2014).

4) **Coordination:** Successful behavioral health integration requires the workforce is appropriately trained (Kessler *et al*., 2009). All team members, including behavioral health clinicians, should be trained and accountable for patient health outcomes (Kessler *et al*., 2009; Mauer and Druss, 2009). Practice-based team training should be used to develop effective communication tools, promote continuity of care, address workflow problems, and define care member roles (Ader *et al*., 2015; Asarnow *et al*., 2017). Medical records, funding streams, decision-making, and revenue streams should all be shared (Baird *et al*., 2013).

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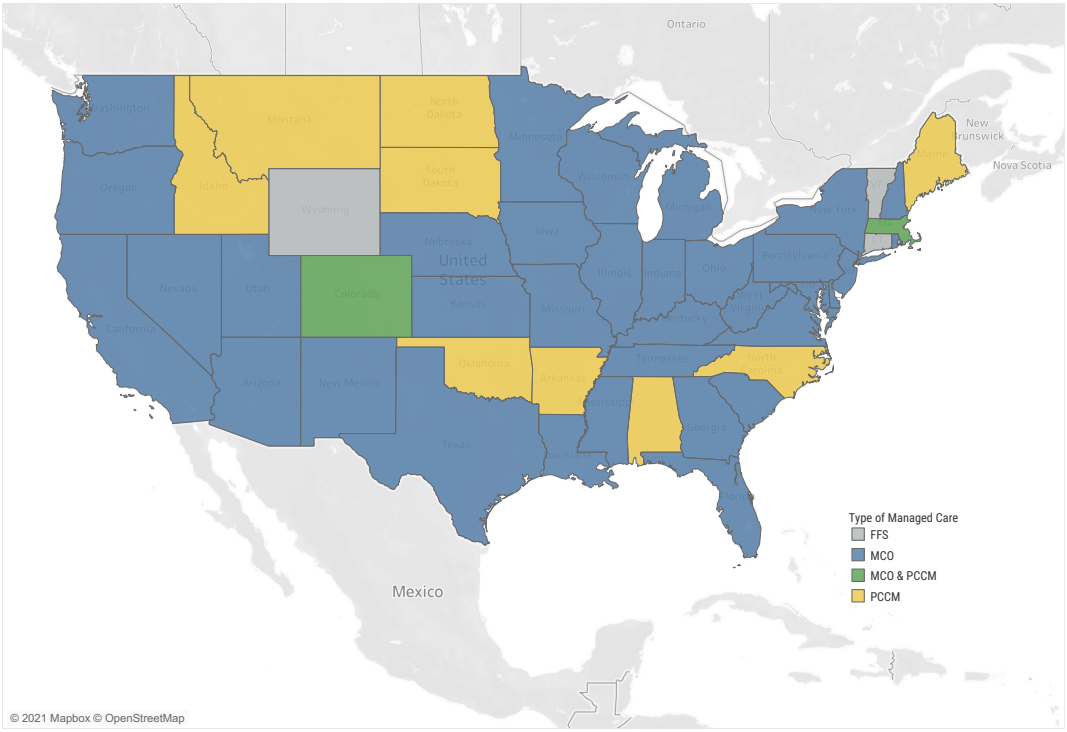
State Summary of Medicaid Policies for Behavioral Health Care in CSHCN



