



Promoting Physical and Behavioral Health Integration in Medicaid Through Section 1115 Demonstrations

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Summary

States face considerable challenges addressing the needs of Medicaid beneficiaries with behavioral health conditions. Historical fragmentation of health care providers, funding streams, benefits, and regulatory functions for behavioral health have resulted in unmet health care needs and poor health outcomes for many beneficiaries with behavioral health conditions. To lower total costs, increase access to high quality care, and improve beneficiary outcomes, many states are testing approaches to promote physical and behavioral health integration (PBHI), a range of clinical and policy strategies that seek to bring together physical and behavioral health care service providers, payment systems, and administrative and oversight functions to address all aspects of a patient's wellbeing. This brief systematically examines how nine states are supporting PBHI at the clinical level through their section 1115 delivery system reform demonstrations. Drawing on state documentation and key informant interviews with policymakers and provider representatives, we find that states primarily use financial incentives, requirements for provider collaborations, changes to managed care program design, and technical assistance to promote PBHI through their section 1115 demonstrations. Qualitative findings point to the importance of using multiple policy strategies that target the delivery system, provider payment mechanisms, and covered benefits to promote PBHI. Although section 1115 demonstrations with elements addressing PBHI have

shown some early signs of progress, persistent challenges related to health information technology, rules governing patient data-sharing, and workforce gaps affect the advancement of PBHI.

Background

One in five Medicaid beneficiaries have behavioral health conditions, including mental health disorders and substance use disorders (SUD). Total spending for this group constitutes nearly half of all spending for the Medicaid program (Medicaid and CHIP Payment and Access Commission 2015). Not only are these beneficiaries more costly, they frequently have unmet care needs, in part driven by insufficient behavioral health screening, treatment, and referrals. Similarly, beneficiaries with serious mental illness (SMI), such as schizophrenia or bipolar disorder, and substance use disorders may not receive adequate services for their physical health needs due to receiving treatment in community behavioral health centers, which have historically offered limited co-located physical health care (Medicaid and CHIP Payment and Access Commission 2015; Center for Behavioral Health Statistics and Quality 2015). The severity of these conditions, coupled with fragmented care, are reflected in beneficiaries' poor health outcomes. Individuals with mental disorders have a premature mortality rate that is 2.2 times higher than the general population (Walker et al. 2015), and people with SMI die 10 to 20 years earlier than the general population (Hayes et al. 2015; Saha et al. 2007).

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

Some states have used section 1115 waiver authority to implement delivery system reform incentive payment (DSRIP) demonstrations. Since the first DSRIP demonstration was approved in 2010, the breadth and specific goals of these demonstrations have evolved, but each aims to advance delivery system transformation among safety net hospitals and other Medicaid providers through infrastructure development, service innovation and redesign, and population health improvements. More recent DSRIP demonstrations have also emphasized increasing provider participation in alternative payment models, which are designed to reward improved outcomes over volume.

To improve overall health outcomes and lower costs, many states are seeking to integrate physical and behavioral health services. Physical and behavioral health integration (PBHI) describes a range of clinical and policy strategies that seek to bring together physical and behavioral health service providers, payment systems, and administrative and oversight functions to address all aspects of a patient's well-being (Medicaid and CHIP Payment and Access Commission 2016).

Efforts to promote PBHI were spurred in part by recent changes in federal law that increased coverage of behavioral health services. The Patient Protection and Affordable Care Act (Affordable Care Act, Pub.L. 111-148) of 2010 provided states the option to expand Medicaid to low-income adults. As part of the Medicaid expansion under the Affordable Care Act,¹ these new beneficiaries must be covered under an Alternative Benefit Plan, which includes coverage for essential health benefits that include mental health and substance use disorder services. In addition, the Mental Health Parity and Addiction Equity Act (MHPAEA, Pub.L. 110-343) of 2008 requires that coverage for mental health and SUD services be no more restrictive than coverage available for medical or surgical conditions (Substance Abuse and Mental Health Services Administration 2017a). By October 2017, states had to comply with federal regulations that apply certain provisions of the MHPAEA to Medicaid and Children's Health Insurance Program (CHIP) plans (Centers for Medicare & Medicaid Services 2016).²

At the same time, federal funding became available to states for new delivery system models that promote integrated care. The Substance Abuse and Mental Health Services Administration (SAMHSA) developed the Primary and Behavioral Health Care Integration (PBHCI) grants program in 2009 to support communities in coordinating and integrating primary care services into community-based behavioral health settings (Substance Abuse and Mental Health Services Administration n.d.). Additionally, the Affordable Care Act created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for Medicaid beneficiaries with chronic conditions, including those with behavioral health diagnoses (Centers for Medicare & Medicaid Services 2015). In 2015, Section 223 of the Protecting Access to Medicare Act (Pub.L. 113-93) authorized a demonstration program for states to implement certified community behavioral health clinics (Substance Abuse and Mental Health Services Administration 2017b). Together, these

“Mental health and substance use [services] being an essential health benefit started to change the conversation across ... the country, but certainly in [our state], our Medicaid recipients would now access this really important benefit.”

—California provider

policy changes, coupled with states' recognition of the need to better address beneficiary health care needs, have influenced states to implement section 1115 demonstrations to improve the delivery system.

Roadmap to the report

This brief describes states' use of Medicaid section 1115 demonstration authority to test delivery system reforms that address PBHI. The following section introduces the components of clinical PBHI and factors influencing the adoption of these components. Next, we present a conceptual framework for the strategies used in section 1115 demonstrations to promote PBHI. We then describe each of the policy strategies states commonly use in section 1115 demonstrations to promote clinical PBHI and early lessons learned from states' implementation experiences with each strategy. We conclude by outlining key considerations for future 1115 demonstrations that seek to promote PBHI and implications for future outcomes evaluations of these demonstrations.

Clinical physical and behavioral health integration

Clinical PBHI involves the integration of health care services and providers at the point of care. Although there are many approaches to and levels of intensity associated with integrated care for physical and behavioral health services,³ clinical PBHI usually entails a common set of location, informational, and workforce components (Medicaid and CHIP Payment and Access Commission 2016; Substance Abuse and Mental Health Services Administration 2015). These components include:⁴

- **Provider co-location:** A practice structure that involves physically locating behavioral health and physical health providers in the same facility. Co-location is intended to support increased communication, referrals, and team-based care among different provider types and simpler, less costly follow-up care for beneficiaries.
- **Care coordination:** Activities by providers to manage and facilitate care for a patient's physical and behavioral health care. For PBHI, coordination is often performed by care managers, who create a care plan for a patient and facilitate access to the services specified in the plan.
- **Provider partnerships:** Formal or informal arrangements between behavioral and physical health providers to create access to a broader spectrum of behavioral health and auxiliary services that facilitate integrated care.
- **Data sharing:** Sharing of clinical and other patient information among providers to communicate and coordinate physical and behavioral health care, typically using a health information technology (HIT) platform.
- **Workforce expansion and training:** Hiring providers to increase workforce capacity or educating physical and

behavioral health providers in one another's disciplines to educate and reinforce the processes necessary for integrated care.

- **Screening, referrals, and treatment:** Procedures for identifying behavioral health conditions, usually in primary care practices, and referring to other providers for appropriate treatment. For example, the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach involves: 1) a quick screening to assess the severity of substance use and to identify the level of treatment; 2) a brief intervention to increase insight and awareness for a behavioral change, and 3) a referral for more extensive treatment as needed (SAMHSA-HRSA Center for Integrated Health Solutions 2015).

Factors influencing clinical PBHI

Historical and contextual factors have contributed to the fragmentation of physical and behavioral health services. To effectively adopt and implement clinical PBHI components, policymakers, payers, and providers need to address these factors.

Health information technology. To leverage patient data to effectively integrate care, providers need access to advanced HIT systems that can share data among providers and care settings. Many behavioral health providers — who were initially excluded from federal programs supporting development of electronic health record (EHR) systems (for instance, the Medicare Electronic Health Record Incentive Program) — still rely on paper health records (Cellucci et al. 2015). Even for behavioral health providers that have implemented EHRs, organizational siloes between physical and behavioral health providers have resulted in instances of separate data systems that are ineffective at data sharing. Further exacerbating this challenge are privacy laws, such as 42 Code of Federal Regulations (42 CFR) Part 2, which governs the confidentiality of SUD patient records. Intended to protect patients' personal health information, this federal statute outlines the limited circumstances under which a patient's treatment for substance use disorder may be disclosed with and without the patient's consent. It is more stringent than the Health Insurance Portability and Accountability Act (HIPAA), the general health information privacy law, and the two are not fully aligned (American Psychiatric Association n.d.). As such, 42 CFR Part 2 makes it challenging for providers to share necessary data on individuals who seek substance use treatment services. In 2018, SAMHSA revised 42 CFR Part 2 to support care coordination for patients with SUD by allowing disclosures of patient information, with the patient's consent, for the purposes of health care operations and payment (Knopf 2018). However, the revision stopped short of fully aligning with HIPAA. It is unclear how these changes will affect PBHI.

