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Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

IMPROVING THE COORDINATION OF SERVICES FOR ADULTS WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS:

PROFILES OF FOUR STATE MEDICAID INITIATIVES

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IMPROVING THE COORDINATION OF SERVICES FOR ADULTS WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS: Profiles of Four State Medicaid Initiatives

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ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ACT	Assertive Community Treatment
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
BHO	Behavioral Health Organization
BHSN	Behavioral Health Safety Net
CCE	Care Coordination Entity
CDBG	Community Development Block Grant
CHI	Tennessee Creating Homes Initiative
CMHC	Community Mental Health Center
CMS	HHS Centers for Medicare and Medicaid Services
CPST	Community Psychiatric Support and Treatment
CSoC	Comprehensive System of Care
CSP	Community Support Program
CSPECH	Massachusetts Community Support Program for Ending Chronic Homelessness
CSW	Community Support Worker
DHH	Louisiana Department of Health and Hospitals
DMHSAS	Tennessee Department of Mental Health and Substance Abuse Services
ED	Emergency Department
EHR	Electronic Health Record
FQHC	Federally Qualified Health Center
HEDIS	Healthcare Effectiveness Data and Information
HFS	Illinois Department of Healthcare and Family Services
HHG	Massachusetts Home and Healthy for Good
HHO	Illinois Heartland Health Outreach
HHS	U.S. Department of Health and Human Services
HMIS	Homeless Management Information Systems
HUD	U.S. Department of Housing and Urban Development
ICM	Intensive Case Management
LBHP	Louisiana Behavioral Health Partnership

LOCUS	Level of Care Utilization System
MBHO	Managed Behavioral Health Organization
MBHP	Massachusetts Behavioral Health Partnership
MCO	Managed Care Organization
MHCC	Illinois My Health Care Coordination
MHCM	Mental Health Case Management
MHSA	Massachusetts Housing and Shelter Alliance
NCQA	National Committee for Quality Assurance
NOM	National Outcome Measure
OBH	Louisiana Office of Behavioral Health
PCC	Primary Care Clinician
PCP	Primary Care Physician
PMPM	Per-Member Per-Month
PSH	Permanent Supportive Housing
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SMI	Serious Mental Illness
SMOC	South Middlesex Opportunity Council
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income
SUD	Substance Use Disorder
T4H	Illinois Together4Health
TAMHO	Tennessee Association of Mental Health Organizations

EXECUTIVE SUMMARY

Medicaid beneficiaries with mental health and substance use disorders (SUDs) require an array of physical, behavioral health, and other supportive services. Access to preventive health care, housing, and social services is particularly challenging for this population (Perese 2007). In the absence of comprehensive coordinated services, these individuals often receive costly inpatient and emergency care and experience negative social and health outcomes, including homelessness and premature mortality. Medicaid beneficiaries with serious mental illnesses in particular are among the most costly Medicaid beneficiaries, due in part to higher rates of emergency department utilization and inpatient hospitalizations (Kronick et al. 2009; Durden et al. 2010).

Historically, the financing and delivery of physical, behavioral health, and other supportive services have been fragmented (New Freedom Commission 2003). Within Medicaid programs, physical and behavioral health services have often been provided through different financing arrangements with inadequate coordination across state and local agencies and managed care plans. In many states and communities, housing supports and other social services are delivered through various providers who have difficulty coordinating care with physical and behavioral health providers. Some states, however, are undertaking efforts to improve the coordination of care for Medicaid beneficiaries with behavioral health conditions at the state and local levels. Such strategies are being implemented in the context of other delivery system reforms, including Medicaid eligibility expansions, which may increase pressure on states to provide care for newly eligible populations with mental health and SUDs.

As delivery and payment systems evolve, policymakers, managed care organizations (MCOs), providers, and other stakeholders need information on how states are financing and delivering coordinated services for Medicaid beneficiaries with mental health and SUDs. To provide such information, the Office of the Assistant Secretary for Planning and Evaluation within the U.S. Department of Health and Human Services contracted with Mathematica Policy Research to conduct case studies to describe the financing arrangements and delivery system mechanisms that four states are using in their efforts to improve the delivery of comprehensive coordinated care for Medicaid beneficiaries with behavioral health conditions. These states are implementing the following strategies:

- **Illinois:** The state Medicaid program is supporting regional care coordination entities that include behavioral health and housing providers to implement in-person care coordination models. The state hopes that MCOs will ultimately contract with these new entities to provide more intensive care coordination for individuals with chronic behavioral health conditions.

- **Louisiana:** The state expanded the scope of Medicaid mental health and substance abuse benefits and contracted with a single statewide managed behavioral health organization (MBHO) to administer all specialty behavioral health services. These changes are intended to ensure that a single entity is responsible for the coordination of services, including housing supports.
- **Massachusetts:** As part of its capitated payment to a MBHO, the state Medicaid program reimburses care coordination support for chronically homeless individuals in permanent supportive housing. The state is hoping to expand this program to other MCOs.
- **Tennessee:** The state Medicaid program has integrated physical health, mental health, and substance abuse benefits within its managed care contracts; MCOs now operate on an at-risk basis for these services along with long-term care services.

These state programs involve different funding mechanisms and rely on diverse strategies to organize and deliver care, with each program reflecting its unique state and local environment. Given their different contexts and target populations, some of these strategies are being implemented within existing Medicaid delivery systems and billing structures; others involve more substantial system reforms. Despite the structural differences of these strategies, the study identified several common themes across states:

- **These states are moving toward greater reliance on Medicaid managed care entities to coordinate care, which has involved expanding and integrating benefits at the health plan level and creating reimbursement mechanisms that support in-person care coordination.** When moving to managed care, states have had to consider ways to minimize disruption of provider billing processes and ensure that service definitions and eligibility criteria support access to ongoing comprehensive coordinated care. In some states, these issues continue to present challenges.
- **In-person care coordination provides a critical service to individuals with serious mental health and SUDs.** Medicaid benefits in these states include reimbursement for case management and other in-person supports (such as Assertive Community Treatment) for beneficiaries with the most serious needs. Stakeholders in these states, particularly providers, noted that telephonic care coordination alone does not provide a sufficient level of support for this population.
- **These initiatives recognize that the success of their strategies depends on the strength of provider buy-in and local partnerships, and have taken steps to foster local collaborations.** Stakeholders stressed that smooth implementation of care coordination strategies requires strong communication among providers, MCOs, state agencies, and consumer organizations.

- **Stakeholders in these states stressed the importance of data-sharing to inform care coordination decisions at the provider level and to identify opportunities for quality improvement.** The availability of data and capacity of providers and other stakeholders to use data for care coordination and quality improvement varies widely across states. Some states, particularly those with managed care arrangements, have more robust data to track service utilization and monitor quality. In other states, data-sharing between providers and/or other entities is more limited, due in part to the lack of common data platforms.
- **All of these strategies include efforts to bridge behavioral health services with housing supports.** These states are taking steps to foster relationships between behavioral health and housing providers and state agencies. They are also either encouraging or requiring Medicaid managed care plans and provider networks to develop and reimburse care coordination or case management strategies specifically focused on beneficiaries with housing needs.
- **Although some of these strategies are relatively new and continue to evolve, the stakeholders involved are generally optimistic that these efforts will improve the accessibility, quality, and outcomes of care while reducing costs.** Stakeholders, particularly provider organizations, noted the importance of reimbursement for care coordination or in-person case management, and identified data-sharing between providers, health plans, and state agencies as critical to the success of their initiatives.

These case studies provide a snapshot of states' activities in a rapidly changing health care system. Although this study could not assess the impacts of these strategies on service utilization, costs, or other outcomes, policymakers, MCOs, and other stakeholders may wish to further consider the key components of these programs in efforts to improve the coordination of care for Medicaid beneficiaries with behavioral health conditions. Further monitoring and research focused on these programs is necessary to examine long-term outcomes and identify any specific mechanisms that may facilitate or impede success.

I. INTRODUCTION

A. Background and Statement of the Problem

Medicaid beneficiaries with mental health and substance use disorders (SUDs) often have complex conditions that require a comprehensive array of physical, behavioral health, and other supportive services. Unfortunately, many of these beneficiaries fail to receive the necessary services and supports. For example, recent research has found that only 5 percent of Medicaid beneficiaries with schizophrenia or bipolar disorder maintain a continuous supply of guideline-concordant medications and receive medication monitoring, preventive physical health care, and outpatient mental health care during the course of a year (Brown et al. 2012). Individuals with serious mental illnesses (SMIs) in particular have high rates of emergency department (ED) use and inpatient hospitalizations, and have been found to be one of the costliest groups of Medicaid beneficiaries (Kronick et al. 2009; Durden et al. 2010; Greenberg 2012). Furthermore, this population is at risk for homelessness and housing instability, and has trouble accessing public benefits and social services, including income support, supportive housing, and employment programs (Perese 2007).

Historically, the financing and delivery of physical and behavioral health, and other supportive services, have been fragmented (New Freedom Commission 2003). Within Medicaid programs, physical and behavioral health services have often been provided through different financing arrangements, with inadequate coordination across managed care plans or providers. In many states and communities, housing supports and other human services are delivered through various agencies that do not coordinate with each other or with state Medicaid programs. Some states and communities, however, are taking steps to improve the coordination of care. The financing strategies to support these efforts range from enhanced primary care case management programs to the integration of physical health, behavioral health, and supportive service benefits within Medicaid managed care contracts.

Ongoing health care delivery system and payment reforms and demonstrations are providing states with opportunities to experiment with different models of care coordination. These include new and enhanced Medicaid options for home and community-based services, the development of health homes and Accountable Care Organizations, and dual-eligible demonstrations. These policy developments are taking place amid Medicaid eligibility expansions that are likely to increase the number of beneficiaries with mental health and SUDs in need of services. Within this rapidly changing system, policymakers and other stakeholder need information on the strategies that states are using to improve the coordination of care for Medicaid beneficiaries with behavioral health conditions. A better understanding of these strategies can help inform the efforts of other states and communities and also provide a foundation for more rigorous evaluations in the future. To be most beneficial, such

research must take into account the perspectives of state officials, managed care representatives, providers, and consumers.

B. Purpose of This Report

In 2013, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health and Human Services (HHS) contracted with Mathematica Policy Research to conduct case studies of the financing arrangements and delivery models that states are using to improve the coordination of care for Medicaid beneficiaries with mental health and SUDs in four states: Illinois, Louisiana, Massachusetts, and Tennessee. These case studies build on earlier research conducted by Mathematica (Andrews et al. 2014). This report profiles and describes the key elements of the strategy used in each state, including the financing mechanisms, state-level and local-level partnerships, use of data and information systems, and efforts to improve coordination with housing. Moreover, the case studies sought to describe the “on-the-ground” operation of the care coordination models from the perspectives of providers, consumers, and other stakeholders. Although these case studies do not evaluate the effectiveness or outcomes of the strategies used in these states, policymakers, managed care organizations (MCOs), providers, and other stakeholders may wish to consider the components of these strategies in their own efforts to improve care coordination.

Through document review, key informant interviews, and site visits, the case studies gathered information to answer five overarching questions:

1. To what extent does the strategy being implemented in each state involve changes in the financing, delivery, and scope of services available to adult Medicaid beneficiaries?
2. In what ways do these strategies seek to improve care coordination by fostering new partnerships and developing new care coordination mechanisms?
3. How do various stakeholders perceive these strategies as influencing the accessibility and quality of care, and health care utilization and costs?
4. How do these strategies provide or coordinate with housing and other social services?
5. What data are available in each state to potentially facilitate the monitoring of these efforts and future evaluations?

C. Roadmap to This Report

These case studies yielded a wealth of detailed information about the mechanisms being used to finance and deliver care in each state. This report attempts to concisely summarize the key findings. After briefly describing the data collection methods in the next chapter, Chapter III provides a short description of each state program (Appendices A-D provide detailed profiles of each program). Chapter IV synthesizes key findings across states in response to each research question. Chapter V concludes with a discussion of themes and similarities, and differences across states.

II. METHODS

The data collection involved three phases: (1) selection of state Medicaid programs that have implemented strategies to improve the coordination of behavioral health, physical health, and housing services; (2) document review and discussions with stakeholders in selected states to identify the key features of state programs; and (3) site visits to gather stakeholders' perspectives on the strengths and limitations of the program.

A. State Selection

States had to meet the following inclusion criteria: (1) have an explicit strategy for coordinating behavioral and physical health care services for Medicaid beneficiaries with behavioral health needs; (2) design the strategy as a single financing arrangement at the state level (or consistently across regions); (3) incorporate coordination of behavioral health and housing services into the financing arrangement; and (4) be in operation long enough for respondents to provide their perspectives on program design and implementation successes, challenges, and lessons.

We conducted outreach to a broad range of organizations and experts to identify potential states for the study, including state and federal Medicaid and behavioral health representatives, and state policy and housing experts at the Center for Health Care Strategies, the Technical Assistance Collaborative, and the National Association of County Behavioral Health and Developmental Disability Directors. These experts identified 11 state programs as possible candidates for the study. We then conducted an environmental scan to gather additional information about the key features of the candidate states, which involved searching the websites of MCOs and state Medicaid and behavioral health agencies. Using this information, we excluded states that did not meet all of the inclusion criteria. We also attempted to achieve geographic diversity and select states that were in different stages of implementation but had enough experience to share. In collaboration with ASPE, we selected Illinois, Louisiana, Massachusetts, and Tennessee.