Type of Managed Care
All

Enrollment
All

PCMH
All

Health Home
All

Case Management
All

Provision of BH services
All

Alternative Payment Methods Related to BH
All

HEDIS
All

Publicly Available Comparison Data
All

Information Exchange Across Practice Settings
All

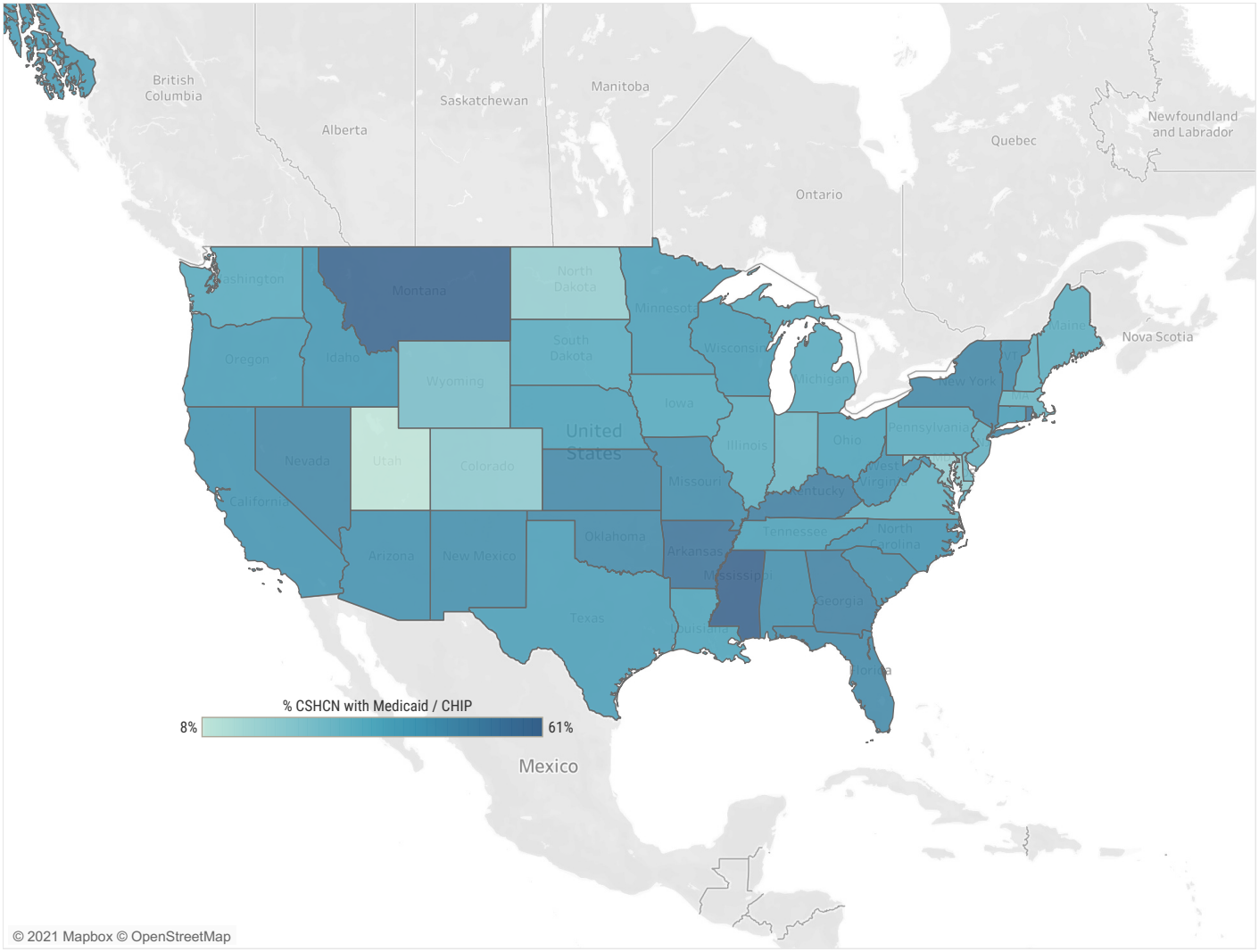
Information Exchange with other Agencies
All