"In mental health and addiction, particularly community providers, they don't even have [electronic health records], or if they do, they're using ones that aren't aligned with other providers, and that I think is a challenge."

— New Jersey provider

Workforce supply. A lack of workforce capacity and supply has been a consistent obstacle to integrating care. Demand for care is increasing as a result of greater coverage of behavioral health services and an opioid epidemic that is disproportionately affecting the Medicaid population (Musumeci 2017). Health systems do not currently have sufficient provider capacity or training to handle this increased demand for SUD treatment (U.S. Department of Health and Human Services 2016). The problem is expected to worsen because the behavioral health workforce is aging, reflected by the fact that 46 percent of psychiatrists are older than age 65 (U.S. Department of Health and Human Services 2016).

Provider culture. The practice environments in which physical and behavioral health providers operate can vary considerably with regard to treatment modalities, workflow, and communication practices. The differences have contributed to distinct provider cultures that make it challenging to integrate care. Provider culture has also contributed to a gap in expertise, with providers often not being sufficiently familiar with one another's discipline, which poses challenges for some integrated models. For instance, some integrated care models expect that primary care providers will perform SBIRT activities for behavioral health conditions for beneficiaries in need. However, primary care providers typically lack extensive clinical training in behavioral health and can be resistant to delivering such services (Crowley and Kirschner 2015). Similarly, some models rely on behavioral health providers to deliver physical health services, but providers can be hesitant to do so because they lack sufficient training (De Hert et al. 2011).

Billing and licensing. Regulations governing the billing of services and licensing of providers play a significant role in efforts to promote clinical PBHI. For example, some state Medicaid agencies prohibit reimbursement for physical and behavioral health services that are delivered on the same day (Roby and Jones 2016), which poses particular challenges for co-located care. In addition, limits on the types of providers, facilities, and services that can be reimbursed—either because of federal or state policy—may create additional barriers to integrated care. For example, federal statute prevents most states from using federal Medicaid funds to reimburse providers for care provided to individuals, ages 21 to 64, at institutions for mental diseases

(IMD). MACPAC (2016) notes that this can have a two-fold impact on participation in PBHI as (1) it creates disincentives for physical health providers to provide care or accept referrals of individuals who are residents of IMDs and (2) discourages residential facilities that provide medical or nursing care from offering behavioral health services, as they run the risk of being classified as an IMD and losing federal financial participation.

Conceptual framework for physical and behavioral health integration in section 1115 demonstrations

Section 1115 demonstration types

To promote PBHI, states have pursued section 1115 demonstrations, because they provide funding and flexibility that can drive delivery system reforms. Federal Medicaid requirements outline key principles for the Medicaid program to which all states must adhere. Section 1115 waiver authority grants states permission to waive certain federal Medicaid program principles so they can test policies or programs that are likely to promote Medicaid objectives (CMS n.d.). Within the budget neutrality requirements of section 1115 demonstrations, states can use the additional flexibility to target benefits to certain beneficiaries, create specialized managed care plans, or use federal Medicaid funding to support delivery system reforms or provide services which would not otherwise be available (Kaiser Family Foundation 2019).

The policy strategies used in section 1115 demonstrations aim to redress the historical and contextual factors inhibiting clinical PBHI and make it easier for providers to adopt integrated care. To compare state section 1115 demonstration strategies to promote PBHI, we selected nine states with active delivery system reform demonstrations as of April 2018, such as Delivery System Reform Incentive Payment (DSRIP) and DSRIP-like programs, which provide incentive payments and funding for infrastructure development, care redesign, and other delivery system changes.⁵ For these states, we examined the breadth of demonstrations implemented under section 1115 waiver authority to promote PBHI, which included a total of 17 demonstrations across the nine states (Table 1). All demonstrations included in this brief seek to promote PBHI to some degree.

In addition to their delivery system reform demonstrations, five of the nine states operate other demonstrations that aim to impact PBHI. These other demonstration types include the following:

- Substance use disorder demonstrations** give states flexibility to improve access to and quality of SUD treatment by covering a broader range of behavioral health services including services provided to Medicaid beneficiaries residing in residential treatment settings and inpatient facilities that qualify as IMDs.⁶ According to CMS guidance, states are expected to take a number of actions to improve access to care, including care for co-morbid physical health conditions among beneficiaries with SUD, and the quality of care provided to these beneficiaries (State Medicaid Director Letter [SMDL] 17-003). In addition to SUD demonstrations,

Table 1. Selected section 1115 demonstrations that support PBHI

State	Demonstration	Time period	Delivery system reform	Substance use disorder	Integrated managed care plan
AZ	Regional Behavioral Health Authorities (RBHAs)	October 1, 2015 - September 30, 2021			X
AZ	Targeted Investment Program (TIP)	January 18, 2017 - September 30, 2021	X		
CA	Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	December 30, 2015 - December 31, 2020	X		
CA	Drug Medi-Cal Organized Delivery System (DMC - ODS)	December 30, 2015 - December 31, 2020		X	
CA	Whole Person Care Pilots (WPC)	December 30, 2015 - December 31, 2020	X		
MA	Delivery System Transformation Initiative (DSTI Renewal)	Waiver: October 30, 2014 - June 30, 2019 DSTI: October 30, 2014 - June 30, 2017	X		
MA	Delivery System Reform Incentive Payment Program (DSRIP)	July 1, 2017 - June 30, 2022	X		
MA	Substance Use Disorder (SUD)	July 1, 2017 - June 30, 2022		X	
NH	DSRIP	January 5, 2016 - December 31, 2020	X		
NJ	DSRIP	August 1, 2017 - June 30, 2022	X		

State	Demonstration	Time period	Delivery system reform	Substance use disorder	Integrated managed care plan
NJ	Opioid Use Disorder (OUD) / SUD	October 31, 2017 - June 30, 2022		X	
NY	DSRIP	December 7, 2016 - March 31, 2021	X		
NY	Health and Recovery Plans (HARPs)	July 1, 2015 - March 31, 2021			X
OR	Coordinated Care Organizations (CCOs)	January 12, 2017 - June 30, 2022	X		
TX	DSRIP	December 12, 2011 - December 31, 2017	X		
TX	DSRIP Extension	January 1, 2018 - September 30, 2022	X		
WA	DSRIP	January 9, 2017 - December 31, 2021	X		

Source: Mathematica’s analysis of section 1115 demonstration special terms and conditions. Waiver names, effective dates, and an overview of each demonstration’s focus on PBHI are included in Appendix Table B.1.

AZ = Arizona; CA = California; MA = Massachusetts; NH = New Hampshire; NJ = New Jersey; NY = New York; OR = Oregon; TX = Texas; WA = Washington

in November 2018, CMS announced a new opportunity for states to pursue section 1115 demonstrations that improve the continuum of care to address chronic mental health care needs of adult beneficiaries with SMI or child beneficiaries with Serious Emotional Disturbance (SED).⁷ As of the writing of this report, CMS had not yet approved SMI/SED demonstrations.

- **Integrated managed care plan demonstrations** create integrated managed care plans (MCPs) that cover both physical and behavioral benefits for special populations. Creating integrated MCPs is not a strategy unique to section 1115 demonstrations as states can create such plans without a section 1115 waiver.⁸ We include two such demonstrations in Arizona and New York to highlight the range of strategies available to states that operate managed care programs under section 1115 demonstration authority and examine their alignment with co-existing delivery system reform demonstrations.

Policy strategies commonly used in section 1115 demonstrations

Within their section 1115 demonstrations, states have pursued a common set of strategies to promote clinical PBHI. These strategies include:

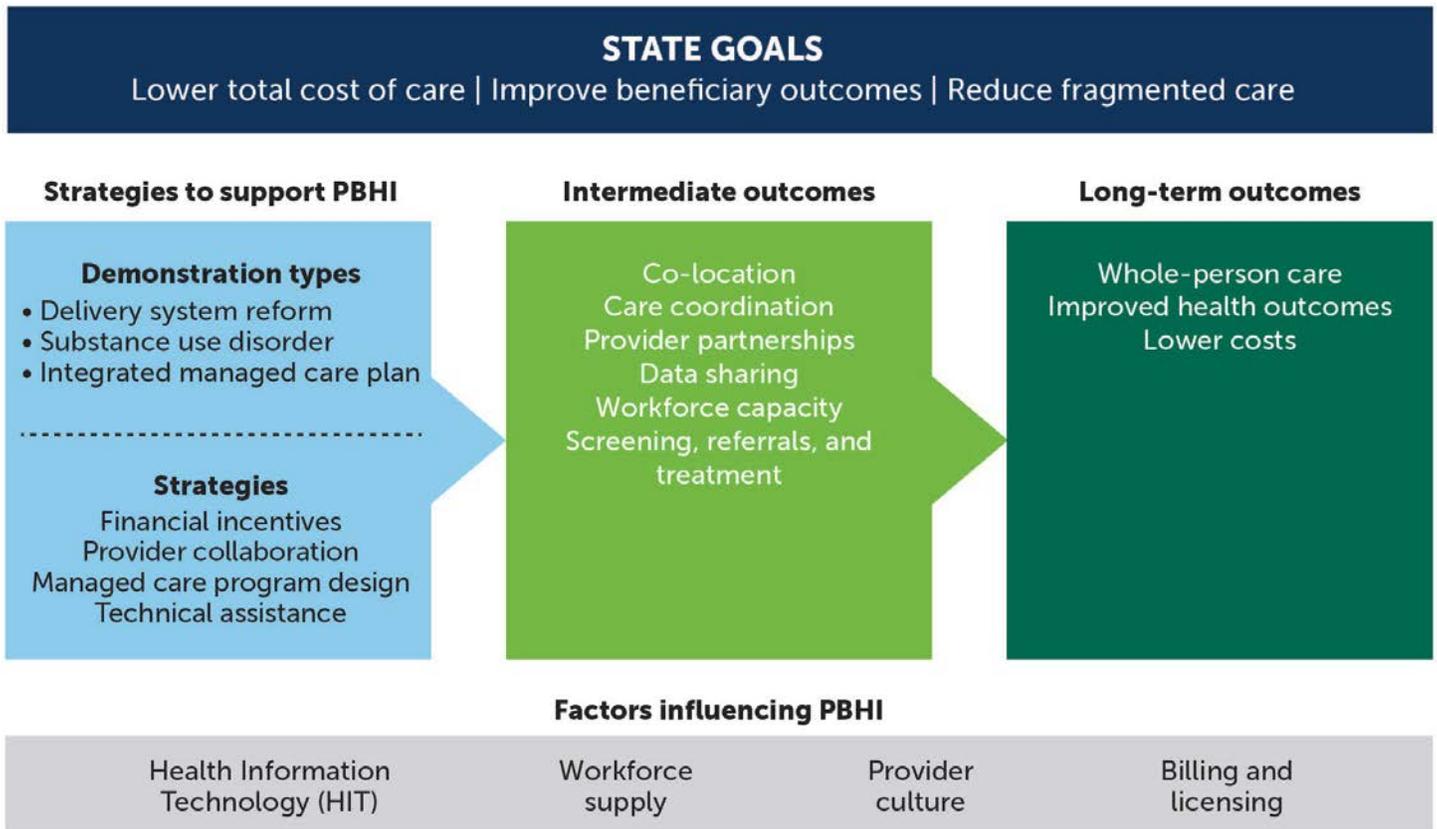
1. **Financial incentives:** States may use funding, incentives, and payment streams to motivate providers to deliver integrated care. In some cases, the funds are directed to specific clinical PBHI components, such as HIT infrastructure and workforce training. Some states also direct funds to providers to report measures of clinical care processes and improve their performance.
2. **Provider collaboration:** Integrated provider networks aim to deliver whole-person care through collaboration between

behavioral and physical health providers. Many delivery system reform demonstrations require provider collaboration and tie participation to eligibility for financial incentives. Provider networks for integrated care are frequently required to include community-based organizations, care managers, or other providers that coordinate physical and behavioral health care delivery for a beneficiary.

3. **Managed care program design:** Covering behavioral health services in the benefit package provided by comprehensive MCPs makes one entity responsible for both physical and behavioral health services. Some states have developed specialized MCPs that cover physical and behavioral health benefits, but only enroll special populations, such as beneficiaries with SMI. States can also require MCPs to contract with certain types of providers that integrate physical and behavioral health care services.
4. **Technical assistance:** Some states also provide nonfinancial support to entities to aid the implementation of integrated care. Support may take the form of guidance to ensure providers can bill necessary services and be licensed, analytics and HIT support, or learning collaboratives on topics that facilitate provider collaboration and education for integrated care.

Figure 1 presents a conceptual framework that outlines how these strategies support the development of the clinical components of PBHI. The framework builds on previous work (MACPAC 2016; Bachrach 2014) and highlights the interaction between policy strategies, intermediate outcomes associated with clinical adoption of PBHI, and the resulting long-term effects of whole-person care, improved health outcomes and lower costs. Although states use several other strategies to promote PBHI, they are not the focus of section 1115 demonstration activity.⁹

Figure 1. Conceptual framework of physical and behavioral health integration in section 1115 demonstrations



Policy strategies used in section 1115 demonstrations to promote PBHI

The most prevalent strategy used in section 1115 demonstrations to promote PBHI is financial incentives, which all nine states implement through delivery system reform demonstrations. Managed care program design strategies are also prevalent; most demonstrations examined

incorporate a version of the strategy. Five of the delivery system demonstrations require provider collaborations intended to support integrated care. In addition, all states examined use of technical assistance (TA) to support participating entities. Table 2 summarizes the common strategies used in the 17 demonstrations implemented in the nine states we examined. Below, we describe each of these four strategies and early lessons learned from implementation of these strategies.

Table 2. Overview of predominant strategies to promote PBHI used in section 1115 demonstrations

Strategy		AZ	CA	MA	NH	NJ	NY	OR	TX	WA
Financial incentives	Project-based incentives	TIP	PRIME	DSTI Renewal	DSRIP	DSRIP	DSRIP	CCOs	DSRIP	DSRIP
	Funding		WPC	DSRIP						
	Performance-based incentives	TIP		DSRIP			DSRIP		DSRIP Extension	DSRIP
Provider collaboration				DSRIP	DSRIP		DSRIP	CCOs		DSRIP
Managed care program design	Provider contracting requirements for managed care plans	TIP	PRIME, DMC-ODS, WPC	DSRIP	DSRIP		DSRIP			
	Fully-integrated managed care plans	RBHAs					HARPs			DSRIP
	Expanded behavioral health benefits		DMC-ODS, WPC	DSRIP, SUD		SUD				
Technical assistance		TIP	PRIME, DMC-ODS, WPC	DSTI Renewal, DSRIP	DSRIP	DSRIP	DSRIP	CCOs	DSRIP	DSRIP

Source: Mathematica’s analysis of section 1115 demonstration special terms and conditions. Waiver names, effective dates, and an overview of each demonstration’s focus on PBHI are included in Appendix Table B.1. Massachusetts’ DSTI Renewal and Texas’s original DSRIP with project-based incentives are no longer effective demonstrations as of the date of this report.

AZ = Arizona; CA = California; CCOs = Coordinated Care Organizations; DMC-ODS = Drug Medi-Cal Organized Delivery System; DSRIP = Delivery System Reform Incentive Payment Program; DSTI = Delivery System Transformation Initiative; HARPs = Health and Recovery Plans; MA = Massachusetts; NH = New Hampshire; NJ = New Jersey; NY = New York; OR = Oregon; PRIME = Public Hospital Redesign Incentives in Medi-Cal; RBHAs = Regional Behavioral Health Authorities; SUD = Substance Use Disorder demonstration; TIP = Targeted Investment Program; TX = Texas; WA = Washington; WPC = Whole Person Care pilots

Financial incentive strategies

Financial incentives are the primary lever for promoting PBHI in section 1115 demonstrations. Financial incentives are intended to help stimulate provider adoption of PBHI components and provide funding for services or infrastructure needed to create clinical integration models. Financial support to participating entities takes the form of project-based incentive payments earned by providers for implementing or participating in PBHI-related activity. Performance-based incentives are also used to encourage performance improvement toward PBHI objectives and hold providers accountable for care processes and outcomes.

Infrastructure development

States may tie section 1115 demonstration funding for providers, counties, and other participating entities to infrastructure investments, rather than projects, that are foundational to PBHI. Such funding is usually directed toward the HIT and workforce needed to develop PBHI models. In DSRIP demonstrations, funding streams are typically targeted to supporting the initial planning and development phase that precedes implementation of projects. For example, Massachusetts' DSRIP demonstration provides funding through the "Statewide Investments" initiative, which provides funding to expand the state's supply of behavioral health providers, invest in workforce training and capacity-building, and develop needed infrastructure, such as HIT investments.¹⁰

Project-based incentives

Payment incentives tied to implementing specific projects are the primary strategy for promoting PBHI in the delivery reform demonstrations included in this brief. States create project menus from which participating entities select projects to implement. In some cases, states may explicitly require certain projects. All delivery reform demonstrations we reviewed include at least one project that is explicitly focused on PBHI. Five of these states require that all entities select these projects, whereas other states include optional PBHI projects (Table 3). To further encourage entities to select PBHI projects, some states assign them a higher value, effectively increasing the amount of incentives.¹¹ Although all delivery system reform demonstrations include a project focused on PBHI within their project menus, they vary in the degree of flexibility prescribed by the state. For example, New Hampshire requires Integrated Delivery Networks (IDNs) (see Table 5 for description of IDNs) to meet a level of integration based on SAMHSA Standard Framework for Levels of Integrated Healthcare, but, like most other states, does not require a specific model for doing so. On the other hand, New York Performing Provider Systems (PPSs) are required to select one of three prescribed integrated care models: (1) integration of behavioral health specialists into primary care clinics using the Collaborative Care Model, (2) integration of primary care services into behavioral health sites, or the (3) IMPACT model.¹²