B. Data Collection

To answer the research questions, we relied on data from: (1) document review including websites, reports, provider manuals, managed care contracts, and news releases; (2) semi-structured telephone interviews with state Medicaid and/or behavioral health agency officials and managed care representatives; and (3) two-day site visits that included in-person interviews with providers (including housing providers) and consumer representatives. Phone discussions and in-person meetings focused on

gathering information about the context in which the initiative was developed, changes in the accessibility and quality of care, the mechanisms used to finance and coordinate physical, behavioral health, and housing services, provider and consumer experiences with the strategy used in each state, perceived health and social outcomes, the availability and use of data for care coordination and quality improvement, and any general successes and challenges.

III. SUMMARY OF SELECTED STATE PROGRAMS

Within the specific context of their service systems and needs of their communities, each state is implementing very different strategies to improve the coordination of care. This chapter presents a brief synopsis of each state program (detailed information about each state is provided in Appendices A-D). Table III.1 summarizes the key features of these programs.

A. Illinois--Medicaid-Funded Care Coordination Entities that Foster Partnerships among Local Providers

In 2013, Illinois launched the first of six regional Care Coordination Entities (CCEs)--new partnerships of existing community-based providers that include behavioral health, physical health, housing, and social service agencies. The state Medicaid agency, which oversees the CCEs, auto-enrolled between 1,000 and 1,500 Medicaid beneficiaries with complex health needs in each CCE and pays a per-member per-month (PMPM) coordination fee. The CCEs have the flexibility to use the PMPM fee to cover costs of their choosing, although they primarily use it to cover those costs associated with care coordination services. The state hopes that this flexibility will encourage the CCEs to find the most cost-effective way to improve care and lower overall costs for this population. Payment for all other Medicaid services is covered separately through a fee-for-service arrangement. The state has judged that, for individuals with complex medical needs, it is more effective to coordinate care and services in person than by telephone. It is using this initiative to test providers' capacity for developing cost-effective models for delivering in-person care coordination. Ultimately, the state hopes the MCOs will find the CCE model appealing and will contract with them to coordinate care for their members.

B. Louisiana--Expansion of Medicaid Behavioral Health Benefits Managed by a Single Statewide Managed Behavioral Health Organization

In 2012, the state contracted with a single statewide managed behavioral health organization (MBHO) to manage all behavioral health services for Medicaid and non-Medicaid adults. This new arrangement is one component of a larger ongoing effort known as the Louisiana Behavioral Health Partnership (LBHP)--a partnership of several state agencies, including the Office of Behavioral Health (OBH) and Medicaid, to improve the accessibility and outcomes of care. Physical health services are managed through separate MCOs, collectively known as the Bayou Health Plans. The MBHO operates under a 1915(b) waiver for a prepaid inpatient health plan, a 1915(c) Home and Community-Based Services Waiver, and a 1915(i) State Plan Amendment. The

MBHO operates on an at-risk basis for Medicaid adult behavioral health services and a non-risk basis for behavioral health services for eligible non-Medicaid adults served by the state's public mental health system. In an effort to better coordinate care for people with housing needs, the MBHO also recently took over management of a permanent supportive housing (PSH) program.

C. Massachusetts--Medicaid Managed Care Plan that Covers Coordination Support for Chronically Homeless Individuals in Permanent Supportive Housing

In 2006, the Massachusetts Behavioral Health Partnership (MBHP)--the Medicaid-managed behavioral health care carve-out--implemented the Community Support Program for Ending Chronic Homelessness (CSPECH). This program provides Medicaid reimbursement for community-based coordination support to chronically homeless individuals now in PSH. CSPECH seeks to achieve Medicaid cost savings by serving this high-cost population in housing rather than on the street or in shelters. CSPECH is currently available throughout the state from eight MBHP providers--all of them local partnerships made up of community-based behavioral health and housing providers. Through its capitation, MBHP reimburses CSPECH services, using a flat per-person per-day case rate. Currently, CSPECH is available only to individuals enrolled in the MBHP-covered plan, although the state is encouraging coverage by the other state MCOs.

D. Tennessee--Medicaid Managed Care System with Integrated Behavioral Health Physical Health, and Long-Term Care Benefits

TennCare is a statewide, mandatory managed care program that serves Tennessee's entire Medicaid population under an 1115 demonstration waiver. In 2007, the state began integrating behavioral health services into its managed care contracts. (Previously, a separate MBHO carved out and managed these services.) In 2010, the state began including long-term care services and supports in its managed care contracts. Three MCOs currently operate on an at-risk basis for physical, behavioral health, and long-term care services. By integrating the management of physical and behavioral health services, the state hopes to encourage service coordination at both the plan and provider levels. The MCOs are able to track service utilization across different sectors of care and use that data to coordinate services.

TABLE III.1. Summary of State Strategies for Improving Care Coordination for Medicaid Beneficiaries with Behavioral Health Conditions				
	Illinois	Louisiana	Massachusetts	Tennessee
Program name and start date	Care Coordination Innovations Project, which funds CCEs; began September 2013.	Louisiana Behavioral Health Partnership (LBHP); began March 1, 2012.	Community Support Program for People Experiencing Chronic Homelessness (CSPECH); began 2006.	TennCare; behavioral health integration; began 2007 (behavioral health services fully integrated by 2009).
Overview	The state's Medicaid agency oversees 6 regional CCEs. CCEs are a formal hub of community-based providers representing behavioral health and physical health services, and housing and social service agencies.	State contracts with a single statewide MBHO that operates on an at-risk basis for Medicaid adults and manages care (non-risk) for non-Medicaid adults.	CSPECH is a Medicaid-reimbursable service that provides total care coordination support to chronically homeless individuals who have been placed in PSH.	TennCare is Tennessee's Medicaid program. All managed care contracts integrate physical, behavioral, and long-term care services.
Population	Adult Medicaid beneficiaries with complex health needs, including those with mental health and SUDs. Most clients are auto-enrolled; voluntary selection allowed.	All Medicaid and non-Medicaid adults enroll in the MBHO. Supportive housing is available to Medicaid adults who qualify for 1915(i) or Ryan White services.	Chronically homeless adults who have been placed in supportive housing and served by the MBHP, the state's MBHO.	All Medicaid beneficiaries in the state.
Financing and Medicaid funding authority	CCEs receive a PMPM coordination fee, supported through a mix of state and federal funds, through a 3-year state contract.	States makes prepaid capitated payments to the MBHO for behavioral health services for Medicaid adults and fixed payments for non-Medicaid adults. It is authorized through a 1915(b) waiver, a 1915(c) waiver, and a 1915(i) State Plan Amendment for adults with SMI.	CSPECH offers a type of community support program service for which the state receives CMS approval for reimbursement through its managed care waiver. All state MCOs are approved to provide this level of care; currently only MBHP covers this service.	TennCare makes capitated payments for Medicaid beneficiaries. It operates under a 1115 waiver.

TABLE III.1 (continued)				
	Illinois	Louisiana	Massachusetts	Tennessee
Mechanism(s) for coordinating behavioral health and physical services	CCEs formalize a partnership between local behavioral health, physical health, and other providers. Care coordination teams work for the CCE, thus operating across sectors.	Coordination requirements are embedded in the managed care contract.	CSPECH services are provided by community support workers (CSWs) who coordinate behavioral and physical health care services.	Management of physical and behavioral health care services occurs under the same MCO contract.
Mechanism(s) for coordinating behavioral health and housing services	CCEs include housing and social service providers and care coordination teams, including members with housing experience. PMPM payments could fund non-Medicaid reimbursed supports, although the 2 CCEs interviewed are not currently doing so.	PSH couples housing and behavioral health services. Management of PSH services is integrated into the managed care contract so that behavioral health or long-term care services can be funded through Medicaid.	CSPECH is part of the state's Housing First initiative; services require a partnership between a behavioral health provider and a housing provider. When a housing unit is available within the partnership, the CSW works with local shelter staff to identify a potential beneficiary.	The TennCare Medicaid-supported housing benefit funds housing support services in supervised group homes for eligible beneficiaries.

IV. CROSS-STATE THEMES AND OBSERVATIONS

Each state implemented a different approach to improving care coordination for Medicaid beneficiaries with behavioral health conditions. Despite these diversities, state Medicaid officials, managed care representatives, providers, and consumer representatives in all states identified similar facilitators, challenges, and lessons learned for improving coordination. In this chapter, we present these cross-state themes and observations, organized according to our five research questions.

A. To What Extent Does the Strategy Being Implemented in Each State Involve Changes in the Financing, Delivery, and Scope of Services Available to Adult Medicaid Beneficiaries?

These states are moving toward greater reliance on Medicaid managed care entities to coordinate care. Louisiana and Tennessee hope that new Medicaid managed care arrangements will facilitate improved care coordination. Tennessee currently contracts with three MCOs that now carve in behavioral health services. Louisiana has a single MBHO responsible for all specialty behavioral health care (physical health services continue to be managed by separate MCOs). Louisiana also has expanded the scope of mental health and substance abuse services available to Medicaid beneficiaries, particularly those having SMIs.¹ Both states required care coordination as part of their managed care contracts. Such coordination typically includes telephone referrals and follow-up, and when necessary, more intensive support for consumers and providers. In addition, these state Medicaid programs cover in-person case management as part of their managed care arrangements.

Rather than alter benefits at the plan level, Illinois and Massachusetts are experimenting with mechanisms to reimburse in-person care coordination. Illinois is using state funding to support local CCEs (which operate outside of capitated managed care arrangements) to spur development of care coordination models. Although the CCEs do not operate at full risk for their enrolled clients, they are responsible for coordinating services across multiple providers in a manner similar to MCOs. In addition, the state hopes that CCEs will market their care coordination services to MCOs in the future. State officials believe that CCEs can provide more intensive in-person care coordination, compared with the more traditional telephonic support the MCOs provide. In Massachusetts, the state Medicaid program reimburses CSPECH care coordination services as part of the MBHO's capitated rate. CSPECH is currently available only to Medicaid beneficiaries enrolled with the MBHO for their behavioral

¹ Louisiana announced in November 2014 that it plans to integrate specialty behavioral health services into physical health managed care plans, starting in December 2015.

health services. However, the state Medicaid program is developing some incentives to encourage other MCOs to adopt the CSPECH model.

Reimbursement for case management or care coordination is a key element of these strategies. State officials, managed care representatives, providers, and consumer representatives in all states stressed the importance of reimbursement for case management or care coordination services. Providers in all states noted the value of dedicated case managers or care coordinators responsible for connecting individuals with serious behavioral health challenges to health and behavioral health providers, and helping them follow through with treatment plans. Physicians and behavioral health specialists said that case managers and care coordinators provide critical information to inform treatment planning. For example, a CCE provider in Illinois noted that the care coordination team provides important contextual information about their clients, including any home-related barriers to care and whether patients are receiving care elsewhere. One provider said, “I can prescribe medication and I can order a test, but it’s the social issues, the financial barriers, the home issues that need to be addressed. I need someone else to address those issues so that I can treat their health issues effectively.” Likewise, CSPECH providers in Massachusetts report that care coordination services are so critical to their clients that they often continue to provide such support without reimbursement, even when individuals lose CSPECH eligibility.²

Consumer representatives also noted the importance of having dedicated case managers and care coordinators to help them navigate services. Stakeholders reported that case management and care coordination would be severely limited if the financing for these services was not directly reimbursable or built into the capitated rates. Providers and state officials in particular were concerned that such services would cease if financing was not available because some behavioral health providers do not have the capacity to take on intensive case management in the absence of funding.

States have taken different approaches to changing billing processes and procedures to coordinate care. Providers and officials in all states noted the importance of thoughtfully engineered and executed billing policies and processes. Providers and state officials reported that billing delays have serious implications for providers, who often operate without much financial cushion and have difficulty in absorbing payment delays. For example, some of the providers interviewed in Louisiana expressed frustration regarding challenges stemming from the implementation of a new billing system and revenue cuts, which they attributed to the implementation of the managed care arrangement. These billing and revenue changes resulted in some providers closing, reducing staff, or refusing to provide care to Medicaid beneficiaries. Likewise, several providers in Tennessee reported that they initially struggled to align internal billing policies to accommodate the different billing processes of multiple MCOs. This was a particular challenge for some community mental health centers (CMHCs),

² Individuals maintain eligibility as long as they remain housed and enrolled in the MBHP-covered plan. A loss in eligibility occurs most notably when a CSPECH participant becomes dually eligible for Medicaid and Medicare. Dually eligible individuals are not eligible for the MBHP-covered plan. As of the writing of this report, none of the available plans for dually eligible individuals covers CSPECH services.

which had little experience in contracting with multiple private insurers. In both states, state officials and managed care entities responded to these concerns by offering provider education and ongoing support to help ease the transition in payment practices.

In contrast, because the initiative in Massachusetts did not involve changes at the health plan level, it built on the existing billing structure. CSPECH providers noted that being able to bill for services under a pre-existing service category minimized disruption in payment. In addition, the MBHO's requirement that providers of CSPECH services already be part of its provider network ensures a minimal need for billing-related training and assistance. (That is, providers must already provide other Medicaid-reimbursable services.)

States are making efforts to ensure that billing codes and service eligibility criteria facilitate ongoing team-based care. State officials, managed care representatives, and providers noted two issues that have had an impact on their ability to provide team-based coordinated care. First, the reimbursement mechanism must offer flexibility. For example, several providers in Tennessee reported that they prefer daily or case rates for case management (such as those used in the Massachusetts and Illinois initiatives). They perceive these rates as offering more flexibility for case management services compared with fee-for-service reimbursement. Second, providers and consumers noted that the service reauthorization processes and medical necessity criteria for services can provide barriers to care or disrupt recovery. These stakeholders stressed that individuals need continued access to services and team-based care coordination that enable functioning above the level of medical necessity. However, when an individual exceeds medical necessity criteria, he or she will lose benefits and access to care. One provider expressed frustration regarding service reauthorizations and said that clients must “fail in order to succeed again.”