Care Coordination
All

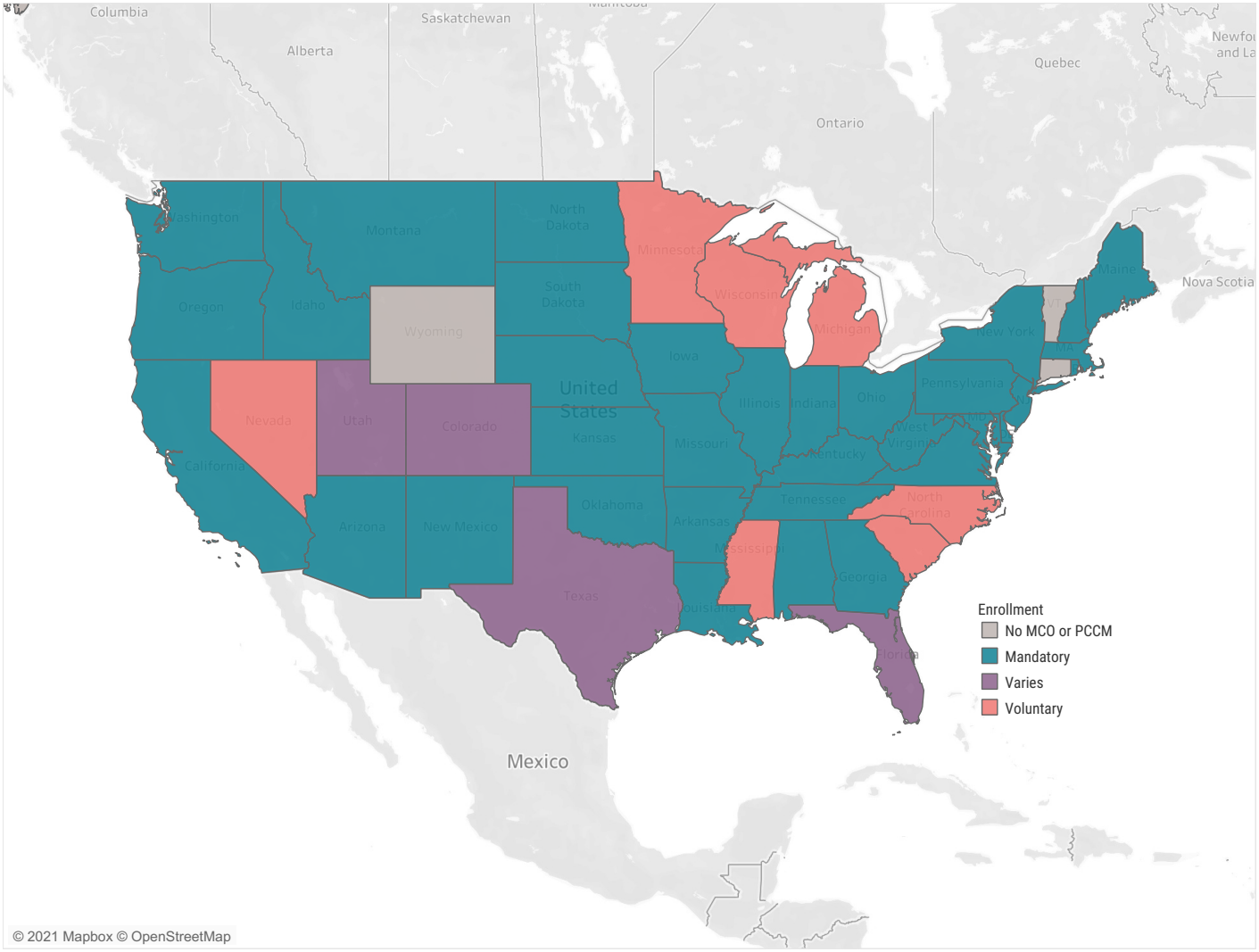
Care Coordination for CSHCN
All

Team Care or Co-Location
All

Percent of CSHCN in Medicaid



Enrollment


Columbia
Saskatchewan
Alberta
Quebec
Ontario
Nova Scotia
Washington
Montana
North Dakota
Minnesota
Oregon
Idaho
South Dakota
Wisconsin
Michigan
Wyoming
Iowa
New York
Maine
Nevada
Utah
Colorado
United States
Illinois
Indiana
Ohio
Pennsylvania
