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Financial integration of behavioral health in Medicaid managed care organizations: A new taxonomy

States are moving away from behavioral health carve-out models to an "integrated" framework. This taxonomy maps out the variety of new arrangements states are testing out

Many state Medicaid programs are moving toward models that integrate the financing of behavioral and physical health care for their beneficiaries. Integration efforts can occur at two levels: at the clinic (or delivery system) level, and at the health plan level. A large body of research has identified the benefits of delivery system integration and has outlined a variety of models and taxonomies for these efforts. Less has been written about financial integration for Medicaid programs, even though these efforts vary significantly in the services provided, the populations covered, and other contracting arrangements.

In this brief, we propose a taxonomy to define the key features of financial integration efforts and demonstrate how state programs can be classified. This taxonomy is intended to serve two purposes. First, it should allow researchers and state administrators to group states according to key policy features, providing a mechanism to compare and contrast different models along a limited number of dimensions. Second, the taxonomy should provide a framework for testing hypotheses for outcomes across different populations and programs.

Background on carve-outs and behavioral health integration

The interest in financial integration of behavioral health represents a shift from carve-out arrangements that have been common in Medicaid going back to the 1990s. In a carve-out arrangement, behavioral and physical health services are reimbursed and administered by separate Medicaid managed care organizations (MCOs). For many years, carve-outs were seen as a promising mechanism for protecting funding for behavioral health care, establishing specialty provider networks, and in

KEY POINTS

- Behavioral health carve-outs, once seen as a reliable way to control spending while securing funding and access for behavioral health services, are often viewed as an impediment to integrating behavioral and physical health services at the clinical level.
- New federal policies create incentives to integrate behavioral and physical health care
- Integratrion can take many forms. We provide a taxonomy and highlight efforts by five states.

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States with managed care contracting carved in some or all of their behavioral health services in 2019 (including the District of Columbia).[4]

the commercial market, mitigating adverse selection, where, in the absence of a carve-out, patients with mental health conditions might be more likely to choose plans with more generous coverage, creating incentives for plans to limit their behavioral health benefits.

However, policy directions have changed. Carve-outs are now perceived as a barrier to integrating the delivery of behavioral and general medical and surgical care. Separate financing of care may inhibit reimbursement for services that include physical and mental health, create challenges in referring patients from primary care to mental health specialists (and vice versa), impede communication across systems, and, more generally, hamper the aspirational potential of integrated care.

CMS developments in 2016 set the stage for change

The shift from "carving out" to "carving in" reflects, in part, an appreciation of the evidence base for clinically integrated care models. Interest in carve-in models may also reflect responses to two federal policies instituted in 2016.

Mental health parity rule alters administrative incentives

First, the Center for Medicare and Medicaid Services (CMS) issued its **managed care mental health parity final rule (81 FR 18389),** which clarified and aligned rules in Medicaid with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

The MHPAEA had established a new era for coverage of behavioral health conditions. Substantially more comprehensive than the previous federal parity law, and considerably stronger than most state parity laws, it required plans that cover mental health and substance abuse services to offer benefits for those services at the same level as benefits for medical-surgical services. Although the law became effective in October 2009, regulations covering its implementation in Medicaid were not finalized until CMS released the final parity rule in 2016.

The way the final parity rule assigned responsibility for MHPAEA compliance also had administrative implications for behavioral health contracting. In states using carve-ins, where MCOs integrate medical/surgical and mental health and substance use disorder (SUD) benefits, the rule puts responsibility for parity analysis and compliance on MCOs. However, in states where behavioral health benefits are carved out, this responsibility lies with the state.[1] This policy, then, placed an extra administrative and financial burden on states with carve-outs and provided an incentive to move toward integrated models.[2]

Managed-care rule adds integration features

The second rule of import was CMS's **2016 Medicaid and CHIP managed care final rule (85 FR 72754).** This rule included a large number of changes, many of which indirectly supported the move to integrated care. For example, the final rule enhanced support for care coordination, an essential component of integrated care. The rule also required MCOs to complete an initial health risk assessment for new beneficiaries within 90 days of enrollment and to ensure that individuals could make smooth transitions between settings of care.[3] These requirements were closely aligned with principles of integrated care.

With new models, the need for a new classification system

Regulatory changes and shifts in financing of behavioral health among MCOs can have considerable implications for millions of Americans covered by Medicaid. Within Medicaid, managed care is predominant, with 39 states and the District of Columbia contracting with MCOs.[4] Among these 39 states and the District of Columbia, in 2019, only six carved out all of their behavioral health services (CA, CO, MD, MI, PA, UT).

Carve-out arrangements have increasingly been perceived as a barrier to better outcomes for Medicaid enrollees.