B. In What Ways Do These Strategies Seek to Improve Care Coordination by Fostering New Partnerships and Developing New Care Coordination Mechanisms?

States are seeking to foster and capitalize on local partnerships between providers. Although each state adopted a different strategy and formed various partnerships at the state level, all four recognized that the success of their initiatives depended on the strength of provider buy-in and local partnerships. For example, Illinois and Massachusetts officials positioned their initiatives within local community-based organizations that understand the needs of their communities and are familiar with local resources. Providers and consumers also noted that case managers and care coordinators in these states often live in the same communities in which they work, and have shared experience with the clients they serve. Likewise, the success of the initiatives in Tennessee and Louisiana depend on building local provider networks and relying on them to identify community resources. Both states hope that the plan-level

changes they have adopted will ultimately encourage local collaboration, including co-location of physical and behavioral health services.

Strong communication among providers, MCOs, state agencies, and consumer organizations facilitates smooth implementation of care coordination strategies. Stakeholders in these states noted the importance of careful planning and transparency when making changes in reimbursement and implementing different approaches to care coordination. For example, providers in Massachusetts and Illinois saw a genuine sense of partnership with the state Medicaid agency, which allowed for flexibility in developing localized coordination models. The CCEs in Illinois were particularly reliant on open and direct communication with the state Medicaid agency--they were led by community-based providers with limited experience and capacity for creating the necessary infrastructure associated with establishing a new entity (such as developing contracts, data-sharing agreements, and other legal documents).

In Tennessee and Louisiana, the managed care entities and state agencies provide opportunities to receive input from providers and consumer representatives, often through advisory board meetings and dedicated provider or consumer relations specialists. Providers and consumer representatives in these states noted the importance of offering more opportunities for dialogue and ensuring that changes in policies and payment practices represent their interests and priorities. Providers in these states also stated the importance of having the opportunity to communicate with managed care entities and state agencies regarding contract language and service definitions.

State Medicaid, mental health, and substance abuse agencies have played different roles in the development and implementation of these initiatives. Given the differences in the service delivery and financing reforms across these states, the role of the state agencies also has differed. Tennessee and Louisiana implemented substantial reforms in their Medicaid benefits, reimbursement strategies, and managed care arrangements that required strong partnerships between the state Medicaid program and behavioral health agencies, and continued involvement of these agencies in implementing the programs. In contrast, the involvement of state agencies in Illinois and Massachusetts has been somewhat more limited. In Illinois, the state Medicaid agency likens its role to that of a venture capitalist--providing CCEs with an initial investment (auto-enrolled clients, claims data, and technical assistance with establishing contracts and legal arrangements). The agency sees its role after that as supportive only, encouraging CCEs to seek their own path toward sustainability. Likewise, the Massachusetts Medicaid agency has been supportive of the MBHO's implementation of CSPECH and has encouraged other managed care entities to adopt the model; the agency itself has not been integrally involved in CSPECH's implementation, however.

Substance abuse services are regarded as critical but are coordinated in different ways. Underlying all four strategies is the belief that there must be coordination with substance abuse services. However, the level of coordination with

state-level and local-level substance abuse service partners varies. In Louisiana, the MBHO is at-risk for both mental health and substance abuse services. The state began consolidating its own substance abuse and mental health clinics before implementing the managed behavioral health arrangement, with the goal of creating integrated care settings to address co-occurring disorders. In Tennessee, Medicaid mental health and substance abuse services are similarly covered under the managed care arrangement, although providers and consumer representatives mentioned significant limitations in the availability of such services. The initiatives in Illinois and Massachusetts promote coordination with substance abuse services through local provider partnerships. For example, the solicitation for the CCEs in Illinois required inclusion of local substance abuse service providers; the state agency responsible for overseeing these services was not a partner in developing the initiative, however. In Massachusetts, substance abuse services are available through all CSPECH sites, either directly, through the lead CSPECH agency, or through a partnership with a local provider.

Partnerships with criminal justice system services remain somewhat limited.

Although all states recognize that a sizable percentage of clients with behavioral health needs have experience with the criminal justice system, partnerships with justice counterparts vary. Some state initiatives have involved strengthening partnerships between state-level Medicaid, behavioral health, and criminal justice agencies, whereas others have focused on strengthening such linkages at the local level. However, stakeholders in every state reported the need for stronger collaboration with the criminal justice system and noted some achievements in developing strategies to help individuals with mental health conditions transition from incarceration to the community. For example, the Louisiana OBH (which oversees the LBHP) and the Department of Corrections have established procedures to facilitate continuous access to medications when individuals transition from prison to the community. Although the Illinois and Massachusetts initiatives do not involve state-level partnerships with the criminal justice system, state officials, providers, and consumers noted the importance of local partnerships. Care coordination team members in these states developed relationships with local prisons and jails as well as jail diversion programs, and reported that they often help clients obtain housing and other supports to allow the individual to remain in the community after incarceration.

Managed care entities and provider networks offer data-sharing opportunities to enhance coordination. State officials, managed care representatives, and providers all cited the importance of data-sharing to facilitate care coordination. Each state has different data-sharing capacities. The MCOs in Tennessee, which are responsible for physical and behavioral health benefits, are encouraged to develop data systems that integrate information on physical and behavioral health service utilization. The MCOs can use this data to alert providers of transitions in care, such as when a beneficiary may need follow-up after an ED visit. Providers can also request information on a client's service utilization to inform treatment planning. In an effort to improve coordination with physical health services, the MBHO recently began to receive data on Medicaid pharmacy and physical health claims, and is planning to exchange encounter data with physical health plans.

Behavioral health providers in Louisiana can contact the MBHO to request information on a client's service utilization.

Illinois and Massachusetts have somewhat limited data-sharing arrangements. The CCEs in Illinois receive Medicaid claims data only; there is limited data-sharing between providers within a CCE, which several providers identified as a barrier to coordinating care effectively. Many CCE care coordination teams have developed their own systems for tracking service use and patient encounters. However, these systems are not integrated with those used by the individual CCE provider agencies. Low client enrollment and uncertainty regarding the long-term sustainability of CCEs limit providers' willingness to invest significant resources in developing a common data platform to use across all CCE providers. CSPECH providers in Massachusetts receive claims data for behavioral health services to help inform care coordination decisions; they may also have access to information about physical health care services if a client signs a release of information. Because the CSPECH partnerships include far fewer organizations than the CCEs (some CSPECH sites consist of a single agency that provides both behavioral health and housing support services), data-sharing and access was less of a concern.

C. How Do Various Stakeholders Perceive These Strategies as Influencing the Accessibility and Quality of Care, and Health Care Utilization and Costs?

Stakeholders across states were cautious in drawing conclusions about the impact of these care coordination strategies. Stakeholders in Illinois and Louisiana expressed concern that more time was needed for implementation before drawing conclusions. Although the program in Tennessee is more established, respondents were hesitant to make assertions regarding outcomes. Likewise, the CSPECH program in Massachusetts first was piloted in 2006, but stakeholders were hesitant to draw conclusions on its generalizability to broader patient populations or other contexts, given that it serves a relatively narrow population. Although most stakeholders were cautious in drawing conclusions, they did offer their perceptions of whether their programs were moving in the right direction and identified several mechanisms that might facilitate or impede success, as described below.

Most stakeholders perceived that the strategies being implemented in their states will ultimately lead to improvements in the quality of care. In Tennessee, several providers and consumer groups reported that introducing multiple MCOs and managed care contracting has encouraged competition among providers, which in turn could lead to improved efficiency and innovation. State officials and managed care representatives in Louisiana believe that stronger provider credentialing and defined coordination requirements for the managed care entity will lead to improvements in the quality of care. Some Louisiana providers, however, expressed fear that the MCOs' required service authorizations could restrict access to care or delay receipt of services. Providers in all four states noted the value of data-sharing to drive quality improvement.

However, as mentioned above, these state programs have very different capacities for data-sharing. Finally, providers and consumers in Illinois and Massachusetts believe that the local partnerships developed through their state initiatives have increased providers' knowledge of resources available in their communities, which will lead to improvements in connecting clients with services.

Stakeholders reported that the strategies used in their states may improve access to care, but not without some challenges. Provider and consumer stakeholders in both Louisiana and Tennessee raised concerns about access to care in the short term. In Louisiana, several stakeholders observed that revenue cuts and reimbursement delays (which they attributed to the new managed care arrangement and changes in state funding) may have led some providers to close, reduce staff, or refuse to serve Medicaid beneficiaries with severe behavioral health issues. (This study could not verify such assertions.) Although providers in Tennessee reported that competition between them may ultimately lead to innovations in the delivery of care, some also expressed concern that certain providers have found it necessary to merge and affiliate to increase their negotiating power with the MCOs--thus potentially limiting the number of independent providers. Some also said that the multiple-MCO structure in Tennessee results in frequent changes to provider networks, which may create confusion for consumers trying to access care.

Providers and consumers emphasized the importance of in-person care coordination and case management as essential for improving access to care. Providers and consumer representatives in Illinois and Massachusetts believe that the care coordination initiatives in their states are making services accessible to individuals who previously had been isolated from health and social service systems. Likewise, property managers in Massachusetts noted that CSPECH provides the support necessary for clients to remain housed while connecting them with services.

All states expect to experience improvements in service utilization patterns and reductions in costs. Respondents in Louisiana and Tennessee were unable to say whether the plan-level changes have impacted service cost and use, although their expectation is that costs would decrease over time. Respondents in Illinois and Massachusetts were more willing to identify changes in service use, particularly a decline in the use of crisis intervention services. Staff associated with the two CCEs in Illinois, for example, reported an immediate reduction in ED use among enrolled clients. Providers associated with the CSPECH program in Massachusetts reported similar reductions in the use of crisis services once individuals are housed and receiving CSPECH services.

D. How Do These Strategies Provide or Coordinate with Housing and Other Social Services?

State initiatives are coordinating with housing providers and fostering local partnerships between behavioral health and housing providers. Each of these states is

seeking to improve coordination of housing supports and services for Medicaid beneficiaries with behavioral health needs (see Table IV.1 for a description of the housing component of each state initiative). State Medicaid and behavioral health agencies are also forging partnerships with housing stakeholders at the state and local levels.

The partnership structures in the four states differ, based on local contexts and funding mechanisms. In some states, the reimbursement mechanisms grant providers the flexibility to develop collaborations that take advantage of existing local housing infrastructure. For example, in Illinois, the Medicaid agency encouraged the inclusion of housing providers and other local housing resources as part of the CCEs. In Massachusetts, the behavioral health entity has structured the CSPECH benefit flexibly enough to enable different partnership structures: three of the eight CSPECH providers are partnerships between a CMHC and one or more housing providers, two are led by a federally qualified health center that has partnered with one or more local housing providers, and three are led by a single organization that provides both behavioral health services and housing. Similarly, behavioral health providers in Tennessee either own and operate a group home themselves or contract with local housing providers who own and operate the housing and support services. Louisiana's housing program, which was built with new housing subsidies, created new formal partnerships between state housing and behavioral health agencies, the managed care entity, local behavioral health providers, landlords, and property managers.

Such collaborations are particularly helpful for identifying limited housing resources, since Medicaid covers only physical and behavioral health services. Local behavioral health providers are building relationships with housing providers, property managers, and developers, educating them about the supports their tenants will receive, and making themselves available to address the physical health, mental health, and psychosocial barriers that often place individuals at risk of losing housing. From the perspective of housing providers, these state initiatives may be an opportunity to further their own housing goals. For example, one CCE housing provider in Illinois noted, "When thinking about the future of health care, housing must be part of the equation and [the CCE initiative] is an opportunity to have housing recognized, even if related [housing] services are not yet being covered [by the CCE's PMPM fee]."

States are encouraging managed care plans to focus on the coordination of behavioral health and housing services. Three of the states--Louisiana, Massachusetts, and Tennessee--have required or allowed their Medicaid managed care plans to develop and reimburse care coordination or case management strategies specifically focused on beneficiaries with housing needs. The managed care entities in these states have a financial incentive to keep individuals housed and control costs, and they are well positioned to use their data to monitor service use and link data on behavioral health and housing participation (as the MBHO in Louisiana has done).

TABLE IV.1. State Strategies to Coordinate Services with Housing

ILLINOIS: Medicaid-funded CCEs foster partnerships between local health and housing providers. Although CCEs primarily focus on the coordination of behavioral and physical health care, the CCEs include housing partners, which often employ coordination team members with housing experience. The state Medicaid agency auto-enrolled Medicaid beneficiaries with complex behavioral health needs, some of whom were homeless. Although CCEs can use the PMPM to cover non-Medicaid-reimbursable costs, such as housing-related expenses, they are unlikely to do so unless enrollment can be scaled up. For housing providers whose services are neither Medicaid-reimbursable nor covered by the PMPM, CCE membership is an investment and part of a long-term strategy to be in on the conversation regarding the evolving health service system. The CCE initiative has not created new housing options or supports; rather, CCEs facilitate access to existing housing and subsidies through their housing provider members.