California
Kansas
Missouri
West Virginia
Kentucky
Oklahoma
Tennessee
North Carolina
Arizona
New Mexico
Arkansas
Mississippi
Georgia
Texas
Louisiana
Florida
Mexico
Enrollment
No MCO or PCCM
Mandatory
Varies
Voluntary
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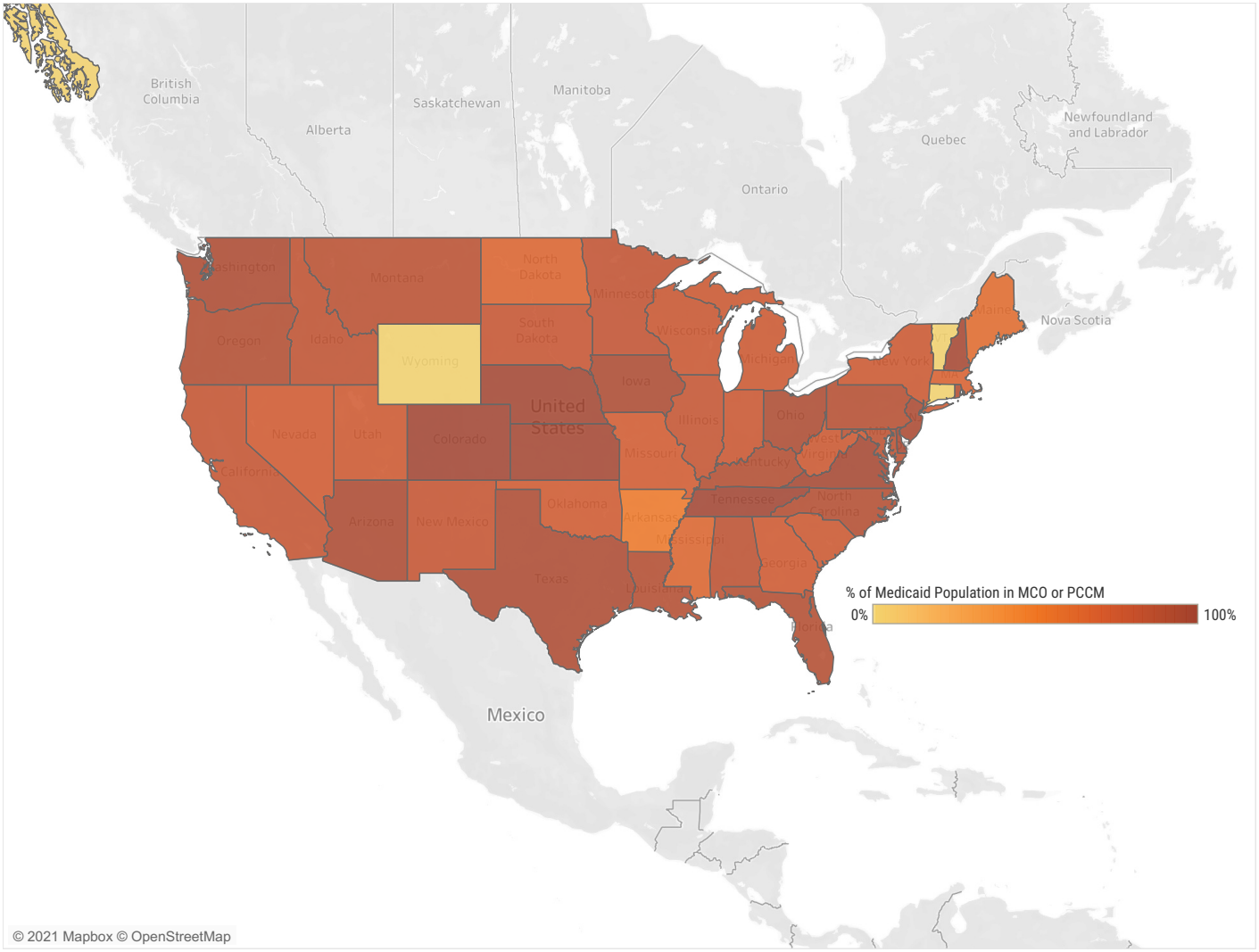
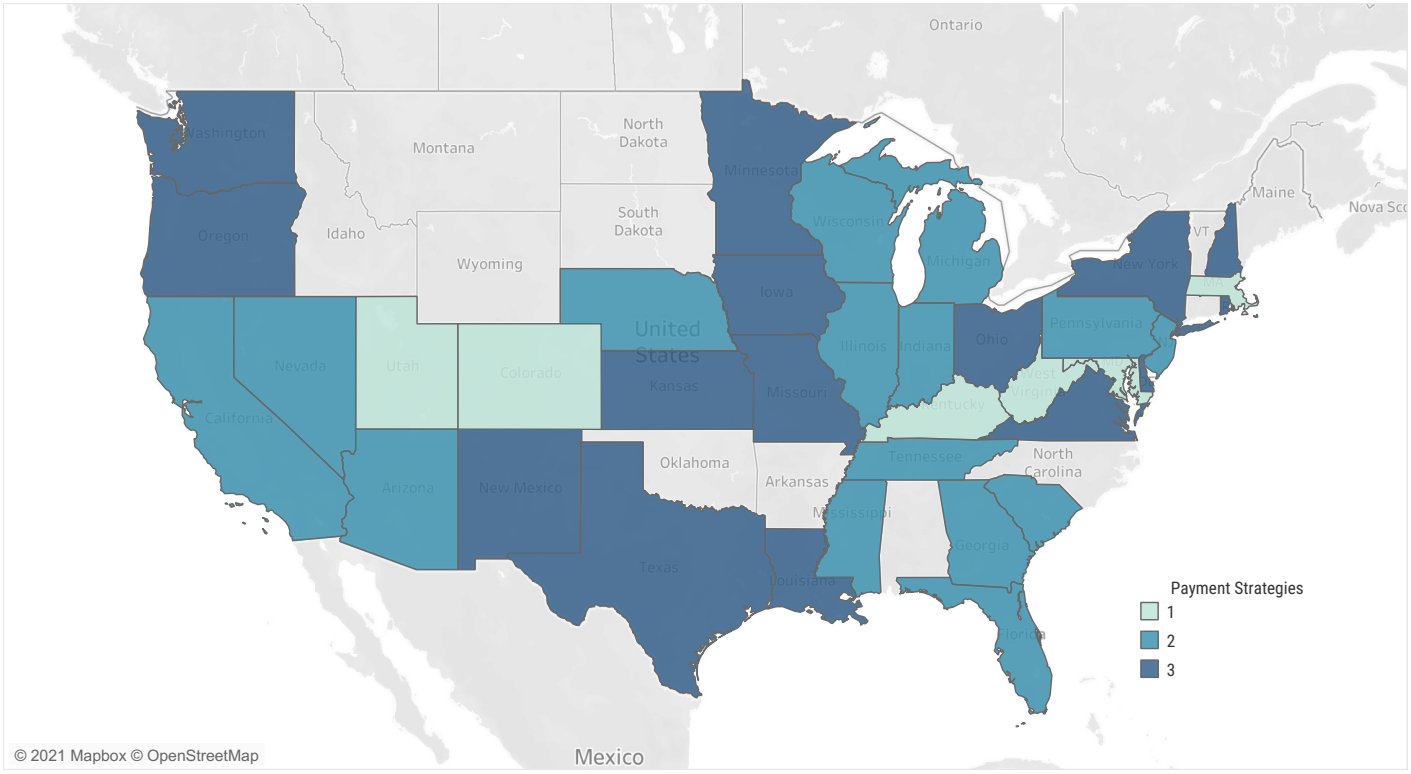
Percent of Medicaid in Managed Care (MCO or PCCM)