However, states have chosen heterogeneous paths when implementing financial integration. For example, 22 states carved in all of their behavioral health services, while 10 states and the District of Columbia varied in the types of services (inpatient, outpatient, specialty) they carved in. In addition, some states use carve-ins only for selected populations (e.g., individuals with serious mental illness), while others carve in broad populations but allow MCOs to subcontract with behavioral health organizations, resulting in a type of *de facto* carve-out arrangement. To effectively compare these different configurations, a new taxonomy is needed.

Classifying integration efforts through four dimensions

Our proposed taxonomy is based on four dimensions: (1) contracting models used to integrate behavioral health services, (2) level of financial risk, (3) populations covered, and (4) services covered. Table 1 summarizes this taxonomy, including the four broad dimensions, their configurations, and sample considerations for each. This taxonomy builds on previous efforts to describe behavioral health integration.[4,5]

1. Contracting Models

An important differentiator between states and their approach to behavioral health is **whether they choose to carve out or carve in (e.g., financially integrate) behavioral health services.** Under a carve-out arrangement, the state Medicaid agency contracts with a behavioral health organization (BHO). Advocates for the carve-out mechanism cite several advantages to this model.

First, MCOs focused on general medical and surgical care might not understand the nuances of behavioral health conditions. Second, these MCOs might have difficulties establishing specialty behavioral health provider networks. Finally, advocates have expressed concerns that a blending of funds might favor physical health services at the expense of needed mental health services.

However, carve-out arrangements have increasingly been perceived as a barrier to better outcomes for Medicaid enrollees.[6–10] The belief that clinically integrated care may be incompatible with separate financing of mental and physical health services is partially responsible for a shift to carving in behavioral health services.

The decision to carve in or carve out behavioral health services is typically viewed as a binary choice. However, many MCOs and states adopt a third option, carving in behavioral health at the state level but allowing subcontracting at the MCO level.

Frank and Gruber denote these arrangements as "health plan carve-outs."[11] Under this scenario, the state contracts with MCOs to provide comprehensive medical and behavioral health care, but the MCO subcontracts with another entity (perhaps a BHO or a county mental health system) for behavioral health services.

In this case, the MCO appears to have financially integrated care from the outside. In reality, mental health and physical health are managed separately, resulting in a *de facto* carve-out arrangement.

2. Level of financial risk

States have several financial risk options. Capitation is the predominant mechanism for contracting with MCOs. States also may contract with some entities and use an administrative services only (ASO) contract, in which a third-party entity is responsible for contracting with and paying providers, but the state (not the health plan or third-party entity) is at financial risk for those claims. A third option is a blend of fee-for-service (FFS) and capitation payments. For example, in the Primary Care Case Management (PCCM)

Table 1

A TAXONOMY OF FINANCIAL INTEGRATION OF BEHAVIORAL HEALTH IN MEDICAID

INTEGRATION DIMENSION	CONFIGURATIONS AND CONSIDERATIONS
Contracting Models 	**Carved-Out** Preserves dedicated financing for behavioral health **Fully integrated with no subcontracting** Designed to facilitate clinical integration of general medical/surgical care and behavioral health care **Integrated but subcontracting allowed** May achieve financial integration from state's perspective but maintain some aspects of a de facto carve-out
Financial Risk 	**Full capitation** Typical arrangement for most MCOs and behavioral health organizations **Partial risk** Possible arrangement that may can reduce risk exposure; may be more attractive to smaller entities **Administrative services only (ASO)** State bears financial risk. May be advantageous for insuring that certain services are covered in full, without concerns of prior authorization or utilization management
Covered Populations 	**Full capitation** Integration model does not differentiate between patient types **Individuals with SMI** Recognizes that individuals with SMI may have specialized provider networks and health needs **Children only** Integration model may be tailored for children with special mental health needs **Adults only** Integration model may apply to adults only
Covered Services 	• Specialty Outpatient (Mental Health) • Inpatient (Mental Health) • Pharmacy (Mental Health) • Crisis services (Mental Health) • Specialty Outpatient (Substance Use Disorder) • Inpatient (Substance Use Disorder) • Pharmacy (Substance Use Disorder) States may vary in which of these services fall under integration. For example, some may integrate outpatient and inpatient services but carve-out pharmacy services as a mechanism to preserve access to medications without concerns for prior authorization restrictions

model, a primary care provider would be responsible for the care of enrolled Medicaid beneficiaries, typically for a small monthly case management fee in addition to FFS reimbursement for treatment. The case management fee could include responsibility for behavioral health services. Under PCCM, providers are not at financial risk.

3. Populations covered

States can apply integration models to their population broadly or select specific populations to be covered under integrated contracts or to be excluded and managed under a carve-out arrangement. Two standard considerations are whether to create separate programs for adults versus children and individuals with moderate versus serious mental illness (SMI).