LOUISIANA: Management of PSH program services is incorporated into the MBHO contract. Louisiana's PSH program subsidizes approximately 3,300 private rental units and offers Medicaid-covered behavioral health and long-term care services. The PSH program originated in 2005, when the state received federal funding to rebuild affordable housing after devastating hurricanes. In 2013, funding for the behavioral health services provided to individuals in PSH shifted from time-limited community development block grants to Medicaid (and specifically into the MBHO contract). This shift was driven by the need for a sustainable funding source. The MBHO also became responsible for screening PSH applications for Medicaid eligibility, coordinating applications and housing placements with the state housing agency, and managing tenant-landlord relationships, in part due to the state's desire to have a single entity centralize these processes. PSH participants must qualify for the federal housing subsidies, Medicaid, and the 1915(i) State Plan Amendment, which authorizes intensive behavioral health services. Individuals not eligible for 1915(i) services, including those with an SUD but not an SMI, are no longer eligible for the PSH program.

MASSACHUSETTS: The Medicaid MBHO covers care coordination for chronically homeless individuals in PSH. The Massachusetts initiative included in this review is fully rooted in a Housing-First initiative; thus, the CSPECH services are available only when the individual's housing needs have been met. Coordination support, provided by a CSW, is reimbursable beginning 90 days before an individual is housed, an arrangement that makes it easier for CSWs to help homeless individuals secure housing. Services continue as long as the individual remains housed in the subsidized unit. CSWs work with a caseload of up to 12 clients, as required by the MBHO, allowing them the time needed to provide intense coordination support to clients. To be eligible for CSPECH, individuals must meet the U.S. Department of Housing and Urban Development's definition of chronic homelessness and elect to enroll in the MBHP plan. The availability of CSPECH services is also constrained by the limited supply of affordable housing and housing vouchers; receipt of services is guaranteed only after a housing unit and subsidy are available.

TENNESSEE: Supervised group homes are integrated into the managed care arrangement. The state's Medicaid program includes a supported housing benefit, which covers support services provided in supervised group housing facilities staffed by mental health providers around the clock and with fewer than 16 beds. The benefit is intended to be relatively temporary and serve as a bridge for individuals coming from institutions and other restrictive settings into more independent living in the community. To be eligible for group home placement, individuals must meet medical necessity and level of care standards, and require services and supports in a highly structured setting. The supported housing benefit thus offers limited coverage to a narrow population. While in a group home, individuals can receive various services covered under the supported housing benefit. For example, through one of the managed care plans, group home residents work with mental health professionals to create individualized and detailed care and discharge plans that address mental health, physical health, and substance abuse conditions. The discharge plans include a housing transition plan that specifies possible housing options for the client, along with next steps for choosing 1 of those options.

The reimbursement mechanisms that facilitate care coordination or case management are critical for helping individuals obtain and maintain housing. Although consumers might access supportive services and housing subsidies through other means, representatives from consumer groups, behavioral health providers, and housing providers consider these state strategies to improve care coordination as critical for housing individuals with severe needs. These stakeholders believe that, without intensive, coordinated support, maintaining housing would be a considerable challenge for many of the individuals they serve. As a behavioral health provider in Louisiana explained, “Getting someone into PSH and keeping them there is largely dependent on the relationship they have with the supports that keep them [housed].” Some providers in Massachusetts and Louisiana said that linking behavioral health and psychosocial services with housing connects consumers to needed services they would not otherwise access. Some consumers who formerly were chronically homeless in Massachusetts regard CSPECH as a “life saver.” A few managers of homeless shelters reported that the availability of CSPECH has also made property managers more comfortable with renting to tenants who need supportive services.

E. What Data are Available in Each State to Potentially Facilitate the Monitoring of These Efforts and Future Evaluations?

Given that each state is implementing a different strategy, the data available for monitoring or evaluating these efforts vary across states. In this section, for each state, we first identify data sources available for a potential evaluation and then describe notable strengths and limitations associated with these sources.

1. Illinois

Physical and behavioral health service data. CCE participants are identifiable in the state fee-for-service Medicaid claims data, which the state uses to track patient outcomes, paying particular attention to hospitalizations and ED use. The Department of Healthcare and Family Services (HFS), which oversees the CCE initiatives, processes all claims related to physical and mental health, and the Department for Alcohol and Substance Abuse Services processes substance abuse service claims.

Provider and consumer experience data. HFS also tracks consumer and provider grievances, which the CCEs receive and HFS submits and handles. Although some CCEs collect information on consumer satisfaction, there are no common or comprehensive surveys conducted across all CCEs.

Housing and social service data. Each CCE maintains its own process for tracking participant-level data, with many using a client database or electronic health record (EHR) system. The data captured and tracked vary by CCE but may include a range of information, including care coordination encounters; housing status and use of housing subsidies; receipt of homelessness prevention services (typically through access to Homeless Management Information Systems [HMIS] by one of the CCE

partners); use of other services not reimbursable by Medicaid, such as transportation or employment services; use of other safety net benefits, such as Supplemental Security Income (SSI), Social Security Disability Insurance, and the Supplemental Nutrition Assistance Program (SNAP); education; employment; criminal involvement; and consumer satisfaction with care. Some of this information is collected through assessments that the care coordination team conducts; CCE providers compile other information. Although some CCEs collect a wealth of data on clients served, these data elements are not consistent across CCEs and they are not submitted to HFS.

Data strengths and limitations. Although it is possible to identify CCE participants in the state Medicaid claims data, these data cannot be used to observe the delivery of CCE care coordination services because those services are not billed separately. Although CCEs track their encounters with patients, service use, and some limited patient outcomes, no consistent method is used across CCEs. Rather, each CCE care coordination team has developed its own mechanism for tracking client data and encounters, with several adopting a client database or EHR system. The types of data tracked through these efforts vary greatly by CCE. Each CCE consists of individual pre-existing provider organizations that often maintain their own distinct EHR or client-tracking systems. For use of all services not reimbursable by Medicaid, including housing-related supports and subsidies, care coordination team members must rely on data tracked separately by their CCE housing and social service partners. Some CCEs have made an effort to enter this information manually into their EHR system but again, the level of data integration varies widely. No CCE has yet invested in developing an EHR system that can be used or accessed by all the participating provider organizations as well as the care coordination team.

2. Louisiana

Physical and behavioral health service data. The MBHO's data systems for authorizing services and paying provider claims capture a range of behavioral health service use and expenditure data, including on mental and substance abuse services, psychiatric hospitalization, and ED visits. The MBHO sends these data files to the state, along with client-level data extracted from the MBHO's EHR system and billing platform. Although the MBHO does not systematically collect data on primary care service use, it has begun receiving information about physical health encounters from the state's Medicaid fiscal intermediary.

Provider and consumer experience data. The MBHO conducts consumer and provider satisfaction surveys at least once a year. It administers the provider survey to all network providers who rendered services during the survey period. It administers consumer surveys to a representative sample of members, gathering input on the care received from network providers. As required by the state, the MBHO also has a grievance process that allows consumers or providers to file complaints about the treatment they receive from the MBHO (or its providers); there is a separate process for appealing decisions on service authorizations or payments.

Housing and social service data. The MBHO tracks data related to the PSH program, including on application status, housing status, and supportive service providers. Although the MBHO's PSH records only date back to October 2013, when it began managing these services, it can link PSH data to current and historical behavioral health data for those members enrolled in PSH.

Health and social indicators. The MBHO collects systematic information on health and social indicators through National Outcomes Measures (NOMs) data requirements established by the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) and the Level of Care Utilization System (LOCUS) assessment of behavioral health functioning. The LOCUS assessment is administered to all individuals with SMI applying for 1915(i) State Plan services. Providers may also track health and social indicators through the MBHO's EHR system; however, such data are not available for all individuals served by the MBHO because the state has not required providers to use this system.

Data strengths and limitations. The MBHO and the state did not express any major concerns about the completeness or reliability of the MBHO's systems for capturing behavioral health encounters. Presumably, these data are relatively complete, given that all providers within the state must submit claims to the MBHO to receive reimbursement. Early in the LBHP implementation process, there were reports of claims not being paid because providers were unfamiliar with the new billing systems and the MBHO's new electronic billing system was still being fine-tuned. Thus, some services may have been provided but not captured in the system. However, it is unclear to what extent this continues to be an issue or whether it is possible to identify rejected claims in their data.

The MBHO only began collecting data on participants in the PSH program in October 2013. Data for previous years would need to be obtained from the state agency that previously managed the program.

Although the MBHO's EHR system could include data on health and social indicators, not all providers within the MBHO's network use the system. Providers interviewed conveyed mixed messages about the usability of and the extent to which they use the EHR system and noted that it has evolved over time; this suggests that EHR data are limited. Although the system is probably not a complete and reliable source of data at this time, it has the potential to be useful for evaluation in the future. Health and social indicators that derive from the LOCUS and NOMs assessments are likely to be consistently available; however, as of this report, the LOCUS assessment data are not in a format that can be used for an evaluation.

3. *Massachusetts*

Physical and behavioral health service data. Individuals who receive CSPECH services are identifiable in the state Medicaid claims data maintained by MassHealth, the state's Medicaid agency. The MBHO is the payer for all mental health and

substance abuse service claims associated with CSPECH clients. The Department of Mental Health processes all claims associated with mental health and psychosocial rehabilitation services, whereas providers send physical health claims directly to MassHealth. CSPECH care coordination services are Medicaid-reimbursable and thus identifiable in the claims data. The MBHO reimburses CSPECH providers using a flat per-day rate for each client in the program.

Provider and consumer experience data. The MBHO tracks consumer satisfaction with care, timely access to care, provider satisfaction, and consumer and provider grievances, although none of these indicators is tracked uniquely for the CSPECH program. These data are collected through surveys and the grievance submission process. However, consumers and providers are surveyed on services beyond CSPECH; thus, these data sources would have limited value to an evaluation of the CSPECH program.

Housing and social service data. Each individual CSPECH site--which consists of either a single organization that provides both housing and care coordination services or a health and housing partnership--maintains its own EHR system. The MBHO does not require the CSPECH providers to track and submit data beyond what is required through the claims process. However, some providers do track other client-level indicators, such as physical and mental health status and functioning; criminal justice system involvement; housing status; use of housing-related supports and subsidies; homelessness-related services (many of the providers operate shelters and have access to HMIS); and use of other safety net services and benefits, such as SSI and SNAP.

Data strengths and limitations. Medicaid claims are probably the strongest data source for evaluating CSPECH client outcomes--particularly service use and costs associated with the program. Because providers are continuously reimbursed for providing the care coordination services that define the CSPECH program, it is possible to identify when an individual enters and exits the program. (However, few clients ever exit the program because receipt of CSPECH services is attached to the housing subsidy.) Although CSPECH providers do track a range of other information on clients, the completeness and reliability of those data vary across providers. For example, the MBHO expects providers to monitor client mental health and physical function, but there is no required method or data collection tool for measuring these indicators; thus, provider-level data may not be comparable. Furthermore, each CSPECH provider site uses its own EHR system, so the way they collect and organize data will also vary.

4. Tennessee

Physical and behavioral health service data. The Bureau of TennCare collects data on service use and expenditures for both physical and behavioral health care, as well as long-term care services for all of its members. Claims and encounter data generally are available going back to 2007, when the state began integrating mental health services into its managed care contracts. The MCOs in the state send encounter

data files, to the Bureau of TennCare at the end of each payment cycle. Additional data on service use for mental health and SUDs are available on individuals who receive treatment services funded by the Department of Mental Health and Substance Abuse Services (DMHSAS) through its Behavioral Health Safety Net (BHSN) and various substance abuse prevention and treatment programs. BHSN providers submit fee-for-service claims through an electronic database that DMHSAS maintains. SUD service utilization data are collected through the Tennessee Web Infrastructure for Treatment Services. This is a robust data collection and billing database that contains a wide range of SUD service use, demographic, and other social service use information for individuals who have received SUD treatment services funded by DMHSAS. This may include some TennCare beneficiaries who have maxed out their Medicaid substance abuse benefits and are receiving care through DMHSAS programs.

Provider and consumer experience data. The Bureau requires each MCO that participates in TennCare to be accredited by the National Committee for Quality Assurance (NCQA), which, in turn, requires MCOs to collect and report consumer perceptions of care through Consumer Assessment of Healthcare Providers and Systems. To meet contract obligations and retain NCQA accreditation status, TennCare also requires MCOs to collect and report on Medicaid-relevant Healthcare Effectiveness Data and Information Set (HEDIS) physical and behavioral health performance measures, including, for example, HEDIS antidepressant medication management and follow-up after-hospitalization measures. MCOs must also report to TennCare on consumer and provider grievances and findings from provider surveys. In addition, DMHSAS collects and reports NOMs, which are used for SAMHSA reporting.

Housing and social service data. TennCare collects and maintains claims and encounter data from MCOs for the beneficiaries eligible for and receiving Medicaid-supported housing services. DMHSAS also has housing data on individuals with behavioral health disorders served through the Department's Creating Homes Initiative, which may include TennCare beneficiaries not eligible for Medicaid-supported housing.

Other indicators. The Tennessee Association of Mental Health Organizations (TAMHO) created a unique database for its member organizations, which include CMHCs and other behavioral health providers in the state. The association and its membership felt the need for a single database that collected data on behavioral health services, regardless of payer source; the association worked with a vendor to develop a database that met providers' and advocates' needs. TAMHO currently collects service use, demographics, payer source, employment and veteran status, receipt of housing supports, recent criminal history, and other data from participating providers, thus giving the association a comprehensive picture of individuals served in the public mental health system. Several providers noted that the TAMHO database is the only statewide source that includes such a wide range of data. However, not all community providers are members of TAMHO or submit information, so data are limited to those individuals served by participating member organizations.