Table 3. Primary PBHI projects in delivery system reform demonstrations

Demonstration	Primary PBHI project in demonstration	Required?
Arizona (TIP)	Ambulatory Project or Hospital Project	Not applicable*
California (PRIME)	Integration of Physical and Behavioral Health	Y
Massachusetts DSTI Renewal [expired demonstration]	Integrate Physical Health and Behavioral Health	N
New Hampshire (DSRIP)	Integrated Healthcare (Project B1)	Y
New Jersey (DSRIP)	Integrated Health Home for the Seriously Mentally Ill	N
New York (DSRIP)	Integration of Primary Care and Behavioral Health Services (Project 3.a.i)	N
Oregon (CCOs)	Integrating Primary Care and Behavioral Health (Focus Area 4)**	Y
Texas (DSRIP) [expired demonstration]	Integrate Primary and Behavioral Health Care Services (Project 2.15)	Y
Washington (DSRIP)	Bi-directional Integration of Physical and Behavioral Health through Care Transformation (Project 2A)	Y

Source: Mathematica's analysis of section 1115 demonstration special terms and conditions, project toolkits, and other available state documentation. Primary projects are those that explicitly denote integration as an objective.

* Providers participating in TIP do not select from a project menu. Participation in a project is based on interested providers meeting eligibility requirements and opting in.

** Oregon's CCO demonstration refers to required provider activity as Focus Areas instead of projects

Project overviews are available in Appendix Table B.2.

CCOs = Coordinated Care Organizations; DSTI = Delivery System Transformation Initiative; DSRIP = Delivery System Reform Incentive Payment Program; PRIME = Public Hospital Redesign Incentives in Medi-Cal; TIP = Targeted Investment Program

In addition to projects that explicitly focus on clinical PBHI, states include projects that aim to improve treatment capacity, care redesign, and infrastructure development, which may facilitate clinical PBHI.¹³ Some projects increase the types of services that are available to support integrated care, including transportation, housing, medication-assisted treatment (MAT), peer supports, and technology-assisted services. Others focus on the expansion of screening for behavioral health conditions.

Additionally, projects help support the development of the HIT infrastructure necessary for PBHI—either as projects focused solely on HIT or through core components within PBHI-related projects, such as establishing data-sharing agreements with participants and MCPs. Table 4 highlights example projects that support PBHI components. States vary which components they emphasize in their project menus, and providers typically have flexibility in the projects they select and activities they implement within that project.

Table 4. Example projects that support clinical PBHI components

Clinical PBHI component	Example project
Co-location	Providers across demonstrations may co-locate as part of a project; however, it is not a required or emphasized activity in projects.
Care coordination	CA PRIME Complex Care Management for High-Risk Medical Populations: Implement, and/or improve upon, a complex care management model for targeted high-risk patient populations, that facilitates the appropriate coordinated delivery of health care services, is better able to meet the patient's needs and preferences, and results in improvement of the patient's health outcomes.
Provider partnerships	NY DSRIP Transitional supportive housing services: Participating hospitals partner with community housing providers and, if appropriate, home care services to develop transitional housing for high risk patients who, due to their medical or behavioral health condition, have difficulty transitioning safely from a hospital into the community.
Data sharing	NH DSRIP Health Information Technology (HIT) Infrastructure to Support Integration: IDNs develop and implement a plan for acquiring the HIT capacity necessary to support high-quality, integrated care. Each IDN participates in a taskforce, which will come up with the implementation plans.
Workforce expansion and training	MA DSTI Implement patient navigation services: Utilize community health workers, case managers, or other forms of patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patient
Screening, referral, and treatment	NJ DSRIP Hospital-Wide Screening for Substance Use Disorder: Implement hospital wide screening tools to assess substance use disorder withdrawal and identify the level of treatment needed

Source: Mathematica's analysis of section 1115 demonstration special terms and conditions, project toolkits, and other available state documentation.

Note: Primary projects are those that explicitly denote integration as an objective. Project overviews adapted from project toolkits or special terms and conditions when available. CA = California; DSRIP = Delivery System Reform Incentive Payment Program; DSTI = Delivery System Transformation Initiative; IDN = Integrated Delivery Network; MA = Massachusetts; NH = New Hampshire; NJ = New Jersey; NY = New York; PRIME = Public Hospital Redesign Incentives in Medi-Cal; TIP = Targeted Investment Program.

Performance-based incentives

Each delivery system reform demonstration requires providers to report and improve on process and outcome measures to qualify for funding. In some states, providers' scores on PBHI-related measures are assigned more weight for purposes of receiving incentive funds, which provides extra incentives for PBHI progress and adoption. Additionally, states use other approaches to hold providers accountable for improvements related to PBHI. For example, in Massachusetts' DSRIP demonstration, ACO performance scores are weighted by domains, with a 35 to 50 percent of the weight placed on domains related to PBHI. Texas' renewed DSRIP demonstration includes measure bundles, three of which are built to measure PBHI progress and outcomes and designated as state priorities. As another example, New York has a high-performance pool to reward high performance on 10 measures, of which six are behavioral health measures. Finally, in some states' section 1115 delivery system reform demonstrations, federal funding may be reduced if aggregate statewide scores, reflecting the performance of all participating providers, do not meet minimum thresholds. Arizona, New Hampshire, and Washington each incorporate measures of behavioral health and integrated care within statewide accountability measures.

Several states examined in this brief also tie DSRIP incentive funding to the adoption of value-based payment (VBP) strategies for provider payment through Medicaid managed care (California, Massachusetts, New Hampshire, New York, Texas, and Washington) (Lipson 2019). Although states' VBP goals are not exclusively focused on PBHI, by promoting movement to VBP, states aim to create flexibility in Medicaid reimbursement to support new care models and services. Furthermore, specific VBP models can explicitly support PBHI. For example, New York's VBP Roadmap outlines payment approaches to support two types of integrated care models: (1) an integrated primary care arrangement, which aims to incorporate primary and behavioral health services, and (2) a total cost of care model for beneficiaries with special needs, including those enrolled in the state's HARP (New York State Department of Health 2017).

Early lessons regarding the implementation of financial incentives

Stakeholders reflected that the financial incentives created through section 1115 demonstrations have helped providers invest in the "building blocks," or infrastructure development, needed for PBHI, particularly for behavioral health providers. Incentive funds also help to signal the importance of PBHI to providers, influencing how providers prioritize and allocate their resources. However, provider representatives across states have mixed views regarding whether states have provided sufficient guidance on which reforms to prioritize. States have sought to balance flexibility, which accommodates local needs and innovation, with more guidance and specificity regarding the state's priorities for reform. Across states, provider stakeholders

wanted state guidance regarding which activities would be most effective for improving PBHI, but they also valued flexibility to develop solutions that worked locally. For example, one stakeholder in New Hampshire reflected, "If we're really looking to [promote] integration in the state, then we should all probably agree to do something the same way."

Within DSRIP demonstrations, both projects and performance metrics are tied to financial incentives that influence provider activities. Stakeholders across states noted the importance of the alignment of activities, data-sharing, and measures. Policymakers and providers identified data-sharing as an integral, and often challenging, aspect of implementation. Providers pointed to often-cited obstacles, such as 42 CFR Part 2 and silo-ed data systems. Providers further noted that it would be beneficial to have guidance and availability of data at the onset of the demonstration. However, providers also noted that DSRIP has helped to expand HIT infrastructure important for integration, such as health registries, clinical support tools, and dashboards, although some stakeholders questioned the validity and usefulness of some reporting and measures. They observed a lack performance measures that accurately measure integrated care, largely because providers either have to report on activities that they view as being less meaningful to PBHI outcomes or on outcome measures that they believe are broader than the direct activities implemented through projects.

"Data security has been a huge pain. The demonstration started, and then the state was working on figuring out what could you share, who could you share it with, what did you need to have in place, what did you need to do to get population level data. I didn't need that data in year 3; I really should have had it right at day 1 of year 1."

— New York Provider

Overall, financial incentives augment an existing motivation to improve integrated care and help focus provider activity. However, financial incentives can only go so far in addressing broader, more persistent barriers. States emphasized that incentive funds cannot resolve the limited supply of behavioral health providers. Furthermore, regulatory constraints and limitations on which services are billable for certain providers are only partially ameliorated through incentives.

"Even if you facilitate the regulatory issues and provide enough incentives, if you have nobody to hire, you cannot integrate."

— New York Provider

Provider collaborations

Delivering more coordinated care often requires overcoming traditional care silos. To implement delivery system reform demonstrations, several states require participating providers to form collaborations, composed of multiple health care providers and sometimes community-based organizations that deliver social services. In most active DSRIP demonstrations, provider networks are the sole entity eligible for DSRIP incentive payments,¹⁴ and providers within a network are evaluated collectively as a single unit based on an attributed patient population for which they are accountable. Provider collaborations are a way to foster relationships between physical and behavioral health providers, align financial incentives across providers, and promote integrated care. Although not focused on PBHI in all states, collaborations are viewed as an important strategy to overcome the historical fragmentation of primary care and behavioral health providers.