Payment Initatives

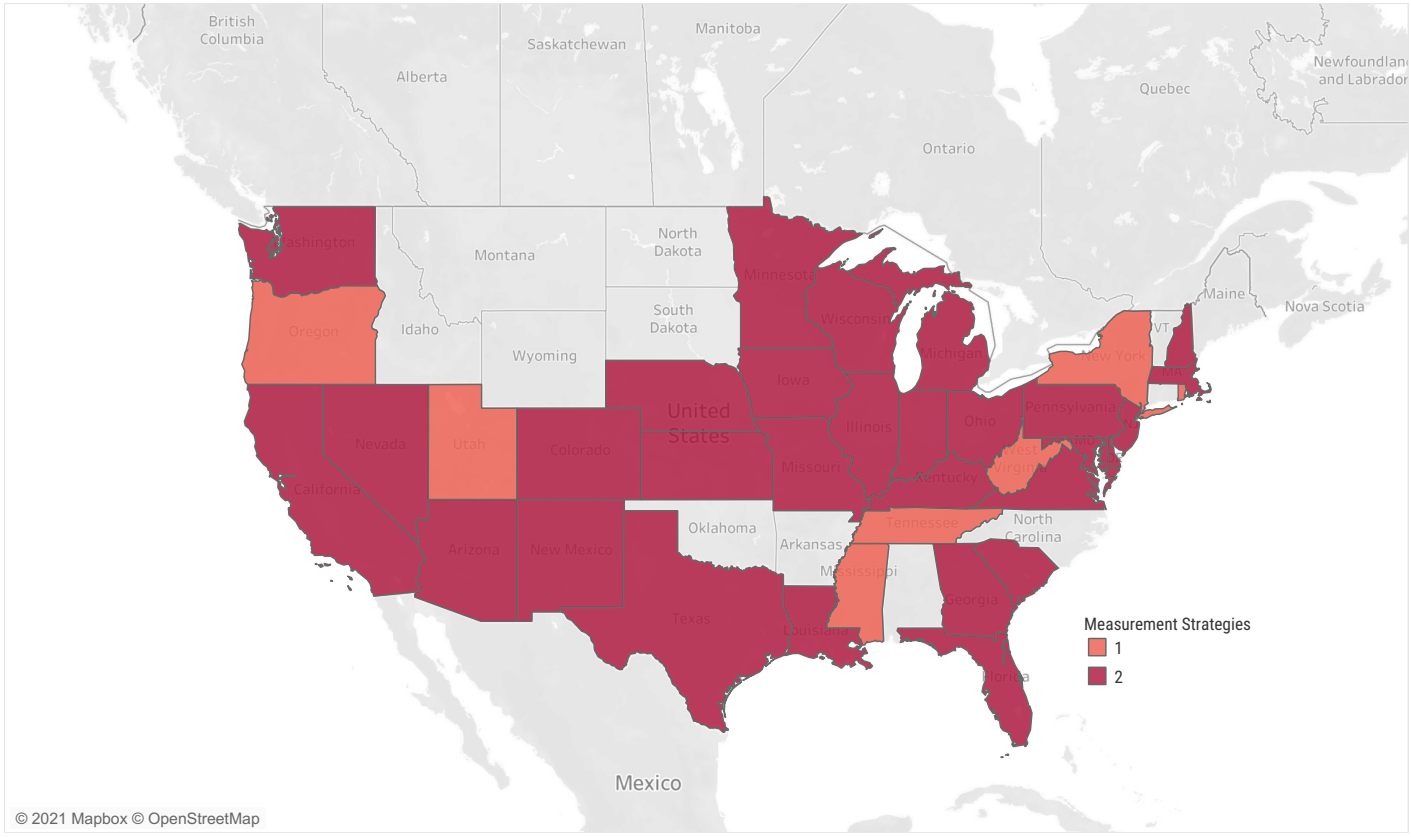


Case Management
All

Provision of BH services
All

Alternative Payment Methods Related to BH
All

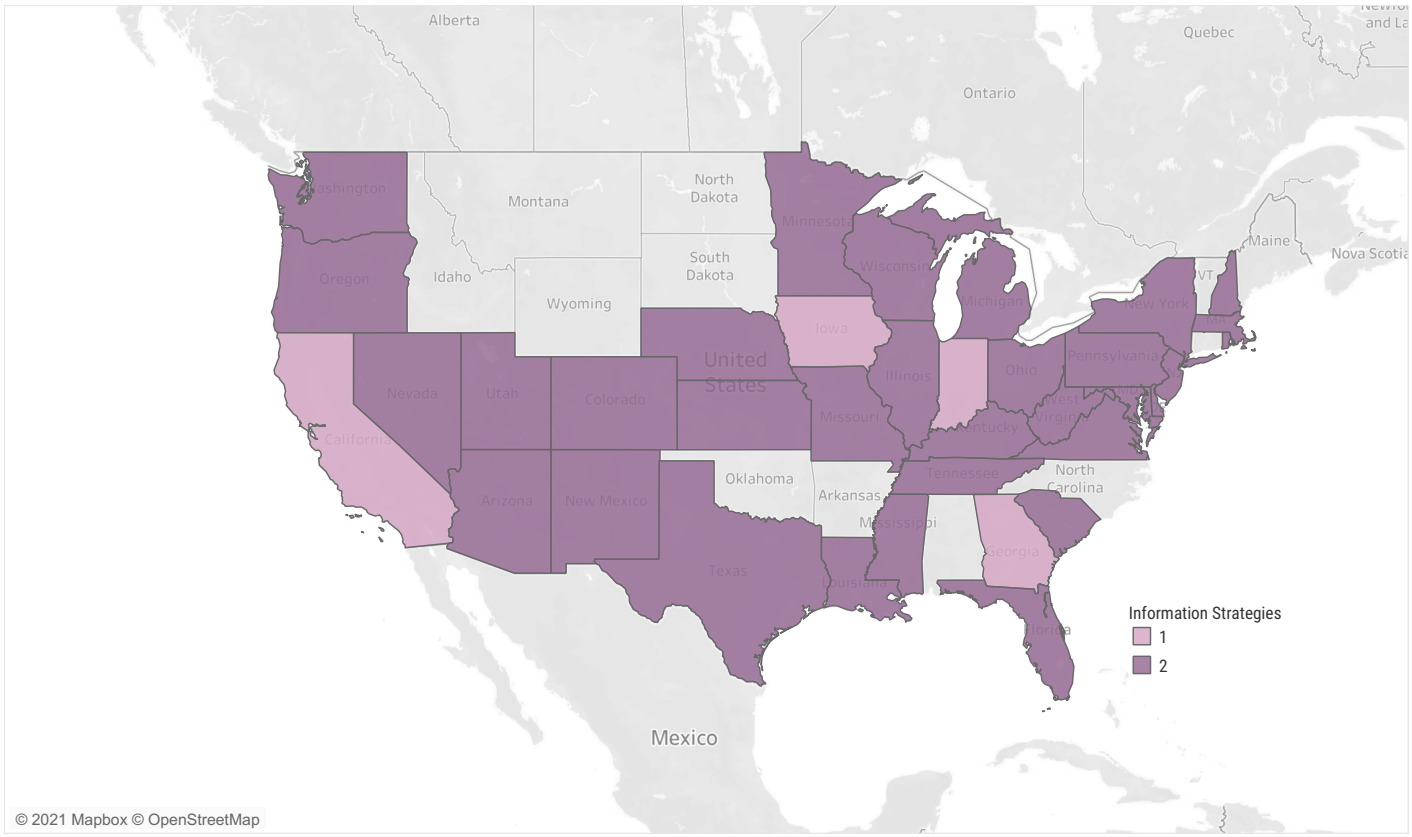
Measurement



HEDIS
All