Data strengths and limitations. Although a wealth of data is collected on Medicaid beneficiaries, each data source has important limitations. Tennessee's Medicaid claims data are a strong source, but officials note that the data quality has improved significantly since integration began. It may thus be difficult to differentiate between true outcomes and artifacts of poor data quality in the earlier years of the integration efforts. Data related to housing are limited to Medicaid beneficiaries eligible for TennCare's supportive housing benefit; beneficiaries may receive supportive housing services through other state initiatives, but there is no statewide comprehensive data source on such services (besides TAMHO, which has other data limitations). Although the state collects information on health status and functioning for various reporting requirements, it is not clear what data are collected for whom, particularly as part of the state's NOMs requirements. Finally, although TAMHO appears to be a promising data source, it is limited to participating providers and its completeness and reliability are unknown.

V. CONCLUSIONS

States are experimenting with an array of strategies to address the fragmented delivery of services for Medicaid beneficiaries with behavioral health conditions. This report highlights the approaches adopted by four states--Illinois, Louisiana, Massachusetts, and Tennessee--to improve the coordination of physical health, behavioral health, housing, and other supportive services. It is not an exhaustive review of all state programs that are attempting to improve the coordination of services for this population. Previous reports have identified several other states and communities that are adopting innovative strategies (Greenberg 2012; Hamblin et al. 2011; Andrews et al. 2014). Rather, these case studies are intended to provide a snapshot of some of the significant features of selected state programs and identify some of the key successes and challenges associated with their strategies, as reported by state Medicaid officials, managed care representatives, providers, and consumers.

Although each state program has unique elements and was developed within the context of its existing service delivery system and political environment, we did observe some common features and perspectives, as detailed in this report and briefly summarized below.

A. Financing and Delivery System Reforms

The states are moving toward greater reliance on Medicaid managed care entities to coordinate care. Louisiana and Tennessee have expanded and integrated services at the health plan level. Louisiana is using a single MBHO, whereas Tennessee is contracting with three MCOs that are carving in behavioral health care. Both states require their managed care entities to provide care coordination services. In contrast, Illinois and Massachusetts have created funding mechanisms that reimburse in-person care coordination services at the provider level. In Massachusetts, the state Medicaid program reimburses CSPECH care coordination services as part of the MBHO's capitated rate. In Illinois, although the CCEs currently operate outside of managed care arrangements, the state hopes that they ultimately will market their services to the MCOs. In implementing these strategies, all four states have attempted to align service definitions and eligibility criteria with the goals of ongoing comprehensive coordinated care. They also have sought to ensure that changes in providing billing processes do not disrupt the delivery or payment of services; these efforts are continuing.

B. Partnerships and Care Coordination Mechanisms

State Medicaid programs recognize that the success of their strategies depends on the strength of provider buy-in and local partnerships, and have taken steps to foster

local collaboration. Medicaid officials in Illinois and Massachusetts have positioned their initiatives within local community-based organizations that understand the needs of their communities and are familiar with local resources. Both the CCEs in Illinois and the CSPECH providers in Massachusetts deliver care coordination through local partnerships with various types of provider organizations. Likewise, the success of the initiatives in Tennessee and Louisiana are dependent on local provider networks' ability to identify and access community resources. Both of these states believe that the plan-level changes they have adopted will ultimately encourage local collaboration, including co-location of physical and behavioral health services. Regardless of the approach, stakeholders consistently reported that the smooth implementation of care coordination strategies requires strong communication among providers, MCOs, state agencies, and consumer organizations.

C. Care and Service Outcomes

Although some of these strategies are relatively new and continue to evolve, most of the Medicaid officials, managed care representatives, providers, and consumer representatives we interviewed were confident that these efforts have the potential to improve access to care and quality while reducing overall costs. Providers in all four states noted the value of data-sharing to drive quality improvement--although these state programs have very different capacities regarding data-sharing. Consumers and providers emphasized in-person care coordination and case management as essential to improve access to care. Future evaluation of these programs would be helpful in determining whether these specific components have furthered such outcomes.

D. Strengthening Linkages with Housing Services

All of these strategies recognize the need to bridge behavioral health services with housing supports and include steps that help foster relationships between behavioral health and housing providers and state agencies. In Illinois, the Medicaid agency encouraged the inclusion of housing providers as part of the CCEs. In Louisiana, by incorporating the PSH program into the state's single MBHO, new formal partnerships have emerged between state housing and behavioral health agencies, the managed care entity, behavioral health providers, and landlords and property managers. In Massachusetts, the MBHO has structured the CSPECH benefit flexibly enough to enable various housing and behavioral health provider partnerships. Finally, in Tennessee, behavioral health providers either own and operate a group home themselves or contract with local housing providers that own and operate the home and support services. These collaborations are particularly helpful in identifying limited housing resources, since Medicaid covers only physical and behavioral health services. The state strategies are also either encouraging or requiring Medicaid managed care plans and provider networks to develop and reimburse care coordination or case management strategies specifically focused on beneficiaries with housing needs.

E. Data Availability

Stakeholders stressed the importance of data-sharing in informing care coordination decisions at the provider level and identifying opportunities for quality improvement at the health plan and state levels. The availability of data and capacity of providers and other stakeholders to use these data for care coordination and quality improvement vary widely across programs. Some states, particularly those with managed care arrangements, such as Louisiana and Tennessee, have more robust data available to track service utilization and monitor quality. In other states, such as Illinois and Massachusetts, data-sharing between providers and other entities is more limited, due in part to the lack of common data platforms.

F. Future Research Opportunities

Although these states are monitoring their initiatives, none of them has conducted an independent, rigorous outcomes evaluation. Such research would be necessary to understand long-term outcomes and to identify specific mechanisms that facilitate or impede success.

The ability to conduct evaluations of these initiatives depends, in part, on the availability of high quality data. The availability of quantitative data varied widely across states. Some data were fairly consistently available, most notably data on the use of health and behavioral health services, such as those reported through Medicaid claims or managed care encounters. To some extent, housing data (such as housing status and use of supportive housing) were also available, particularly through states' HMIS. In contrast, the availability of data on physical and mental health functioning, consumer experiences with care, employment, and encounters with the criminal justice system varies. The initiatives in Tennessee and Massachusetts were implemented earlier and may have sufficient quantitative data to support an evaluation. In contrast, the initiatives in Louisiana and Illinois are relatively new and their future is uncertain. Further study of the implementation of these state initiatives could yield useful findings to inform the development of other efforts.

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APPENDIX A. ILLINOIS STATE PROFILE

A. Program Description

Overview

As part of its state Medicaid reform law, signed in July 2012, Illinois has committed to ensuring that at least 50 percent of Medicaid beneficiaries are enrolled in a care coordination program no later than January 1, 2015. To achieve this goal, Illinois has adopted a two-year care coordination roll-out plan, overseen by the Department of Healthcare and Family Services (HFS). A critical element of this plan is launching the Care Coordination Innovations Project, through which the state has awarded a three-year contract to six regional Care Coordination Entities (CCEs) to coordinate services for adult Medicaid beneficiaries with complex health needs, with a particular focus on those with mental health and substance use disorders.

A CCE is a new formal network of pre-existing community-based providers. The providers composing the CCE vary but may include local hospitals, mental health providers, substance abuse service providers, federally qualified health centers (FQHCs), public health departments, mental health departments, pharmacy chains, and housing and social service agencies. The individual members of the CCE are bound together through a formal agreement and linked to each other through a newly developed care coordination component. The structure of this coordination component differs by CCE but generally consists of a team of care coordination professionals who work directly with clients, linking them to the services available through the CCE network. The care coordination team, which is employed by the CCE, not by any individual provider member, is the mechanism through which the individual provider organizations collaborate.

Financing

Illinois has not altered the provider payment model for this initiative; CCE providers of Medicaid services continue to be reimbursed through a fee-for-service arrangement. The CCEs do, however, receive a per-member per-month (PMPM) coordination fee to provide in-person care coordination services to clients.³ The PMPM is supported through a mix of state and federal Medicaid funds. The CCEs have the flexibility to use the PMPM to cover costs of their choosing, although they use the fee primarily to cover costs associated with care coordination services. The state hopes that this flexible approach will incentivize the CCEs to find the most cost-effective way to improve care while reducing overall costs, with particular attention to costs associated with hospitalizations and emergency department use.

³ The amount of the PMPM is not publicly available.

Goals

Although the state is moving toward mandatory managed care, it believes that the telephonic coordination model that managed care organizations (MCOs) often use is not effective in reaching and engaging individuals with complex medical needs. This is particularly true of those with serious behavioral health issues, who are often hard to engage and remain isolated from health and social systems. This CCE model is based on the idea that local community-based organizations, which understand the needs of the local client base and are knowledgeable about local resources, are best situated to find and engage these hard-to-reach clients. The initiative is testing provider interest in and capacity to implement models of care delivery and coordination beyond the traditional MCO model. State officials do not wish to run the CCE program, however. Instead, they view the state as a venture capitalist that provides only an initial investment to establish the CCEs, including a capped auto-enrolled number of clients (between 1,000 and 1,500 per CCE), agency support in developing the necessary legal contracts, and provision of Medicaid claims data for quality monitoring.⁴ Long-term expansion and survival depends on the CCEs' ability to perfect and market their care coordination services to the larger state MCOs. The state believes that the MCOs will purchase these services if the CCEs can demonstrate associated long-term cost savings.

State Context

Illinois is working to reform its health care system into one that is more patient centered and focused on outcomes, access, and safety. State law requires that 50 percent of Medicaid beneficiaries, or about 1.8 million people, be in "risk-based care coordination" by January 1, 2015. Illinois intends to achieve this goal through various initiatives beyond the CCE program. These include its submission of a State Plan Amendment to Section 2703 (part of the Affordable Care Act) of the health home demonstration option for persons with chronic conditions; its care integration model for Medicare-Medicaid dual-eligible beneficiaries; and the recently established Affordable Care Entities, which will serve the expanded Medicaid population. State officials believe that if these CCE models prove effective, they can be integrated into the broader efforts.

Partnership Structure

HFS is the sole state agency responsible for CCE oversight; there is little formal collaboration with other state agencies regarding the CCE program. Instead, the state has encouraged partnerships between various private and government entities at the local level. This review focused on two CCEs as illustrative examples: My Health Care Coordination (MHCC), which began operations in September 2013 and covers five

⁴ The state uses an algorithm that auto-enrolls the most expensive Medicaid beneficiaries to the CCEs, including a large proportion who are homeless. Individuals dually eligible for Medicare and Medicaid are ineligible for CCE enrollment.

downstate counties; and the Chicago-based Together4Health (T4H), operational as of December 2013.

MHCC is led by the Macon County Mental Health Board. It includes six other core collaborators: two community hospitals, an FQHC, a certified mental health and substance abuse service provider, the Decatur Housing Authority, and the Macon County Health Department. According to the stakeholders we interviewed, the development of this CCE grew out of a sense of shared accountability for the well-being of community members. The partnership includes all of the major health and service institutions in the region; although there is a formal and binding memorandum of understanding, the CCE is governed more informally through the existing relationships between member organizations.

T4H is led by Heartland Health Outreach (HHO), the health care arm of Heartland Alliance, a private non-profit provider of health and social services for the poor. Hoping to impact the transformation of the broader safety net system, HHO incorporated a diverse range of health and social service providers into the CCE, many of which had never worked together previously. T4H consists of 34 different entities, including hospitals, primary care physicians, a pharmacy chain, mental health providers, substance abuse and detoxification facilities, and various social and housing service providers. To join the CCE, organizations must make an initial capital contribution, thus transforming them into invested owners. T4H is governed by a representative board of managers that includes the various executives of the 34 owner organizations.

B. Coordination or Integration with Physical Health

Coordination Mechanism and Financing

Both T4H and MHCC have based their care coordination structure on the health home model; the state intends to pursue the Section 2703 health homes option, and thus has encouraged applicants to meet the related requirements. The composition and structure of the care coordination teams for these two CCEs are somewhat similar. Both have assembled a care coordination team of 15-20 individuals. These include mental health care coordinators, community health workers, and registered nurses at T4H; and care coordinators (who are registered nurses) and community navigators at MHCC. Clients are assigned to the appropriate team members based on level of need. Following a comprehensive needs assessment, the team develops a care plan and begins to work with clients, helping them connect with a range of available services and resources by relying heavily on the CCE provider network. The CCE teams are mobile; care team members meet clients out in the community and, when necessary, work out of provider offices. The state uses an algorithm to auto-assign the most complex clients to the CCEs. In addition, many of them are homeless and isolated from health and social service systems, so care coordination staff spend a significant amount of time searching for clients in the community; knocking on the doors of relatives and neighbors; and checking homeless shelters, local jails, food pantries, churches, and

other places frequented by this population. For this reason, the MHCC team in particular emphasized the importance of assembling a care team consisting of individuals with roots in the local community.

Coordinated Services and Stakeholder Interactions

The CCE program has not altered the landscape for providing Medicaid services, which still are reimbursed through a fee-for-service arrangement.⁵ CCE enrollees have access to all health services covered by Medicaid. Each CCE network includes providers of physical, mental, and substance abuse services, as required by the state. The diverse range of partners required for inclusion in the CCE ensures that a broad range of services are available through the CCE network, including comprehensive primary care, specialty care, inpatient care, emergency and crisis services, medication management, assertive community treatment services, case management, psychosocial rehabilitation, and detoxification services. The CCE model, which introduces a care coordination team that connects the various provider organizations, does not necessarily alter the level of direct interaction between providers. Rather, this model aims at providers becoming more informed about their clients as a result of the care coordination component.