Across demonstrations, provider network structures vary considerably in the number and type of providers that must be included, the governance structure under which the networks operate, and the way in which payments are distributed among participating providers. Some states require that these provider networks feature collaborations between medical care providers and behavioral health and community partners to support coordination of care for beneficiaries with behavioral health (Table 5).¹⁵ For example, Massachusetts policymakers explained that the state included the requirement to include community partners (CPs) in ACOs to address the concern that recently-created ACOs may be inexperienced at coordinating care. Massachusetts' CPs and Community Services Agencies (CSAs) are responsible for care management, rather than ACOs and MCPs, for beneficiaries with serious or complex behavioral health conditions.

Table 5. Provider collaborations that emphasize integrated care

State	Provider collaboration models	Overview
Massachusetts	Accountable Care Organizations	Generally, provider-led health systems or organizations with an explicit focus on integration of physical health, behavioral health, long-term services and supports and health-related social service needs
New Hampshire	Integrated Delivery Networks	Regional networks of physical and behavioral health providers and social service organizations. Networks must include community-based organizations, SUD providers, and peer-based support.
New York	Performing Provider Systems	Provider networks that include a wide variety of physical, behavioral, and community-based providers to support clinical integration
Oregon	Coordinated Care Organizations	Network of health care providers, including physical health care, substance use and mental health care, and dental care providers that are responsible for coordinating care
Washington	Accountable Communities for Health	Regional coalition of providers and community organizations responsible for leading progress towards demonstration goals, including integration of physical and behavioral health care

Source: Mathematica's analysis of section 1115 demonstration special terms and conditions, project toolkit, state websites, and other available state documentation.

Early lessons regarding the implementation of provider collaborations

In states that require provider collaborations, provider representatives tended to view the requirements as motivating a range of providers to work together. Many states sought to include a broad array of provider types to ensure that beneficiaries would have access to the full spectrum of services. Stakeholders viewed the inclusion of certain providers, such as Federally Qualified Health Centers — which have experience with patients with behavioral health needs and integration—and social service providers, as especially constructive for facilitating clinical PBHI.

The types of providers that participate in the demonstration can influence the type of integrated care taking place. Stakeholders in California and New York viewed the integration of behavioral health providers in primary care settings as the predominant integrated care model in their states. The role of hospital systems in the demonstrations may contribute to this circumstance. A New York PPS lead reflected that most PPSs in New York were hospital-led and that hospital systems tend to have the resources needed to integrate behavioral health care into the primary care settings. Similarly, California's PRIME largely promotes delivery system reform among public hospital systems and district municipal hospitals, and the majority of their services are focused on physical health, although these hospitals also deliver behavioral health services.

Interview respondents indicated, however, that provider participation requirements were often insufficient to overcome workforce capacity issues and ensure access to behavioral health services. One provider representative suggested that broader inclusion of nontraditional health workers in provider networks, such as patient navigators or peer supports, might help to mitigate workforce capacity deficits.

Managed care program design strategies

States have pursued several strategies under section 1115 demonstration authority that involve managed care program design. The primary strategies include (1) requiring MCPs to contract with providers that participate in PBHI delivery models, (2) establishing fully-integrated MCPs that cover all physical and behavioral health benefits, and (3) expanding coverage of additional behavioral health support services. These policies serve to encourage managed care and provider partnerships and align managed care contract provisions with the objectives of achieving integrated care.

Provider contracting requirements for managed care plans

As a condition of participating in the demonstration, some states require providers to partner with MCPs. For example,

in Massachusetts, to be eligible for DSRIP funding, CPs must execute a contract with MCPs. There are similar requirements within California's WPC and Drug Medi-Cal Organized Delivery System (DMC-ODS) programs, where participating entities must contract with Medi-Cal MCPs. Some states try to motivate MCPs' involvement in integrated care, placing the responsibility for establishing provider relationships on plans. For instance, Arizona's TIP requires plans to make incentive payments to participating providers that improve physical and behavioral health care integration and coordination for individuals with behavioral health needs. Other states try to encourage provider partnerships with MCPs but stop short of outright contractual requirements. For example, New York's project toolkit includes a suggested component for PPSs to pursue agreements with MCPs for services incorporated in projects.

Fully-integrated managed care plans

Fully-integrated MCPs can be another lever to help support clinical integration as they create a unified benefit package for beneficiaries. Some states, such as Arizona and New York, have fully-integrated MCPs for beneficiaries with complex behavioral health conditions. Arizona's Regional Behavioral Health Authorities (RBHAs) manage the delivery of physical health services, in addition to behavioral health services for persons with SMI.¹⁶ New York's HARPs provide care management and coverage of physical and behavioral health services, also targeted for beneficiaries with SMI or SUD conditions. In addition, the HARPs include home- and community-based services not otherwise covered by the state plan.

Another approach is to incentivize regional authorities to adopt integrated MCPs, as Washington is doing. The state is set to implement integrated care in 2020 but is using funding within DSRIP to incentivize regional authorities to make faster progress. County or regional authorities responsible for covering behavioral health services that choose to adopt fully integrated MCPs sooner than 2020 are eligible to receive incentives through Accountable Communities of Health (ACH). To qualify for incentive funds, county or regional officials must submit binding letters of intent to implement full integration. Additional incentives are available upon implementation of integrated managed care. By providing incentive funding, Washington intends to support behavioral health providers' development of the systems and infrastructure necessary for working with an integrated MCP.

Expanded behavioral health benefits

The flexibility and funding afforded by section 1115 demonstrations can support coverage of additional services and providers that can facilitate PBHI. California, Massachusetts, and New Jersey all have SUD demonstrations that authorize

an expanded array of services for people with SUD (Table 6). Funding for additional services are also featured in California’s WPC Pilots and the Massachusetts DSRIP demonstration.^{17,18}

“We recognized the need to redesign the SUD system to bring the level of service up in line with what’s being provided with physical health and mental health services, so that was why the direct Medi-Cal Organized Delivery System was included as part of the waiver as well—to make sure there was a system of care with enough modalities of service for the patients to receive what they needed in that area.”

— California policymaker

Table 6. Expansion of services in demonstrations

State	Demonstration	Overview of additional covered services
California	Drug Medi-Cal Organized Delivery System (DMC - ODS) Substance Use Disorder (SUD) demonstration	Counties cover an expanded array of SUD services for recovery services, case management, and physician consultation. Specific services include: residential treatment, withdrawal management, narcotic treatment, recovery services, case management, physician consultation, additional medication assisted treatment (optional), partial hospitalization (optional).
California	Whole Person Care Pilots (WPC)	WPC pilots receive funding for providing services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population. Examples include housing components and care managers.
Massachusetts	SUD demonstration	Program provides outpatient, residential inpatient and community SUD services to promote treatment and recovery as part of a statewide opioid action plan. Approved services include recovery support navigator services, recovery coach services, and other residential services based on ASAM [American Society of Addiction Medicine] principles.
Massachusetts	Delivery System Reform Incentive Payment Program (DSRIP)	State provides funds to ACOs for "Flexible Services," that is, services not currently reimbursed by MassHealth but support "health-related social needs." Examples include behavioral health-related services and transition services.
New Jersey	SUD demonstration	Demonstration provides a comprehensive and coordinated SUD benefit to adults and children, including the continuum of SUD services provided to Medicaid beneficiaries who reside in residential treatment facilities. The services include residential treatment, withdrawal management, medication-assisted treatment, peer supports and targeted case management.

Source: Mathematica’s analysis of section 1115 demonstration special terms and conditions, project toolkits, state websites, and other available state documentation.

Early lessons regarding the implementation of managed care program design strategies

Policymakers view strategies targeting managed care, specifically regarding the integration of benefits, as being necessary but not sufficient for achieving clinical PBHI. As a policymaker in New York said: "... having a single point of accountability with a health plan is essential...The services are complicated enough without having the benefits aligned." On the other hand, a policymaker in Massachusetts noted that having an MCP without sufficient experience caring for complex populations can be problematic, and bringing in additional supports to ensure care is appropriately managed for beneficiaries with behavioral health needs is critical.

Beyond benefits integration, states are enhancing or adding new services to managed care—for example, through their SUD demonstrations—to ensure providers get paid for delivering these services. However, even with expanded benefits, some services supportive of PBHI are still not covered. For example, a provider noted that care management is not always covered by MCPs.