4. Services covered

States may use integrated models to comprehensively cover services or focus their carve-in efforts on specific areas. States may also separate the management of mental health and SUD treatment. They may further differentiate among inpatient, specialty outpatient, and pharmacy coverage within mental health and SUD treatment. Some states also hold out mental health crisis services.

We note that these are general assessments. Many states have particular exceptions for long-term care, American Indian populations, and children in foster care. Our taxonomy does not comprehensively cover the options for these populations and services.

State Integration Efforts

To better understand the diversity of approaches to behavioral health care, we conducted a review of Medicaid state agency websites, approved waivers, program evaluations, and other publicly available sources. We highlight selected states to demonstrate the diversity of approaches and align these with our taxonomy. Table 2 provides a side-by-side comparison.

Arkansas

In 2017, Arkansas passed legislation to create the **Provider-led Arkansas Shared Savings Entity (PASSE) model,** which focuses on beneficiaries with intellectual and developmental disabilities (IDD) and SMI. Under this model, beginning in 2019, the PASSE entity assumed full financial risk for its beneficiaries, receiving a global payment to cover each beneficiary's total cost of care. The remainder of the population is covered by a PCCM program, with mental health reimbursed as FFS through the state. Other beneficiaries who enrolled during the state's 2014 Medicaid expansion are covered through a program called Arkansas Works, which offers Medicaid-eligible beneficiaries private health insurance integrating physical and mental health care.)

Arizona

Arizona's move toward integrated care has occurred in stages. For example, in 2010, the state implemented a carve-in arrangement in Maricopa County for persons with SMI. In 2014, the state's behavioral health plans, called Regional Behavioral Health Authorities (RBHAs), began covering both physical and behavioral health services for adults with SMI, with the BHO entity becoming responsible for general medical and surgical care.

In 2015, the state merged the Arizona Health Care Cost Containment System (AHCCCS) and the Department of Health Services' Division of Behavioral Health Services (DBHS), moving responsibility for physical and behavioral health services into a single agency. With this move, the state created integrated care models for most adults and children who were served under one of seven AHCCCS Complete Care (ACC) plans. However, RBHAs continued to provide integrated care for persons with SMI. RBHAs were also responsible for crisis services.

In 2022, the state plans to move specialized care for persons with SMI from RBHAs to

Table 2. Selected State Approaches to Behavioral Health Integration

Dimension	Configuration	States								
		Arkansas		Arizona			New York		Oregon CCO Model	Washington Integrated Managed Care
		Members with SMI (PASSE)	Other Medicaid Members	Most members (2020)	Members with SMI (2020)	Planned approach 10/1/22	Members with SMI	Most members		
Integration of behavioral health services	Carved-Out									
	No Managed Care (FFS or PCCM)		•							
	Fully integrated with no subcontracting	•		•	•	•			•	
	Integrated but subcontracting allowed						•	•		•
Level of financial risk	Full capitation	•		•	•	•	•	•	•	•
	FFS with case management		•							
	Blend of FFS/capitation/ case management									
	Administrative services only (ASO)									
Populations covered	Broad population					•			•	•
	Individuals with SMI	•			•		•			
	Individuals without SMI		•	•				•		
	Children only									
	Adults only						•			
Services covered	Specialty Outpatient (Mental Health)	•	•	•	•	•	•	•	•	•
	Inpatient (Mental Health)	•	•	•	•	•	•	•	•	•
	Pharmacy (Mental Health)	•	•	•	•	•	•	•		•
	Crisis services (Mental Health)	•	•		•	•	•	•	•	
	Specialty Outpatient (SUD)	•	•	•	•	•	•	•	•	•
	Inpatient (SUD)	•	•	•	•	•	•	•	•	•
	Pharmacy (SUD)	•	•	•	•	•	•	•	•	•

*There may be some rare circumstances in which MCOs are permitted to subcontract administrative and operational functions. All Administrative Services subcontracts the plans enter into are required to obtain prior approval by AHCCCS. RBHA and ACC Contracts state the following:Delegated agreements for operational functions which are determined by AHCCCS to inhibit integrated service delivery for the Medicaid or Medicare D-SNP lines of business are prohibited. Furthermore the RBHA contracts specifically state the following: The Contractor shall not delegate or subcontract key functions of health plan operations that are critical to the integration of behavioral and physical health care for members as set forth in Section D, Paragraph 36, Management Services Agreements, unless one entity under subcontract provides all of the delegated functions for both the Medicaid, which includes physical and behavioral health, and Medicare lines of business.

Financial integration may decrease access to appropriate care for individuals with severe mental illness.

ACC plans.[12] Subcontracting is allowed in Arizona's models.