C. Coordination or Integration with Housing or Other Social Services

Coordination Mechanism and Financing

The CCE initiative does not introduce a new or distinct housing program, nor does it provide new funding to support the use of any housing-related services. State officials strongly encouraged the inclusion of housing support-related providers in the CCE, although they did not make it a requirement. In theory, CCEs could use their PMPM funds to cover some of these non-Medicaid-reimbursable services; however, until CCEs further perfect their model, increase enrollment, and scale to efficiency, it is unlikely that such coverage will be possible. (The two CCEs we visited are not using PMPM funds directly for housing supports.) Instead, CCEs rely on their networks to connect clients with existing housing services, subsidies, and supports, which are often scarce. The lack of housing is a significant challenge for CCEs, since a large proportion of clients are homeless or at risk of being homeless. For social service and housing providers, whose services are not Medicaid-reimbursable or covered by the CCE's PMPM fee, involvement in the CCE is a significant investment. For these providers, being included is part of a long-term strategy to be represented in an evolving service system.

⁵ During an open enrollment period, Medicaid members must contact the Illinois Client Enrollment Broker to enroll in either a CCE or in one of the many managed care options. The state auto-enrolls those who do not contact the Broker in an MCO or CCE. Individuals who select to enroll or are auto-enrolled with a CCE are not served by an MCO. The state pays all services, using a fee-for-service arrangement.

Coordinated Services and Stakeholder Interactions

Although the CCE initiative provides no new housing services or resources, clients enrolled in a CCE work with a care coordination team that assesses and attempts to address such needs. Recognizing that the CCE population would have significant housing needs, both MHCC and T4H ensured that their teams included staff with experience in providing supportive housing. Through connections with housing-related partners, team members are able to link clients to scarce available resources. The T4H network, for example, includes several providers who manage housing units tied to Chicago's centralized referral system. Using this system, T4H care coordinators who have clients with housing needs are able to efficiently determine whether there are housing opportunities. MHCC similarly relies on its network to access available housing units for clients, including supportive housing properties and group homes managed by several core collaborators.

D. Key Perceptions and Lessons Learned for Implementing the Care Coordination Strategy

All stakeholders viewed the in-person care coordination component as critical to improving care for individuals with behavioral health conditions. State officials firmly believe that improved outcomes for the target population require localized care coordination that only community-based providers can achieve. Providers noted that the coordinators are valuable because they provide important information about their clients, including any home-related barriers to care, whether they are seeking needed and prescribed health care services at other facilities or taking prescription medication prescribed by other providers, and whether they are being connected to any needed social services. Care coordination team members can also take the time to help educate clients about their conditions and prescribed treatments. Consumers had positive perceptions of the CEE teams, describing their relationship as a partnership but emphasizing the importance of their being willing to develop a relationship with their care coordinator.

CCE implementation required intense technical assistance from the state. States should not overestimate the capacity of community-based organizations to develop the necessary infrastructure associated with a new entity (for example, legal arrangements, contracts, and data agreements). Those involved viewed direct communication with state Medicaid staff as critical to getting the CCEs off the ground and understanding how to operate within the confines of Medicaid rules and regulations. State officials emphasized that significant staff time and resources were devoted to providing technical assistance to the CCEs during the roll-out period. Staff associated with the CCEs noted the importance of having access to a dedicated liaison at the Medicaid agency.

Lack of a shared electronic health record (EHR) system or client database has been a significant limitation for CCEs. Although the teams maintain a system for

tracking their care coordination efforts, such as encounters and referrals, neither CCE visited for this review had a system fully integrated with the systems of the individual CCE provider members. Not having a single system limits communication between care coordination team members and the staff of the various providers, which creates barriers to efficient coordination and communication. Despite these limitations, neither CCE intended to develop a single EHR platform, as the costs and efforts required would be significant.

Although uniquely arranged and potentially more efficient, the new care coordination teams must avoid competing with or duplicating existing case management services. Many CCE clients have pre-established relationships with case managers at other organizations, including those that are part of the CCE network. This can create confusion (for both consumers and provider staff) regarding roles and responsibilities, as well as fears of service duplication. Care coordination team members devote considerable time to establishing a relationship with these other case management teams and work to ease any sense of competition. The CCE teams are structured to do more than the typical case manager, including coordinating a broader range of services, providing health-related education and motivational support, and driving and accompanying clients to appointments. Care team members associated with both CCEs emphasized that they do not compete or attempt to alter existing relationships between clients and case managers; instead, they offer to support the case managers, who are often far more limited in what they can do for a client.

Sustainability is challenged by the partial-risk structure and limited state support. A consequence of the state's hands-off approach is that providers feel uncertain about the CCEs' future. The state has indicated that no further auto-enrollment will occur, believing that the limited number of enrolled clients allows the CCEs to focus on developing a localized and cost-effective model of care coordination. State officials report that they will view this initiative as a success if the CCEs are able to market their model to the state MCOs, which are serving a larger population at full risk, or to the newly established affordable care organizations. These entities often lack the capacity to provide the level of care coordination that the CCEs focus on developing, thus creating an opportunity for partnership. However, there are two reasons providers may hesitate to commit additional resources toward model expansion: (1) the CCEs are only at "partial-risk" (at-risk only for the care coordination services); and (2) individual providers do not rely on the CCE to operate (all providers would continue to serve clients if the CCE fails).

Effective care coordination teams must have the ability to help enrollees access a broad and diverse range of services. Both CCEs devoted significant time to constructing the right kind of care coordination team and emphasized that staff must be equipped not only to coordinate a broad range of health and social services, but also must be skilled in engagement. A large number of CCE enrollees are homeless or have

been isolated from safety net systems, and staff must be able and willing to be flexible and creative in developing engagement strategies. To be effective, care coordination teams have established relationships with a wide range of other community entities, including shelters, churches, and the local criminal justice system. CCE staff thus emphasized the value of assembling a care team embedded in the local community.

APPENDIX B. LOUISIANA STATE PROFILE

A. Program Description

Overview

The Louisiana Behavioral Health Partnership (LBHP), effective March 2012, transformed the state's mental health and substance abuse services for all Medicaid-eligible and non-Medicaid-eligible adults into a managed care system that operates as a prepaid inpatient health plan. A single managed behavioral health organization (MBHO; currently Magellan Health Services of Louisiana) manages all behavioral health services in Louisiana. Physical health services are managed separately through managed care organizations (MCOs), collectively referred to as Bayou Health plans; they are not part of the LBHP (Andrews et al. 2014). In November 2014 (after the data collection period for the current study concluded), Louisiana announced plans to integrate specialized behavioral health services into the Bayou Health managed care plans starting in December 2015, thus terminating use of a single MBHO to manage all specialty behavioral health services. This decision was driven in part by the desire to further coordinate behavioral and medical care (DHH 2014).

Financing

The MBHO operates on an at-risk basis for Medicaid adult behavioral health services and manages (on a non-risk basis) behavioral health services for eligible non-Medicaid adults served by the Office of Behavioral Health (OBH) within the Department of Health and Hospitals (DHH). Non-Medicaid services, including for those individuals with co-occurring mental health and substance use disorders (SUDs), are funded through state general funds and block grants (Andrews et al. 2014). Before LBHP, quasi-public, locally governed human services districts or authorities provided most of the behavioral health services in the state, using general funds, transfers from DHH and, to a lesser degree, fee-for-service Medicaid payments (Louisiana Legislative Auditor 2013).

Goals

The goals of the LBHP include improving access to and quality and efficiency of behavioral health services for adults, and coordinating behavioral health and physical health care services (Andrews et al. 2014). According to OBH officials, the first two years of the LBHP were focused on building the managed care infrastructure, including the provider network. In 2014, OBH focused on facilitating coordination between behavioral health and primary care services, and integrating the permanent supportive housing (PSH) program into the LBHP.

State Context

OBH was created from the merger of the Offices of Mental Health and Addictive Disorders before the inception of the LBHP. The merger consolidated state-funded substance abuse and mental health clinics. Although our study focuses on the service system for adults, it is worth noting that the LBHP encompasses a comprehensive system of care (CSoC) for children and youth with behavioral health challenges. Since the beginning of the LBHP, four child-serving state agencies have pooled funds into the MBHO contract to support the CSoC (Andrews et al. 2014). According to OBH, this funding arrangement only impacts the delivery of mental health services for children enrolled in the CSoC. Additionally, OBH is working to increase integration outside of the LBHP umbrella through Substance Abuse and Mental Health Services Administration (SAMHSA) policy academies and technical assistance. Louisiana will not be expanding Medicaid eligibility under the Affordable Care Act.

Partnership Structure

OBH manages and oversees the LBHP. Since its implementation, OBH has contracted with Magellan for the latter to serve as the single MBHO. In 2014, the DHH Bureau of Health Services Financing (the state's Medicaid office) executed a memorandum of understand with Magellan and the Bayou Health plans to begin defining what coordination between the state management organization and MCOs will entail. Behavioral health providers have direct contact and formal relationships with OBH and Magellan. The LBHP requires providers to be credentialed with both OBH and Magellan, and each provider establishes a service contract with Magellan.

B. Coordination or Integration with Physical Health

Coordination Mechanism and Financing

LBHP is attempting to use the MBHO contract as a mechanism for coordinating behavioral and physical health care. Managed care offers the promise of helping individuals better connect to services by providing a central point of entry and access to a wealth of patient and provider data. Although the original MBHO contract had a general coordination requirement, OBH officials reported they were just beginning to define care coordination at the plan and provider levels at the time of this report. Specific coordination strategies will likely change in the future when the state carves behavioral health services into the Bayou Health MCOs.

Although recent efforts to facilitate coordination through the health plans have yet to affect consumers directly, some coordination has been available to them since the beginning of the LBHP. Magellan's care navigators offer consumers or their families telephonic support to identify resources. Additionally, Medicaid adults with a serious mental illness (SMI) who qualify for services under the 1915(i) option can receive some degree of care coordination through Medicaid case management benefits, which are

covered by the MBHO. Such benefits include community psychiatric support and treatment (CPST), assertive community treatment (ACT), and intensive case management (ICM) (Andrews et al. 2014). Case managers and multidisciplinary ACT team members coordinate with providers of different service systems and help ensure that clients can access any needed service.

Coordinated Services and Stakeholder Interactions

Interviews with Magellan and OBH leadership identified some recent efforts to coordinate between behavioral health and physical health plans, including the following:

- Magellan began receiving Medicaid pharmaceutical data, physical health claims, and encounter data, and began sharing their encounter data with the physical health plans.
- Magellan has been working with the state Medicaid office to obtain information on clients' primary care physicians (PCPs).
- Magellan and the Bayou Health plans have developed a common referral form to refer patients between care systems.
- Magellan officials indicated that they have been communicating more regularly with the Bayou Health plans and discussing how ultimately to co-locate physical and behavioral health providers. (To date, co-location has not yet occurred through the LHBP, although a SAMHSA grant and a provider's own initiatives have funded a few local co-location efforts.)
- State officials are considering strategies to help PCPs respond to some behavioral health needs, such as by requiring the health plans to have a behavioral health specialist on staff for consultation. OBH is also exploring ways to support behavioral and physical health integration and co-location as part of a SAMHSA grant.

Coordination efforts are beginning to trickle down to the provider level. According to behavioral health providers and Magellan administrators, examples of recent efforts include the following:

- Magellan has encouraged hospitals and providers to help patients identify a PCP and obtain a release of information so providers can exchange information.
- Magellan is beginning to encourage behavioral health providers within its network to assess patients' medical histories and address certain medical issues in the treatment plans (such as discussing anxiety about PCP appointments or medications).

C. Coordination or Integration with Housing or Other Social Services

Aside from the PSH program and the individual efforts of case managers and other providers, there do not appear to be formal policies or programs to coordinate behavioral health with other types of social services. OBH indicated that it is, however, attempting to improve coordination with the criminal justice system, recognizing that a large percentage of behavioral health clients are in the correctional system. Individual providers may also have their own means of service coordination. For example, one quasi-public behavioral health provider operates the Supported Employment model.

Permanent Supportive Housing Background

The PSH program, which originated after Hurricanes Katrina and Rita, subsidizes approximately 3,300 rental units and offers tenants behavioral health and long-term care services. Rent is subsidized mainly through the federal Section 8 Project-Based Voucher and Shelter Plus Care programs. Congress appropriated \$73 million for 2,000 Section 8 units and 1,000 Shelter Plus Care units in summer 2008, and the state was awarded Section 811 Project Rental Assistance vouchers in March 2013. Units are scattered across various sites, and tenants contribute up to 30 percent of their adjusted income toward rent. The program currently operates in the hurricane-prone region of the state, with plans to expand statewide. It is based on the Housing First model, which prioritizes maintenance of housing over treatment. PSH is centralized at the state level, with formal agreements between the state housing agency and DHH, which includes OBH, the Office of Adult and Aging Services, and Office for Citizens with Developmental Disabilities.

Coordination Mechanism and Supportive Services Financing

A supportive housing program, by definition, integrates housing and support services. In October 2013, funding for the supportive services provided to PSH participants shifted to Medicaid from time-limited community development block grant (CDBG) funding. Management of the services shifted from local providers to the MBHO (and, by extension, the LBHP). The need for a sustainable funding source drove this decision. The MBHO also became responsible for screening PSH applications for Medicaid eligibility, coordinating applications and housing placements with the state housing agency, and managing tenant-landlord relationships--in part due to the state's desire to have a single entity centralize these processes.

According to interview respondents, financing the services through Medicaid restricted program eligibility to those who qualify for the authorizing waivers. Participants now must be eligible for Medicaid and the 1915(i) State Plan Amendment that authorizes intensive behavioral health services. According to two local providers, individuals who do not qualify for 1915(i), including those with SUDs without a co-

occurring illness, are no longer eligible.^{6,7} PSH participants must also be in need of both housing and behavioral health services, and qualify for the federally funded housing programs.