States are seeking to engender shared accountability between MCPs and provider networks for the care of beneficiaries with behavioral health needs, which has resulted in some new collaboration between MCPs and providers. However, stakeholders in Massachusetts, New Hampshire, and New York noted the lack of clearly defined roles and responsibilities between plans and providers for integrating care as well as blurred lines of accountability. One provider representative in New Hampshire noted that delineating responsibilities for care management and care coordination between IDNs and MCPs is a "holy grail" because it informs actual investments made by the two entities. There is also the perception that participation in integration is not a high priority for MCPs, because behavioral health often comprises a small component of their overall business.

Technical assistance

States are providing a variety of TA activities to support clinical PBHI through section 1115 demonstrations. Directly, or through intermediaries, states have developed tools, resources, and training to support integrate care. TA is an important vehicle to provide targeted aid, especially for behavioral health and community providers who are facing new challenges with integrated care, such as billing or HIT requirements.

Much of this support takes the form of learning collaboratives and seminars that can bring providers together to share best practices and discuss challenges. New York established the Medicaid Accelerated eXchange (MAX) Series Program to provide topic-specific support to PPSs. One of the MAX series focused on integrating behavioral health and primary care services. The series combined learning collaboratives, "action teams" comprised

of participating providers, in-person workshops, and training in integrated care. The MAX series culminated in a final report that summarizes key insights for all PPSs (Integrating Behavioral Health and Primary Care Services 2017). Massachusetts has a specific TA program to support organizations in implementing evidence-based interventions for PBHI. TA is also built in to some programs by requiring participating entities to facilitate learning among their members. For example ACHs in Washington and IDNs in New Hampshire are expected to provide the necessary TA for their members.¹⁹ Table B.3 (Appendix B) highlights additional examples of PBHI-specific TA.

Early lessons regarding the implementation of technical assistance

Policymakers and providers in California, Massachusetts, New Hampshire, and New York cited TA and learning collaboratives as being beneficial, specifically for bringing various provider types together and changing provider culture—a particularly meaningful outcome given the traditional lack of collaboration between physical and behavioral health providers. In California and New Hampshire, TA has also been useful for addressing specific issues, particularly how to use HIT for measure reporting and analytics. However, in some states, TA offered by other organizations reduced the need for state-provided TA. For example, one provider representative said that organizations with greater subject matter expertise had been more helpful than the TA available through the demonstration.

Considerations for future section 1115 demonstrations addressing physical and behavioral health integration

We sought to understand how states designed their section 1115 demonstrations and how the policy strategies included in their demonstrations influenced PBHI activity at the provider level. Overall, through their section 1115 demonstrations, states have made clinical PBHI a priority in delivery system reform, brought primary care and behavioral health providers together, and fostered shared accountability among MCPs and providers for the management of beneficiaries with behavioral health needs. Stakeholder feedback reflected the importance of using multiple policy levers simultaneously to both address various challenges to integration and also tailor strategies to certain patient populations. It is too early to determine whether PBHI strategies and initiatives have been effective in reducing health care costs and improving health outcomes. However, based on stakeholder reflections and our synthesis of qualitative findings regarding the implementation of strategies to address PBHI, we outline a set of considerations to inform future section 1115 demonstrations addressing PBHI.

Encourage coordination at the state agency level. To promote integrated care models, states need to ensure coordination across state agencies. This approach can range from collaboration to full integration of separate agencies that oversee physical, mental, or behavioral health. State policymakers should ensure that new programs and demonstrations align with current programs focused on integrated care and that demonstration components promote aligned incentives for providers and MCPs, given other state initiatives that may affect the same entities. According to CMS officials, CMS intends to make cross-agency collaboration an aspect of the SMI/SED demonstrations.

Address barriers to data-sharing before implementation. States should clarify and redress state regulatory barriers to sharing patient data. To facilitate coordination, they should provide guidance to facilitate data sharing across providers and with MCPs. Creating uniform data-sharing agreements may be one method to support providers as they negotiate and enter into new agreements for the purposes of clinical PBHI. Through training, states should help providers learn how to navigate the numerous privacy laws germane to PBHI, most notably 42 CFR Part 2. CMS can also support states by including TA, guidance, and potentially funding for data sharing through demonstrations and outreach initiatives, such as the Innovation Accelerator Program.^{20,21} Finally, as SAMHSA continues to explore revisions to 42 CFR Part 2, CMS should consider actively soliciting and relaying provider and beneficiary input regarding potential benefits and costs of any revisions intended to support PBHI.

Allow for flexibility to target specific patient populations. Flexibility in designing clinical or community-based strategies is important when moving to PBHI, because different populations and localities may require different models of care integration. At the same time, where there are evidence-based models and practices, state programs should prescribe that core components be adopted. This approach can help to scale up proven models and give providers leeway to adapt the models to different contexts, which is consistent with the intent of section 1115 demonstrations to test new approaches.

Construct requirements for provider collaborations that support integrated care models. The inclusion of various provider types in the provider collaborations that participate in section 1115 delivery system reform demonstrations can influence which integrated care models are most feasibly implemented. As states determine which patient populations have the highest needs, they should consider which providers are necessary to meet those needs and create provider participation requirements for collaborations that align with targeted integrated care approaches.

Design an integrated care approach with workforce capacity in mind. Although DSRIP demonstrations include expanding workforce capacity, this challenge continues to affect clinical PBHI. Providing infrastructure investments to hire additional providers is likely insufficient to ensure an adequate network of behavioral health providers. As in the Massachusetts Statewide Investments initiative, states may consider using DSRIP funds to support solutions to increase the overall supply of behavioral health providers, such as student loan repayment programs, residency training, and clinical leadership opportunities. Another alternative, also incorporated in demonstrations, is to rely more heavily on community health workers, peer wellness specialists, or personal health navigators who can mitigate workforce shortages and provide critical supports to people with behavioral health conditions.

Specify expectations for integrated care in agreements between MCPs and providers. To promote fully integrated care, states should outline MCP contractual requirements regarding the types of providers, benefits, and payment arrangements MCPs should include in their networks and provider contracts. States should also provide guidance regarding the respective roles and responsibilities of MCPs and providers in advancing PBHI.

Provide guidance on how to sustain PBHI activities. As states seek to promote VBP for provider payment through Medicaid managed care, they can leverage VBP as a potential mechanism for sustaining the PBHI changes beyond the demonstration period. To inform MCP and provider activity, states should provide guidance on how PBHI activities can be sustained through VBP models. Outside the context of VBP, states must develop a process for ensuring reimbursement for behavioral health activities. Some providers noted that in the near-term, DSRIP funds helped overcome gaps in payment for behavioral health services; however, a process for reimbursing these behavioral health services is necessary for supporting a long-term transition to PBHI.

Conclusions

States seeking to achieve PBHI for Medicaid beneficiaries face complex and pressing challenges that require multifaceted policy strategies. Section 1115 demonstrations grant policymakers the flexibility to develop multiple concurrent strategies to promote integrated care. In designing their section 1115 demonstrations, policymakers targeted challenges at the system and provider levels, such as gaps in services, workforce shortages, inadequate data-sharing and coordination, and fragmented provider networks. States appear to be making progress, as qualitative findings suggest that the infrastructure investments and increased provider collaboration are supporting clinical PBHI. However, gaps and persistent challenges

remain, such as HIT and data-sharing barriers which reinforce fragmented care. In addition, a shortage of behavioral health professionals frustrates reform efforts and can only be partially addressed through demonstration policies.

Our qualitative findings also highlight the diversity of state approaches underway. Although outcome evaluations for

each of the state demonstrations are not yet completed, the diversity of state approaches makes it possible to compare the effectiveness of the mix and intensity of these strategies. Evaluations of the state demonstrations will help illuminate which strategies result in increased integration and improved outcomes, such as improved behavioral health screening, appropriate follow-up care, and reduced inpatient utilization.

DATA SOURCES AND METHODS

This issue brief compares state strategies to promote physical and behavioral health integration (PBHI) through section 1115 delivery system reform demonstrations. We selected states that operated a delivery system reform demonstration as of April 2018, which included: Arizona, California, Massachusetts, New Hampshire, New Jersey, New York, Oregon, Texas, and Washington. Some of these states (California, Massachusetts, and New Jersey) also operated demonstrations focused on substance use disorder services. By including states with both types of demonstrations, we sought to learn how certain strategies, such as delivery system changes and service expansions, work together to promote PBHI.

We analyzed data from multiple sources. Between May and June 2018, we conducted 14 semi-structured telephone interviews with state policymakers and primary care and behavioral health representatives in five states implementing delivery system reform incentive payment (DSRIP) demonstrations: California, Massachusetts, New Hampshire, New Jersey, and New York. We sought to interview state evaluators in states that were further along in their demonstration implementation to glean any insights on the effectiveness of various strategies. We contacted evaluators in three states, all of whom indicated that their data collection was either too nascent or did not focus explicitly on PBHI, so it was not appropriate to interview them. Interviews focused on the state context motivating efforts to promote PBHI, the types of clinical activities states sought to influence, state strategies to promote PBHI, and the effects of those strategies on provider and clinical changes. We recorded interviews, with the interviewees' consent, transcribed the notes, and extracted data from the notes into analytic tables organized by factors in the conceptual framework. For the full range of included states, we also collected data from the states' Section 1115 demonstration special terms and conditions and other documentation, to understand the range of strategies states are using to promote PBHI through section 1115 waiver authority. See Appendix A for a full list of state resources reviewed for this brief.

ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica, IBM Watson Health, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program, as well as to inform CMS decisions regarding future section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four categories of demonstrations: (1) delivery system reform incentive payment (DSRIP) demonstrations, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports (MLTSS). This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. The reports informed an interim outcomes evaluation in 2018 and will inform a summative evaluation report in 2020.

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Endnotes

¹ Thirty-three states and the District of Columbia have opted to expand Medicaid as of July 2018 (Kaiser Family Foundation 2018).

² This includes Medicaid managed care plans, CHIP plans, and Alternative Benefit Plans.

³ For example, the Standard Framework for Levels of Integrated Healthcare details six levels of integrated care that vary according to the proximity and care delivery approach of behavioral health and physical health providers (see SAMHSA-HRSA Center for Integrated Health Solutions 2013).

⁴ Adapted from: Medicaid and CHIP Payment and Access Commission. "Chapter 4: Integration of Behavioral and Physical Health Services in Medicaid." Washington DC: Medicaid and CHIP Payment and Access Commission, March 2016.

⁵ Arizona's Targeted Investment Program (TIP) and California's Whole Person Care Pilots have an exclusive objective of supporting PBHI, which is a more specific focus than DSRIP or DSRIP-like demonstrations. We have classified these programs as delivery system reform demonstrations because they primarily rely on funding and performance-based incentives to support care coordination activities, necessary infrastructure, or treatment expansions.

⁶ Federal statute prevents most states from using federal Medicaid funds to reimburse providers for care provided to individuals, ages 21 to 64, at Institutions for Mental Disease (IMD).

⁷ SMI/SED demonstrations permit the use of federal funds to provide services to these beneficiaries who are short-term residents of IMDs primarily to receive mental health treatment. Under this opportunity, federal matching funds will be tied to states' engagement in a number of actions to improve the quality of care in IMDs and improve community-based mental health care, and as such, may be part of states' broader efforts to advance PBHI (State Medicaid Director Letter [SMDL] 18-011).

⁸ For example, states can use section 1932(a), 1915(a), or 1915(b) federal Medicaid authorities to create integrated managed care programs.

⁹ For example, states can integrate or promote greater collaboration among agencies that oversee physical or behavioral health services (Bachrach 2014; MACPAC 2016). Because enhanced intergovernmental integration is generally not done through section 1115 demonstrations, it is not discussed in this brief. However, according to CMS officials, CMS intends to make cross-agency collaboration an aspect of the SMI/SED demonstrations.

¹⁰ The initiative consists of four programs: (1) Primary care integration models and retention program, (2) Investment in Primary Care Residency Training, (3) Workforce professional development grant program, and (4) Additional funding sub-streams for Accountable Care Organizations, Community Partners, and Community Service Agencies. The primary care integration models and retention program is a grant program that allows primary care and behavioral health providers to design and carry out one-year projects related to accountable care. In addition, to help offset hospital and community health center costs of filling residency slots for community health and mental health centers, the state has the Investment in Primary Care Residency Training program. The other funding streams help support participating providers' ongoing investments in workforce and health information technology.

¹¹ Valuation is the method for assigning value to specific projects or performance metrics in the context of DSRIP demonstrations. States have developed different valuation approaches, but they are broadly intended to capture such factors as the complexity, value, and investment necessary to implement the project.

¹² The IMPACT (Improving Mood—Promoting Access to Collaborative Treatment) Model is an integrated care model that focuses on beneficiaries with depression and is typically provided in a primary care setting. Trained depression managers work with patient, primary care provider, and a psychiatrist to develop and administer a treatment plan (Unützer et al. 2013).

¹³ In demonstration special terms and conditions and state project toolkits, states have generally provided a framework for delivery system reform without prescribing specific approaches to clinical PBHI adoption. Given this flexibility, project implementation can vary across participating providers within a state. We identified PBHI-related projects and projects that support clinical PBHI components based on the projects descriptions outlined in state demonstration documentation, such as special terms and conditions.

¹⁴ In Massachusetts, behavioral health and LTSS community partners are eligible to receive DSRIP funds in addition to ACOs.

¹⁵ Not all provider collaborations in section 1115 demonstrations are required to include behavioral health or community partners. For example, Texas's DSRIP includes requirements for states to organize Regional Healthcare Partnerships (RHPs). However, RHPs are not designed to support integrated care with a continuum of behavioral, physical, and community health providers.

¹⁶ Arizona moved to a fully integrated benefit package for all of Medicaid managed care in October 2018.

¹⁷ Projects are also a vehicle for expanding availability of PBHI-supporting services. This use is detailed within the “Financial Strategies” section.

¹⁸ Similar to SUD demonstrations, the forthcoming SMI/SED demonstration opportunities may also expand services through expanded federal financial participation (FFP) for beneficiaries who are short-term residents in IMDs. The additional FFP may be administered through a variety of payment strategies, including enhanced administrative match, fee-for-service payments, or payments through managed care entities (State Medicaid Director Letter [SMDL] 18-011). These demonstrations have yet to be implemented as of January 2019.

¹⁹ In Washington's DSRIP, a project domain (Domain 1 Health and Community Systems Capacity Building) specifies cross-cutting support for workforce and systems for population health management that are necessary for projects.

²⁰ Through the Medicaid Innovation Accelerator Program, CMS offers technical assistance, tools, and other resources across program and functional areas, including Substance Use Disorder, Physical and Mental Health Integration, and Data Analytics. See: Centers for Medicare & Medicaid Services. “Medicaid Innovation Accelerator Program,” available at <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/index.html>

²¹ In the State Medicaid Director Letter on SMI/SED demonstrations, CMS has noted that enhanced federal Medicaid matching funds could be made available to improve data-sharing between hospitals and other settings (State Medicaid Director Letter [SMDL] 18-011).

Appendix A. State documents

ARIZONA

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MASSACHUSETTS

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Centers for Medicare & Medicaid Services. “MassHealth Medicaid Section 1115 Demonstration (No. 11-W-00030/1).” Demonstration approval period: July 1, 2017 through June 30, 2022. Amended June 27, 2018. Available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf>

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NEW HAMPSHIRE

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Centers for Medicare & Medicaid Services. “New Hampshire Building Capacity for Transformation (No. 11-W-00301/1).” Demonstration approval period: February 22, 2017 through December 31, 2020. Technical Corrections February 22, 2017. Available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-building-capacity-transformation-ca.pdf>.

NEW JERSEY

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OREGON

Centers for Medicare & Medicaid Services. “Oregon Health Plan (OHP) (No. 21-W-00013/0 and 11-W-00160/0).” Demonstration approval period: January 12, 2017 through June 30, 2022. Available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-plan2-ca.pdf>.

“Coordinated Care Organizations.” Available at <https://www.oregon.gov/oha/HSD/OHP/Pages/Coordinated-Care-Organizations.aspx>.

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TEXAS

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WASHINGTON

“Attachment C: DSRIP Planning Protocol.” June 28, 2017. Available at <https://www.hca.wa.gov/assets/program/dsrip/planning-protocol.pdf>.

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Appendix B: Detailed tables on section 1115 demonstrations

Table B.1. State section 1115 demonstrations that support physical and behavioral health integration (PBHI)