Publicly Available Comparison Data About MCOs
All

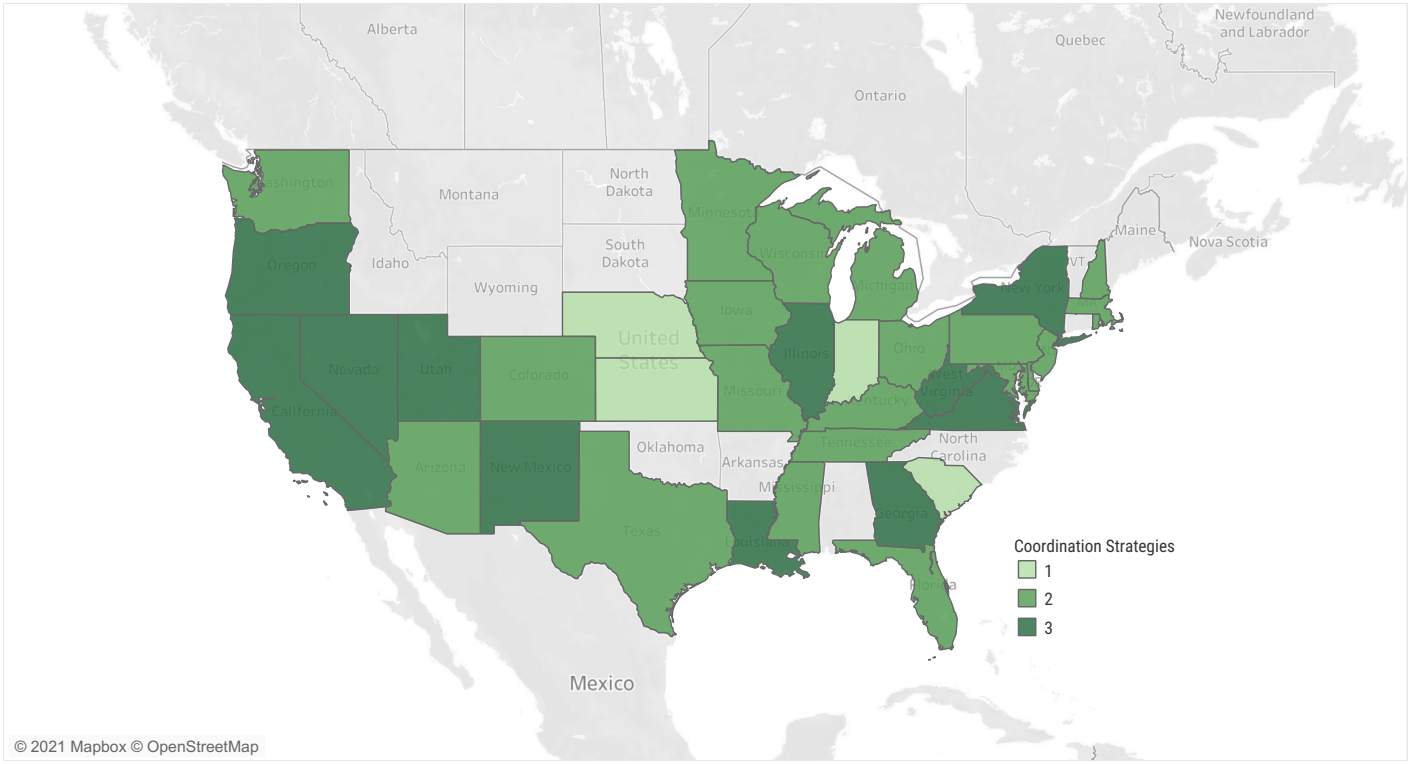
Information Sharing in MCOs



Information Exchange of One or More Types of Clinical Care Information Across Professional Practice Settings
All