Coordinated Services and Stakeholder Interactions

Although participation in services is voluntary, participants must have a certified PSH service provider. The services for PSH participants are available to anyone in the state who meets the appropriate Medicaid eligibility. PSH participants are likely to receive intensive supports, such as ACT, ICM, or CPST. Providers noted that one change to service delivery under Medicaid is that providers can now bill only for face-to-face interactions with clients who have been approved for services. Time spent searching for a client in the community, assisting a client telephonically, or contacting another provider or landlord without the client present is no longer reimbursable. Additionally, providers are no longer reimbursed for the services that transitioned to the MBHO (such as application assistance and tenant-landlord mediation).

State, MBHO, and provider respondents agree that delivering supportive services to PSH participants requires frequent communication across partners. At the ground level, local stakeholders--including behavioral health providers, Shelter Plus Care subsidy administrators, and landlords/building managers--work closely with one another, the state agencies, and the MBHO. They communicate regularly about program and service eligibility, applications, wait list status, unit availability, tenant-landlord challenges, and any issues that could lead to eviction.

D. Key Perceptions and Lessons Learned for Implementing the Care Coordination Strategy

Changes in billing processes impact providers; clear communication and careful, upfront planning is essential. Several of the providers we interviewed expressed frustration with initial challenges in processing claims in the new electronic billing system (Clinical Advisor), which resulted in significant reimbursement barriers. These providers also reported that revenue declines (which they attributed to the implementation of the managed care arrangement and new billing practices) led some providers to close, lay off staff, or refuse to see Medicaid beneficiaries. Some providers and consumer representatives felt that these challenges--especially related to changes in rates, provider and beneficiary eligibility, authorizations, and certification processes--could have been mitigated through better planning and communication. These respondents stressed the importance of seeking input from providers and consumer advocates, and ensuring new billing system adequacy and training before a launch.

⁶ Applicants who are no longer eligible have been removed from the wait list. Participants who were previously housed but would no longer qualify are still being served through CDBG funding.

⁷ This report focuses exclusively on the mechanisms for serving adults with behavioral health conditions; PSH serves children and adults with long-term physical or developmental disabilities through different mechanisms.

In-person case management is an important service for those with SMI. Adult Medicaid beneficiaries with SMI who are eligible for 1915(i) services can receive case management. Providers and a consumer advocacy organization emphasized the importance of case management in coordinating care for individuals with SMI. As one provider explained, “This population needs someone to follow up with them to make sure they attend appointments and receive whatever assistance they need.” Respondents emphasized that delivering care management in person is critical. One respondent recommended having a single case manager positioned overall service systems touched by a client.

Managed care entities are well positioned to share useful data with providers in support of care coordination. Providers indicated that they would benefit from systematically learning about patient events (behavioral or physical) or a client’s physical health needs through the MBHO or other providers, rather than relying on self-reported updates from clients. The MBHO is beginning to make progress in exchanging some information with providers. It recently began receiving pharmaceutical data and physical health claims and encounter data, and is working to obtain information on clients’ PCPs. Efforts to co-locate physical and behavioral health providers will further improve the potential for data exchange.

Improvements in billing practices could streamline behavioral and physical health coordination. In a behavioral health carve-out model, financial responsibility must be clearly delineated between physical health and behavioral health plans. Managed care representatives and providers identified some confusion in determining which plan is financially responsible for behavioral health care delivered in primary care settings, which creates reimbursement challenges.

A flexible contract between a state and a managed care entity can help address evolving service and coordination needs. Louisiana included care coordination as a requirement when initializing the MBHO contract in 2012 but did not begin to detail specific elements until 2014. The contract terms allowed for this type of flexibility, which also enabled the state and MBHO to add to the service definition manual based on needs that became apparent over time. For example, the contract had initially neglected to add billing codes for nursing services, an oversight corrected through an “in lieu of” agreement. The state reported creating 11 “in lieu of” agreements with the MBHO as of March 2014.

Medicaid may be a sustainable funding source for PSH supportive services; centralizing management of services comes with trade-offs. Funding PSH supportive services through Medicaid has enabled the PSH program to continue past the availability of time-limited grant funding. There were two notable trade-offs, however: (1) eligibility is restricted to those who qualify for Medicaid 1915(i) services; and (2) providers are reimbursed only for face-to-face time with participants. Providers generally felt that integrating behavioral health services into the MBHO contract streamlined communication with state agencies, although the transition was perhaps

easier for those already enrolled in the MBHO's network and familiar with Medicaid eligibility rules. Providers are no longer reimbursed for the services related to supportive housing that transitioned to the MBHO (such as application assistance and tenant-landlord mediation), requiring consumers to seek support from the MBHO rather than their local behavioral health provider.

APPENDIX C. MASSACHUSETTS STATE PROFILE

A. Program Description

Overview

Recognizing the critical role that housing plays in stabilizing the health conditions of chronically homeless individuals, MassHealth, which administers the state Medicaid program, authorized the Massachusetts Behavioral Health Partnership (MBHP), the state's managed care behavioral health carve-out, to implement the Community Support Program for People Experiencing Chronic Homelessness (CSPECH). This program, which began operation as a pilot in 2006, provides Medicaid reimbursement for community-based care coordination support of chronically homeless individuals in supportive housing. CSPECH services are available through local partnerships of community-based providers of behavioral health and housing services. CSPECH seeks to achieve Medicaid cost savings through directing resources toward individuals in permanent supportive housing (PSH) rather than managing medical conditions on the street or in shelters. Through CSPECH, housing itself is viewed as the primary medical intervention, capturing the essence of the state's Housing First Initiative. The program's success has prompted the state to promote the CSPECH model among the other state managed care organizations (MCOs).

Financing

CSPECH services include targeted outreach and coordination support provided by a community support worker (CSW). Under Medicaid, the state classifies CSPECH services as a type of community support program (CSP).⁸ In 2006, MassHealth approved the reimbursement of CSPECH services as a type of CSP specialty service. Unlike standard CSP services, however, which are reimbursed through a fee-for-service arrangement, MBHP reimburses CSPECH services using a flat case rate of \$17.30 per day. To date, MBHP is the only managed care entity that covers CSPECH services.⁹ The one MCO interviewed for this study provides "social care management," which is a

⁸ CSP is an outreach service aimed at engaging individuals who, by not complying with a treatment plan, are putting themselves at serious risk. CSP services are typically provided to individuals being discharged from a psychiatric hospital or detoxification facility. Recognizing the value of such interventions, MassHealth received Centers for Medicare and Medicaid Services approval, through its managed care waiver program, to allow them as a reimbursable service.

⁹ MassHealth members have the option of enrolling with either one of six MCOs or in the state's primary care clinician (PCC) plan. Under the PCC plan, MassHealth directly reimburses a member's physical health services, and MBHP pays for behavioral health services. The six MCOs are responsible for covering a member's physical health and behavioral health services, although the latter typically are provided through a behavioral health partner of the MCOs. At the time of this report, CSPECH services are available only through the PCC/MBHP plan; none of the MCOs have opted to cover this service.

telephonic outreach and case management model used for high-risk members. The MCO provides this service centrally (financed through its capitation with the state); it is not reimbursable. The MCO refers clients requiring an in-person level of care coordination to a local CSP provider. All services coordinated through CSPECH are reimbursed through the standard mechanisms. MassHealth reimburses physical health services, using a fee-for-service arrangement; MBHP pays for health services; and funding for housing services and supports comes through various mechanisms, including U.S. Department of Housing and Urban Development (HUD) funding and state housing grant programs.

Goals

CSPECH services help the state to achieve three main goals. First, following the principles of the Housing First model, CSPECH helps stabilize and improve the lives of a high-risk, high-cost population. Between 2009 and 2014, MHBP has provided CSPECH services to more than 1,250 beneficiaries. A second goal is to reduce the use of high-cost health services, such as the emergency department (ED). The CSWs work closely with CSPECH recipients once they are housed to ensure their access to needed health services. Although service use can be expected to increase in the short term as individuals are connected to needed health services, the expectation is that, over time, their use of costly emergency and crisis intervention services will decline. Finally, CSPECH is part of a broader state effort to reduce homelessness. Considering itself a “right to shelter” state, Massachusetts has diverted funding from the management of shelters toward the development of low-threshold housing and subsidies.¹⁰ CSPECH services, which are available for as long as an individual remains housed, aids the state in this effort by helping clients establish life structure, learn self-management and independent living skills, and ultimately reintegrate into the community.

State Context

The state’s ability to provide CSPECH services as reimbursable is the result of a policy window that appeared in the mid-2000s. In 2006, the state passed a health insurance reform law that expanded Medicaid access to include single homeless adults, encouraging MassHealth to adopt means to control health care costs for this high-cost population. The Massachusetts Housing and Shelter Alliance (MHSA), a non-profit advocacy organization that leads the state’s efforts to end homelessness, intervened to actively promote the concept behind CSPECH. MHSA partnered with MBHP to develop a service model that could easily be approved by MassHealth by structuring CSPECH in accordance with the already reimbursable CSP service. MBHP, which serves the largest proportion of MassHealth members with disabilities compared to the other state MCOs, may have felt a stronger incentive to adopt such a program. The state is in the process of implementing initiatives that aim to encourage the other MCOs to reimburse for a similar level of service.

¹⁰ Under the Housing First model, homeless individuals are moved directly into housing and offered a range of supportive services in an effort to maintain housing. The receipt of housing is not dependent on successful completion of treatment.

Partnership Structure

At the state level, CSPECH is a product of a partnership between MBHP, MHSA, and MassHealth. MassHealth does not require or directly oversee the program; rather, it is strictly a service that MBHP has opted to cover. The operational partnerships occur at the local level. CSPECH is available statewide through eight providers or provider partnerships. Three sites consist of a partnership between a community mental health center and one or more housing providers, three sites are led by a single organization that provides both behavioral health services and housing, and two sites are led by a federally qualified health center (FQHC) that has partnered with one or more local housing providers.

We visited two CSPECH providers for this review. The South Middlesex Opportunity Council (SMOC) is an antipoverty community action agency that supports and manages more than 1,700 supported housing units across the state through diverse funding sources. SMOC also supports an integrated program model that links its residents to a range of resources, including physical and behavioral health services, employment and education training, and other social benefit programs. In this model, housing support, behavioral health services, and CSPECH services all are provided through one organization.

In contrast, Eliot Community Human Services is a private, non-profit human services organization that provides homeless individuals with a range of mental health and substance abuse services, and other supportive services, but does not directly provide housing support. For this service, Eliot subcontracts with a range of other organizations that provide housing. Eliot has expanded the model by encouraging its partners, which are scattered across the state and not in MBHP's provider network, to hire their own CSWs and then submit CSW claims through Eliot. This arrangement has allowed several community housing providers (many of which also manage local shelters) to house individuals who otherwise would not have been housed due to lack of access to the supports needed to remain housed. As the manager of one shelter put it, "Without CSPECH, we'd have to find another way to support the case manager. And without having the ability to do that, these folks would have stayed in our shelter."

B. Coordination or Integration with Physical Health

Coordination Mechanism and Financing

The CSW operates as the coordinator for CSPECH clients. CSW services are approved for 90 days before an individual becomes housed, allowing the CSW to work with shelter staff in identifying a potentially eligible resident. Individuals must meet the definition of being "chronically homeless," defined by HUD as an individual with a documented disability who has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the previous three years. Once the client

is housed, the CSW begins to work with the client to identify service needs. CSWs maintain a caseload of about 12 clients, as required by MBHP program rules, and typically meet with each client at least once per week. CSPECH service providers are reimbursed using a fixed, flat per-day case rate, used to cover the CSW's salary.

Coordinated Services and Stakeholder Interactions

The providers of health services vary by CSPECH site; however, because all partnerships include an MBHP behavioral health provider, these services are provided through the CSPECH site partnership. With the exception of the two CSPECH sites led by an FQHC, the CSPECH partners do not provide physical health services; thus, CSWs must work with clients to identify a nearby primary care physician (PCP). CSWs often obtain a release of information from clients so PCPs can share information with them. Regardless of health service type, either MBHP or MassHealth reimburses the providers for all services. Although MBHP maintains a managed care arrangement with the state, it reimburses providers in its network on a fee-for-service basis. The low caseload allows CSWs to play an active role in coordinating service receipt, often driving and accompanying clients to appointments, and following up on referrals and prescriptions. Providers unaffiliated with the CSPECH agency, such as PCPs, have embraced CSW involvement because it often helps to ensure compliance with prescribed treatments and follow-up with suggested referrals.

C. Coordination or Integration with Housing or Other Social Services

Coordination Mechanism and Financing

CSWs are trained in how to navigate both the Medicaid and housing systems, and thus are responsible for helping coordinate access to all of these services for CSPECH recipients. Housing is prioritized before other services. CSWs begin working with a client the moment a housing unit or subsidy is identified. Because CSPECH does not provide funding for housing, CSWs rely on existing and available resources within the provider network. Although the statewide supplies of affordable housing and subsidies are in high demand, CSWs are linked to organizations able to leverage and access these scarce resources. Most CSPECH provider organizations manage subsidized housing units. Because MBHP limits the number of clients a CSW can serve (roughly 12), some of the housing providers dedicate this number of units to CSPECH clients. In most cases, the units are funded with a project-based subsidy, either through HUD or state funding.