New York

As part of its 1115 waiver demonstration, New York transitioned its adult beneficiaries in 2015 into either "mainstream" Medicaid managed care organizations, which provided physical and behavioral health, or (beginning in 2016) Health and Recovery Plans (HARPs), designed for adults with select SMI and SUD diagnoses having serious behavioral health issues.[13]

HARP-eligible individuals are identified quarterly and are passively enrolled into HARPs. Beginning in 2017, children were included in mainstream MCOs, which covered physical and behavioral health. Subcontracting is permitted in New York's model.[14]

Oregon

In 2012, Oregon transitioned its Medicaid program to a system of Coordinated Care Organizations (CCOs).[15–17] Oregon's 15 CCOs are similar to MCOs in their acceptance of financial risk and responsibility for contracting with providers and their accountability for beneficiary care. However, CCOs are geographically defined and locally governed, with most regions served by a single CCO.

Oregon's transition to CCOs represented a shift to "carving in" behavioral health services. Prior to 2012, the majority of behavioral health services were managed by county behavioral systems, which acted as the recipient of behavioral health carve-out financing and the provider of services. Under CCOs, financing for behavioral health is integrated with general medical and surgical services and is directed to the CCO.

CCOs are expected to manage and pay for all of these services in an integrated fashion. Initially, CCOs had the option to subcontract with BHOs (typically, counties), but this subdelegation was ruled out beginning in 2020. Although CCOs are comprehensive in the services and populations covered, prescription drugs for mental health (therapeutic classes 7 and 11) are carved out and paid on a FFS basis.[18]

Washington

Beginning in 2016, Washington began to implement its **"Integrated Managed Care" (IMC) initiative.** Under this initiative, Medicaid beneficiaries receive comprehensive physical and mental health services through a single, integrated managed care plan. The implementation of IMC took place in a staggered fashion across regions between 2016 and 2020.

Under IMC, financing for behavioral health and general medical-surgical services is integrated at the level of the five MCOs serving the state. However, MCOs may subcontract with BHOs, at least for interim periods. The state is served by five MCOs. The IMC model is comprehensive in the services and populations covered. Crisis services, however, are held out, and payment resembles FFS, although ASO contracts include multiple sources of braided funding.

Considerations for different approaches for financing behavioral health care

Based on the literature, our conceptual model, and our own experience in collecting these data, we propose hypotheses or considerations for how these arrangements might influence outcomes. For example:

Integrated care for SMI: Best models?

States differ in their approach to caring for individuals with SMI. Comprehensive integration may be appealing in its simplicity and holistic approach.

However, suppose financial integration's greatest impact is its facilitation of integration of mental health services in the primary care setting. In that case, the main

Health-plan level subcontracts may create a *de facto* carve-out that could mediate the benefits of a true carve-in.

beneficiaries may be individuals with more moderate mental illness.

In contrast, individuals with serious mental illness may be more likely to receive their health services through community mental health centers. These clinics and networks often have longstanding relationships and agreements with behavioral health organizations. In this case, comprehensive financial integration may create disruptions and decrease access to care for individuals with SMI, if, for example, community mental health centers face new administrative burdens in coordinating with MCOs, who may have less experience in how mental health services are delivered.

On the other hand, carve-outs that are restricted to individuals with SMI may inhibit access to care in this population for acute and chronic physical health conditions (e.g., cardiovascular disease, diabetes, and cancer), the number one cause of death for these individuals.

Do plan-level subcontracts mediate benefits of a carve-in?

States may define "integration" as an arrangement wherein payments for physical and behavioral health care are provided as one payment to MCOs, rather than separate capitation payments flowing to MCOs for physical health and to BHOs for behavioral health care.

However, an MCO can ostensibly receive capitation payments for integrated physical and mental health care but subcontract its behavioral health care to another entity. This entity may be, for example, the county mental health system. In this case, the Medicaid managed care plan appears to have financially integrated care while, in reality, mental health and physical health are managed separately, with counties holding financial risk and serving as a provider organization.

This "health plan carve-out" or subcontracting may create a *de facto* carve-out arrangement. In this case, **subcontracting could potentially mediate the benefits anticipated with a true carve-in.** In addition, in these arrangements, states may have less control over access, quality, and network adequacy than in the arrangements in which states pay BHOs directly.

Pharmacy carve-outs: unintended incentives?

Carving out specialty mental health drugs may be one way of preserving access to these drugs for Medicaid beneficiaries, as it does not place risk on the MCO or provider for these expenses. However, on the margins, these arrangements may lead MCOs and some providers to increase the use of prescription medications and restrict access to outpatient therapy in order to manage costs.

Implications

Managed care's role in Medicaid is likely to continue to grow. Current trends suggest that behavioral and physical health care will be increasingly integrated within MCOs.

However, integration takes multiple forms, including the extent to which integrated plans are comprehensive in the coverage of populations and services. Experimentation and heterogeneity across states offers an opportunity to identify the optimal combinations to create a high-value public insurance system.

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