Information Exchange with other Agencies and Programs
All

Coordination

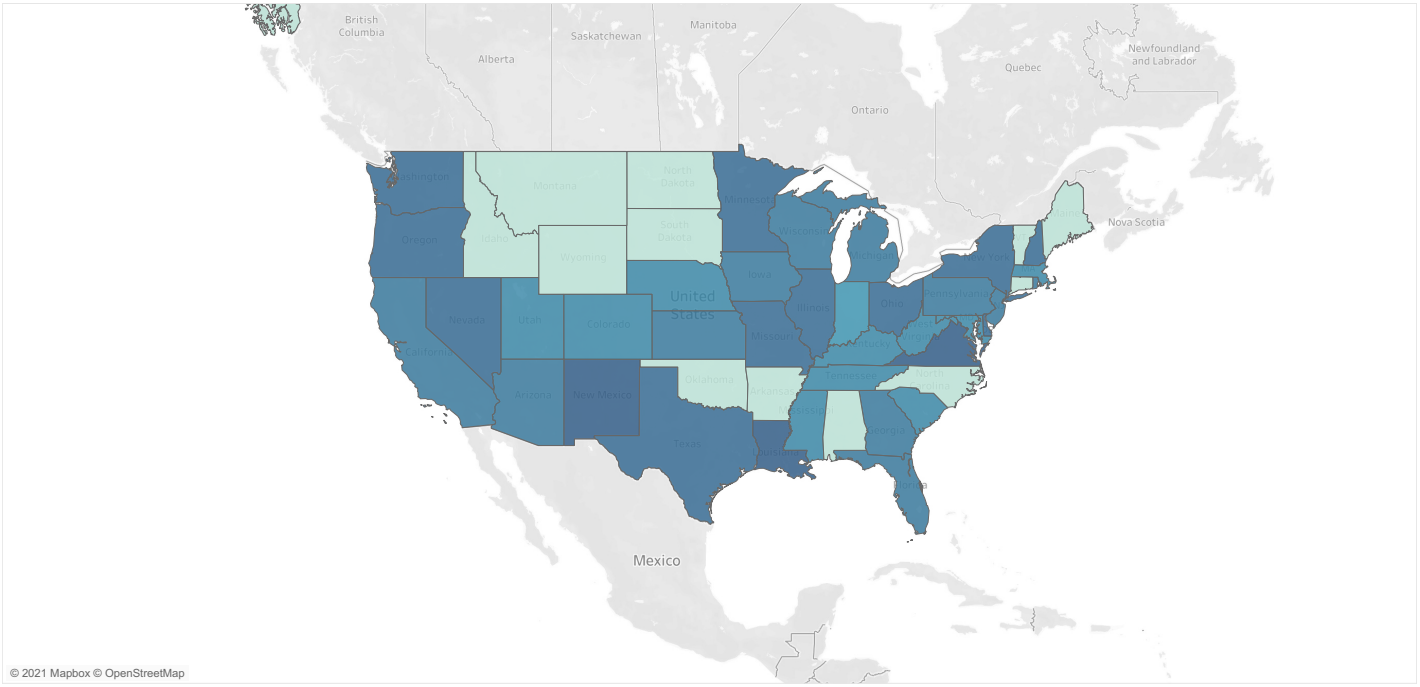


Team Care or Co-Location
All

Care Coordination
All

Care Coordination for CSHCN
All

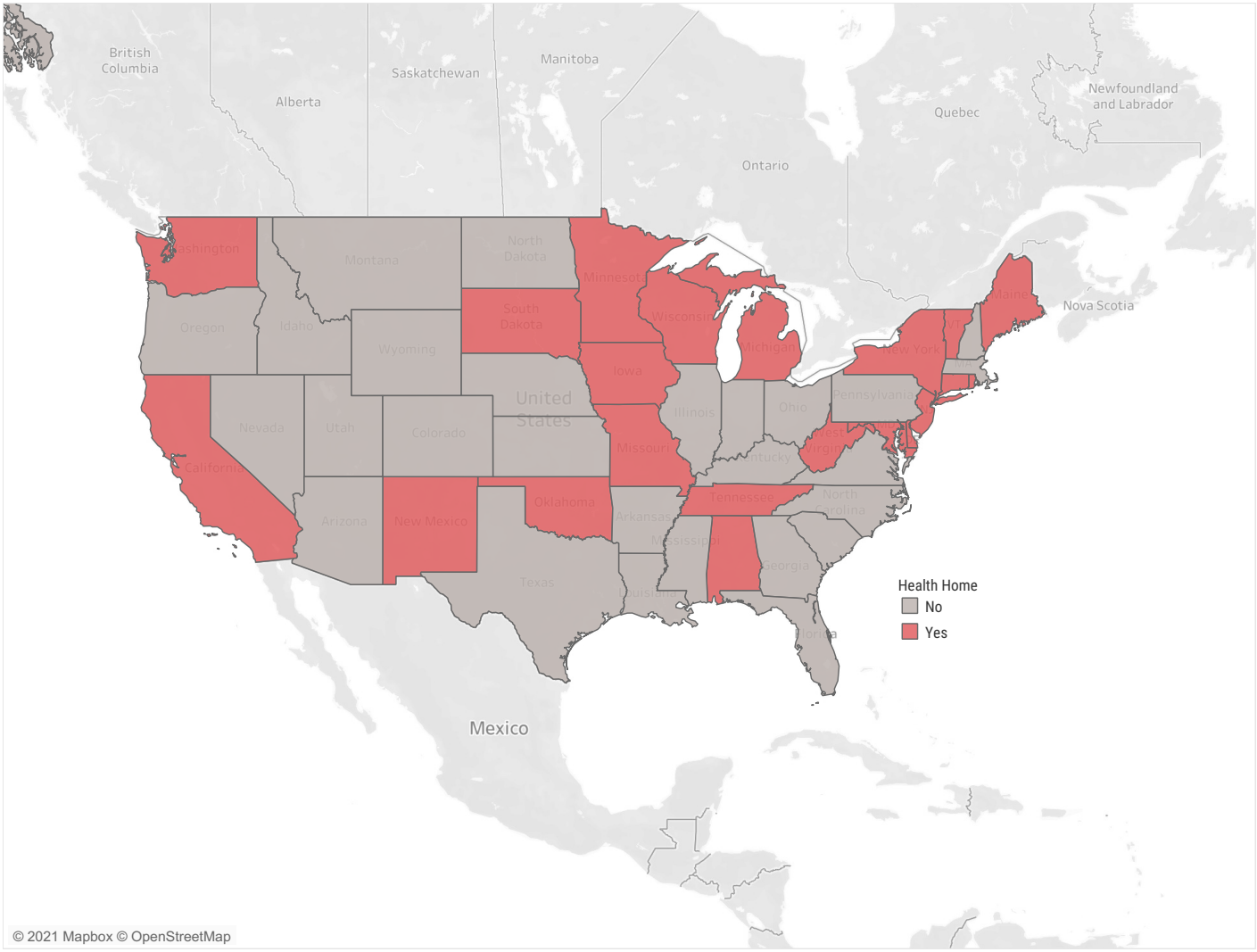
Payment, Measurement, Information, and Integration



# of selected initiatives in place in state MCO

0 10

Health Homes



References

Ader, J., Stille, C. J., Keller, D., Miller, B. F., Barr, M. S., & Perrin, J. M. (2015). The medical home and integrated behavioral health: advancing the policy agenda. *Pediatrics*, *135*(5), 909-917.

Asarnow, J. R., Kolko, D. J., Miranda, J., & Kazak, A. E. (2017). The pediatric patient-centered medical home: innovative models for improving behavioral health. *American Psychologist*, *72*(1), 13.

Baird, M., Blount, A., & Brungardt, S. (2014). The Working Party Group on Integrated Behavioral Healthcare. Joint principles: integrating behavioral health care into the patient-centered medical home. *Ann Fam Med*, *12*(2), 183-185.

Bao, Y., Casalino, L. P., & Pincus, H. A. (2013). Behavioral health and health care reform models: patient-centered medical home, health home, and accountable care organization. *The journal of behavioral health services & research*, *40*(1), 121-132.

Kathol, R. G., Butler, M., McAlpine, D. D., & Kane, R. L. (2010). Barriers to physical and mental condition integrated service delivery. *Psychosomatic medicine*, *72*(6), 511-518.

Kathol, R. G., Degruy, F., & Rollman, B. L. (2014). Value-based financially sustainable behavioral health components in patient-centered medical homes. *The Annals of Family Medicine*, *12*(2), 172-175.

Kessler, R., Stafford, D., & Messier, R. (2009). The problem of integrating behavioral health in the medical home and the questions it leads to. *Journal of clinical psychology in medical settings*, *16*(1), 4-12.

Knutson, K. and Rajkumar, R. (2020). Behavioral Health: A Payer-Based Strategy For Improving Access And Quality During COVID-19 And Beyond. Health Affairs.

Mauer, B. J., & Druss, B. G. (2010). Mind and body reunited: Improving care at the behavioral and primary healthcare interface. *The journal of behavioral health services & research*, *37*(4), 529-542. Soper, M. H. (2016). *Integrating behavioral health into Medicaid managed care: design and implementation lessons from state innovators*. Center for Health Care Strategies, Incorporated.