State	Waiver	Demonstration	Time period	Overview
AZ	Arizona Health Care Cost Containment System (AHCCCS)	Regional Behavioral Health Authorities (RBHAs)	October 1, 2015–September 30, 2021	RBHAs manage the delivery of physical health services and behavioral health services for individuals with serious mental illness.
AZ	Arizona Health Care Cost Containment System (AHCCCS)	Targeted Investments Program (TIP)	January 18, 2017–September 30, 2021	The TIP provides financial incentives to participating AHCCCS registered providers for “increasing physical and behavioral health care integration and coordination for individuals with behavioral health needs.” The TIP aims to “reduce fragmentation that commonly occurs between acute care and behavioral health care, increase efficiencies in service delivery for members with behavioral health needs and improve health outcomes for the affected populations.” (Arizona Health Care Cost Containment System, Section 1115(a) Special Terms and Conditions, p. 42)
CA	Medi-Cal 2020 Demonstration	Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	December 30, 2015–December 31, 2020	The PRIME Program is a five-year initiative under the Medi-Cal 2020 Section 1115 waiver that builds upon the Delivery System Reform Incentive Payment (DSRIP) program established under the Bridge to Reform waiver. Physical and behavioral health integration is listed as one of the primary goals of the PRIME program.
CA	Medi-Cal 2020 Demonstration	Drug Medi-Cal Organized Delivery System (DMC-ODS)	December 30, 2015–December 31, 2020	Counties participating in DMC-ODS can cover an expanded array of substance use disorder (SUD) services for Medi-Cal enrollees in their community.
CA	Medi-Cal 2020 Demonstration	Whole Person Care Pilots (WPC)	December 30, 2015–December 31, 2020	WPC is a five-year federally funded pilot program to test county-based initiatives that coordinate health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems and have poor outcomes.
MA	MassHealth	Delivery System Transformation Initiative (DSTI Renewal)	Waiver: October 30, 2014–June 30, 2019 DSTI: October 30, 2014–June 30, 2017	The DSTI is an incentive payment program to support eligible safety net hospitals’ investments in delivery system transformation initiatives that aim to enhance the quality of care, improve population health, and lower health care costs. Objectives of the demonstration include improving integration among physical health, behavioral health, long-term services and supports (LTSS), and health-related social services.
MA	MassHealth	Delivery System Reform Incentive Payment Program (DSRIP)	July 1, 2017–June 30, 2022	The DSRIP demonstration provides funding for several initiatives, including accountable care organizations, behavioral health and LTSS community partners, community service agencies, and statewide investments, many of which have a focus on behavioral health integration. Improving PBHI is also one of the overall state demonstration goals.
MA	MassHealth	Substance Use Disorder (SUD) Demonstration	July 1, 2017–June 30, 2022	The SUD program provides enhanced services to beneficiaries. “By providing improved access to treatment and ongoing recovery support, EOHS [Executive Office of Health and Human Services] believes individuals with SUD will have improved health and increased rates of long-term recovery. These SUD services will contribute to reduced use of the emergency department and unnecessary hospitalizations.” (MassHealth Medicaid Section 1115 Demonstration, Section 1115 Special Terms and Conditions, p. 42)
NH	Building Capacity for Transformation	DSRIP	January 5, 2016–December 31, 2020	Through its DSRIP demonstration, New Hampshire seeks to transform its behavioral health delivery system by “integrating physical and behavioral health to better address the full range of beneficiaries’ needs, expanding provider capacity to address behavioral health needs in appropriate settings, and reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.” (New Hampshire Building Capacity for Transformation, Section 1115(a) Special Terms and Conditions, p. 2)
NJ	New Jersey FamilyCare Comprehensive Demonstration	DSRIP	August 1, 2017–June 30, 2022	New Jersey’s DSRIP demonstration offers incentive payments to hospitals for completing projects in multiple focus areas, one of which is behavioral health.

State	Waiver	Demonstration	Time period	Overview
NJ	New Jersey FamilyCare Comprehensive Demonstration	Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) program	October 31, 2017–June 30, 2022	New Jersey will provide a comprehensive and coordinated SUD benefit to adults and children while also allowing for the continuum of SUD services provided to Medicaid beneficiaries who reside in residential treatment facilities.
NY	Medicaid Redesign Team	DSRIP	December 7, 2016–March 31, 2021	New York's DSRIP includes an emphasis on PBHI in its project selection. All participants must select one project to create integrated delivery systems as well as another project on care coordination or connecting settings. New York also requires a behavioral health clinical improvement project.
NY	Medicaid Redesign Team	Health and Recovery Plans (HARPs)	July 1, 2015–March 31, 2021	HARPs "integrate physical, behavioral health and HCBS [Home and community based services] for Medicaid enrollees with diagnosed severe mental illness (SMI) and/or substance use disorder (SUD) to receive services in their own homes and communities." (Medicaid Redesign Team, Section 1115 Special Terms and Conditions, p. 4)
OR	Oregon Health Plan	Coordinated Care Organizations (CCOs)	January 12, 2017–June 30, 2022	The Oregon Health Plan demonstration provides incentive payments to community-based managed care organizations called CCOs, which focus on integrating physical, behavioral, and oral health care.
TX	Texas Healthcare Transformation and Quality Improvement Program	DSRIP	December 12, 2011–December 31, 2017	Texas' DSRIP demonstration provides incentive payments to Regional Healthcare Partnerships for participating in a set of projects, which includes PBHI projects.
TX	Texas Healthcare Transformation and Quality Improvement Program	DSRIP Extension	January 1, 2018–September 30, 2022	Texas' DSRIP demonstration provides incentive payments to Regional Healthcare Partnerships for participating in core activities designed to achieve certain measure goals. State core activities include availability of appropriate levels of behavioral health care services, SUD, and behavioral health crisis stabilization services. The state's DSRIP renewal provides incentives for measure bundles, several of which are related to behavioral health.
WA	Medicaid Transformation Project	DSRIP	January 9, 2017–December 31, 2021	Washington's DSRIP demonstration provides performance-based incentive payments to Accountable Communities of Health for completing projects that fulfill demonstration objectives, which include "bi-directional integration of physical and behavioral health" and "community-based whole-person care." (Washington State Medicaid Transformation Project, Section 1115 Special Terms and Conditions, p. 18)

Source: Mathematica's analysis of section 1115 demonstration special terms and conditions.

AZ = Arizona; CA = California; MA = Massachusetts; NH = New Hampshire; NJ = New Jersey; NY = New York; OR = Oregon; TX = Texas; WA = Washington

Table B.2. Physical and behavioral health integration (PBHI) project descriptions in section 1115 demonstrations

Demonstration	Primary PBHI project in demonstration	Required?	Project objective
AZ (Targeted Investments Program)	1) Ambulatory Project 2) Hospital Project	Not applicable	Ambulatory project: Integrate primary care and behavioral health services for the purposes of better coordination of preventive and chronic illness care. Hospital project: Coordinate care for adults with a primary discharge diagnosis of behavioral health and persons with a serious mental illness designation who are being discharged from an inpatient stay
CA (Public Hospital Redesign and Incentives in Medi-Cal)	Integration of Physical and Behavioral Health	Y	Integrate mental health and substance abuse with primary care and ensure coordination of care for all services.
MA (Delivery System Transformation Initiative Renewal—expired demonstration)	Integrate Physical Health and Behavioral Health	N	Implement an integrated care delivery model for physical health and behavioral health (BH)
NH Delivery System Reform Incentive Payment Program (DSRIP)	Integrated Healthcare (Project B1)	Y	Primary care providers, BH providers, and social services organizations must partner to implement an integrated care model; Integrated Delivery Networks provide training and support to various practices and types of providers in becoming a “coordinated care practice” or an “integrated care practice.”
NJ (DSRIP)	Integrated Health Home for the Seriously Mentally Ill	N	Fully integrate BH and physical health services for those with a serious mental illness diagnosis.
NY (DSRIP)	Integration of Primary Care and Behavioral Health Services (Project 3.a.i)	N	Select one of three different clinical models for integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.
OR (Coordinated Care Organizations)	Integrating Primary Care and Behavioral Health (Focus Area 4) ^a	Y	Develop and implement a health care delivery model that integrates mental health and physical health care.
TX (DSRIP—expired demonstration)	Integrate Primary and Behavioral Health Care Services (Project 2.15)	Y	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
WA (DSRIP)	Bi-Directional Integration of Physical and Behavioral Health Through Care Transformation (Project 2A)	Y	Implement at least one approach integrating BH into primary care settings and at least one approach integrating primary care into BH settings.

Source: Mathematica’s analysis of section 1115 demonstration special terms and conditions, project toolkits, and other available state documentation.

Note: Primary projects are those that explicitly denote integration as an objective.

AZ = Arizona; CA = California; MA = Massachusetts; NH = New Hampshire; NJ = New Jersey; NY = New York; OR = Oregon; TX = Texas; WA = Washington

^a Oregon’s demonstration refers to required provider activity as focus areas instead of projects.

Table B.3. State technical assistance that supports physical and behavioral health integration (PBHI) in section 1115 demonstrations

State	Demonstration	Description
Arizona	Targeted Investment Program (TIP)	As a core component for projects, state requires participation in a learning collaborative or other training.
Massachusetts	Delivery System Reform Incentive Payment Program (DSRIP)	Massachusetts, as part of the “Statewide Investments” program, has a Technical Assistance (TA) program for ACOs, Community Partners (CPs) and Community Service Agencies (CSAs) to help with implementation of evidence-based interventions. The state pays for the TA for entities that apply and are awarded funding.
New Hampshire	DSRIP	New Hampshire provides technical assistance through IDN [Integrated Delivery Network] Learning Collaboratives that is intended to support project implementation and address operational, administrative and data challenges.
New York	DSRIP	New York has the Medicaid Accelerated eXchange (MAX) Series Program MAX to support PPSs in DSRIP. One of the MAX series focused in integrating behavioral health and primary care services. The series included creating teams of providers that attended in-person workshops and training on PBHI. The MAX series culminated in a final report that summarizes key insights for performing provider systems integrating physical and behavioral health care.
Oregon	Coordinated Care Organizations (CCOs)	Oregon’s demonstration includes a Transformation Center that, in addition to learning collaboratives, offers 10 hours of TA to each CCO to support a behavioral integration project. The center also helps with the development of reporting, data, and analytics to improve care coordination and management.

Source: Mathematica’s analysis of section 1115 demonstration special terms and conditions, project toolkits, and other available state documentation.