Coordinated Services and Stakeholder Interactions

In addition to helping clients find housing, CSWs work with them to maintain housing. Many clients have not lived independently for years and often struggle with community reintegration, paying utility bills, and establishing independent living skills.

CSWs, many of whom are able to connect with clients through their own lived experiences, work with clients to address these issues. Because employment may not be an option for many CSPECH clients, and due to the prevalence of ongoing substance abuse issues, CSWs focus on helping clients establish daily routines and structure, and encourage clients to volunteer in the community or enroll in a day program. To track clients, some CSPECH providers have established relationships with entities within the local criminal justice system and prison diversion programs. Finally, clients often are eligible for a range of benefits, such as Supplemental Security Income, Social Security Disability Insurance, or Supplemental Nutrition Assistance Program. CSWs help their clients navigate the complicated and often lengthy approval processes for these and other benefits.

D. Key Perceptions and Lessons Learned for Implementing the Care Coordination Strategy

The success of the CSPECH program is rooted in the state’s willingness to embrace a Housing First model and low-threshold housing. Many CSPECH clients are active substance users and have criminal backgrounds, preventing them from meeting the requirements associated with some HUD-funded housing programs. In 2006, the state began funding MHSAs’ Home and Healthy for Good (HHG) program, a dedicated funding source that can be used flexibly by housing and service providers as long as they are promoting low-threshold housing for chronically homeless adults. Many CSPECH clients reside in HHG-supported homes. The state also views itself as a “right to shelter” state, comparing homeless shelters to an ED--a type of triage until the individual can be moved into a more permanent living environment. The state has recognized that to successfully reduce shelter populations, housing and support services must be available.

Program access is restrained by the supply of affordable housing and related subsidies. Receipt of CSPECH services is limited to those who have been moved into PSH; thus, access to these services is limited to the availability of subsidized units. The state’s embrace and funding of low-threshold housing has helped address this challenge to a certain extent, yet the demand for CSPECH services remains higher than the supply of housing.

Providers and consumers perceive that many individuals would not have housing or be able to remain in their housing in the absence of the CSPECH program. Consumers regard the CSWs as critical to their personal success, noting that the CSW has connected them to housing, health, and social services they would not otherwise have accessed. For many consumers, the CSPECH program literally is viewed as a life saver. Providers report that the availability of CSPECH services has allowed housing developers and service providers to pursue new funding opportunities, such as HHG, more robustly; the availability of the CSPECH supports creates a market for housing a population that previously might have remained on the streets or in the shelters.

Minimal changes in billing structures and reliance on existing provider relationships have facilitated program implementation. CSPECH services are billed as a type of CSP service--a pre-existing service category. This arrangement has allowed for minimal billing system changes, an advantage noted by several providers in the state. MBHP's requirement that CSPECH service providers already be part of MBHP's provider network ensures a minimal need for billing-related training and assistance. (That is, these agencies must provide other Medicaid-reimbursable services.) Several CSPECH providers however, contract with organizations that do not otherwise provide Medicaid-reimbursable services, such as property management companies and homeless advocacy organizations. In these cases, a centralized billing process is used, through which the MBHP network provider submits all CSPECH reimbursement claims. These arrangements allow for expanded access to CSPECH services, as well as a stronger link between the behavioral health services and the housing resources required for CSPECH participants.

Limitations in coverage have created service gaps. The other state MCOs have not yet chosen to reimburse for CSPECH services, although the state is introducing an initiative that will create an incentive for them to do so. A more significant challenge occurs when a CSPECH participant becomes dually eligible for Medicaid and Medicare. Duals are not eligible for the PCC/MBHP plan. As of the writing of this report, none of the plans available for dually eligible individuals cover CSPECH services, including those that serve the state's One Care dual demonstration. Thus, upon eligibility for Medicare, a CSPECH recipient enrolled in a plan for dual-eligible beneficiaries is no longer eligible to receive these services. Housing is not lost, however, since it is not linked to the service. The providers interviewed for this review reported that, out of compassion for clients, most CSWs continue to provide service to dual-eligible clients without reimbursement, an arrangement that is not sustainable.

APPENDIX D. TENNESSEE STATE PROFILE

A. Program Description

Overview

TennCare, Tennessee's Medicaid program, is a statewide, mandatory managed care program that serves the state's entire Medicaid population. In 2007, Tennessee began integrating behavioral health services into its managed care contracts; these services were previously carved out and managed by a separate behavioral health organization (BHO). In 2010, the state rolled long-term care services and supports into its managed care contracts for certain beneficiaries as part of the state's CHOICES program.¹¹ Three managed care organizations (MCOs) currently are responsible for managing a range of services for more than 1.2 million beneficiaries across the state.

Financing

Since 2002, TennCare has operated under an 1115 demonstration waiver, now called TennCare II, which the Centers for Medicare and Medicaid Services recently extended; it now expires in 2016. MCOs are in an at-risk situation for beneficiaries' physical health, behavioral health, and long-term care services. Four plans currently are available to TennCare beneficiaries: UnitedHealthcare, Amerigroup, and BlueCare are available in certain regions of the state. TennCare Select, a partial-risk prepaid inpatient health plan administered by BlueCare, is also available to beneficiaries who meet additional financial and needs-based eligibility criteria.

Goals

The TennCare II demonstration aims to use managed care to provide an integrated package of acute and long-term care services at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program. It also endeavors to ensure access and quality care to enrollees, and provide appropriate and cost-effective home and community-based services that will improve the quality of life for eligible beneficiaries.

Context

The state recently completed an MCO rebid process; the three incumbent MCOs will retain contracts in 2015. However, the distribution of beneficiaries among the three organizations, which currently varies by region, will be evenly divided across the three

¹¹ Tennessee's CHOICES program includes nursing facility services and home and community-based services for adults 21 years of age and older with a physical disability, and seniors (age 65 and older).

organizations, and all three plans will be available statewide. State officials also do not intend to expand Medicaid eligibility at this time.

Partnership Structure

The Bureau of TennCare (the Bureau) is the state agency responsible for the management and administration of the TennCare program. The state's Department of Mental Health and Substance Abuse Services (DMHSAS), formerly responsible for oversight of Medicaid behavioral health services in the state, maintains a memorandum of understanding with the Bureau of TennCare. The department staffs meet monthly and quarterly to share information and collaborate around specific initiatives. The Bureau also maintains partnerships with other state agencies, such as the Department of Intellectual and Developmental Disabilities, and Department of Child and Family Services.

At the provider level, behavioral health providers (including community mental health centers [CMHCs]) that serve Medicaid beneficiaries have formal contractual relationships with the MCOs operating in their region. The MCOs provide opportunities for open communication, both formal and informal, with contracted CMHCs and other behavioral health providers through, for example, MCO advisory board meetings and provider relations specialists.

One provider described the partnership model in the state as “triangular”; the Bureau and MCOs communicate, and MCOs and providers communicate. This is consistent with what we heard from other providers we interviewed: they did not have much direct interaction with the Bureau, except through MCO advisory meetings.

B. Coordination or Integration with Physical Health

Coordination Mechanisms and Financing

By bringing management of physical and behavioral health services into one contract and “under one roof,” the state hoped to encourage coordination of physical and behavioral health services at both the state administrative and MCO levels. The state has urged MCOs to integrate their data systems so that their staffs can access both physical and behavioral health information and see the “whole picture” of a beneficiary; MCOs have also integrated physical and behavioral health staff to varying degrees. In addition, MCOs provide case management services at the plan level to individuals with complex health needs--such as comorbid physical and behavioral health disorders--through required Population Health Programs, but typically only to high service utilizers and for a brief time. Among the MCO case management services offered are comprehensive health risk assessments, assistance in making and keeping needed medical and or behavioral health appointments, and health coaching. Integration is intended to encourage coordination at all levels; however, state officials, managed care representatives, and providers indicated that the state is operating on a

case management model that shifts the bulk of service coordination efforts for TennCare beneficiaries with behavioral health disorders to the CMHCs through the Medicaid mental health case management (MHCM) benefit included in the MCO benefit package.

Coordinated Services and Interactions

Case managers located at CMHCs and other providers provide MHCM. Beneficiaries must meet medical necessity requirements to receive case management services, and these services generally are unrestricted if they meet continued medical necessity. The state's Medicaid plan offers multiple levels of case management based on need. One level of MHCM benefit allows for provision of team-based approaches, such as Assertive Community Treatment or Continuous Treatment Team services, to beneficiaries with the greatest needs. All MCHM case managers are required to assess beneficiaries' needs so as to refer and coordinate services that will improve functioning and/or maintain stability, which may include coordinating with clients' primary care physicians and other providers of physical health care. Providers mentioned that case managers often facilitate beneficiaries' physical health care by helping clients navigate appropriate provider networks, access services, and interpret information provided by primary care and specialty providers.

In addition to MHCM, the CHOICES program assigns a care coordinator to all TennCare beneficiaries enrolled in its program. This coordinator conducts a health assessment that includes behavioral health and provides referrals to needed services and programs. The care coordinator follows up with the member at least quarterly to ensure that his or her needs are being met. Although multiple-MCO care management staff may be involved in a CHOICES member's care, the beneficiary's CHOICES care coordinator has primary responsibility for coordination of all care needs.

State officials and managed care representatives also mentioned that the integrated arrangement was intended to and has opened the door for conversations between MCOs and providers about coordination of physical and behavioral health services through various models at the provider level. For example, one provider we visited integrated a nurse practitioner into the agency to provide clients with primary care services and has worked with MCOs to better coordinate billing systems for integrated care. Providers in other regions are undertaking similar efforts.

C. Coordination or Integration with Housing or Other Social Services

The TennCare supported housing benefit covers supervised group housing facilities staffed by mental health providers 24 hours a day, seven days a week. Individuals receiving these services must meet medical necessity and level of care standards, and require services and supports in a highly structured setting. Medicaid-supported housing services are intended to be relatively temporary and serve as a

bridge for individuals coming from institutions and other restrictive settings into more independent living in the community.

Coordination Mechanism and Financing

The TennCare Medicaid benefit package includes supported housing as a psychiatric rehabilitation service--a service available before the integration of behavioral health services into managed care contracts. Integration of behavioral health benefits into the MCOs' contracts generally was not intended to alter the housing landscape for individuals with behavioral health conditions. Management of TennCare-funded housing support services and other psychiatric rehabilitation services simply was shifted to the MCOs. However, reviewing and enhancing the definition of supported housing was one of the first initiatives upon which the Bureau and MCOs collaborated after integration occurred.

Contracting arrangements for housing and support services vary by provider. MCOs contract with some CMHCs or psychiatric rehabilitation agencies that own and operate housing and support services. Other behavioral health providers subcontract with housing providers that own and operate housing and/or support services. DMHSAS licenses group homes providing supported housing services. TennCare covers the support services provided to supported housing beneficiaries. Beneficiaries themselves generally cover room and board through their Supplemental Security Income (SSI) benefit or other means.

Beyond the Medicaid-supported housing benefit, other housing options that provide varying levels of independence and support are available to both TennCare and non-TennCare beneficiaries with behavioral health disorders. Much of the housing work for individuals with behavioral conditions appears to center on the Creating Homes Initiative (CHI), through which DMHSAS has worked to create and sustain a variety of permanent, supportive housing opportunities for individuals with mental illnesses. Since its inception in 2000, CHI has created more than 11,000 affordable housing opportunities, with support services as needed, for people living with mental illness, including many of the supervised groups homes in which TennCare supportive housing services are provided. Each region of the state has a regional housing coordinator who works with communities to develop affordable housing options. Although there do not appear to be formal mechanisms linking TennCare and CHI, regional housing facilitators work closely with both TennCare-funded CMHCs and housing providers to find or establish housing opportunities for beneficiaries with mental illnesses.

Coordinated Services and Stakeholder Interactions

Case managers at CMHCs may also coordinate housing for TennCare beneficiaries who are not eligible for supported housing and/or can succeed in less restrictive and more independent settings. Other means--such as housing subsidies, SSI benefits, and others--typically cover room, board, and other expenses for these

options, and CMHC case managers or other providers offer support services through state or federal grant funding.

MCOs have partnered with the Bureau and state associations to expand and enhance housing supports for particularly vulnerable populations. UnitedHealthcare, for example, worked with the state to enhance supported housing services that assist individuals with behavioral health conditions and complex medical needs. These individuals were residing in subacute beds in state hospitals due to comorbid medical conditions that existing providers were unable to adequately address in less restrictive settings without enhanced support. UnitedHealthcare worked with providers to add medical support to supported housing services to permit individuals with high medical needs to move into less restrictive settings. As a result of this enhanced support, UnitedHealthcare reports that it was able to move 95 percent of its members who had been residing in subacute facilities to less restrictive levels of care.

D. Key Perceptions and Lessons Learned for Implementing the Care Coordination Strategy

All stakeholders view case management as critical to improving care for individuals with behavioral health disorders. At both provider and consumer levels, a key component for service coordination for individuals with behavioral health conditions is the state's MHCM benefit. Providers and consumer representatives mentioned that case managers coordinate a broad range of health and social services for beneficiaries, and serve as a bridge to the clients' other providers. Consumer representatives said that consumers without access to such services often contact consumer organizations for assistance in navigating service systems. State officials and MCO representatives also recognized the critical role MHCM plays in care for beneficiaries with behavioral health conditions, and are looking at ways to enhance the benefit by increasing focus on quality and outcomes.

Open communication among providers, MCOs, and the Bureau is critical. Providers commented on the importance of communication with MCOs in allowing them to innovate and implement coordination strategies. Provider relations specialists and other provider-specific contacts at MCOs serve as key sources of information and assistance for providers as they attempt to apply service definitions and bill for services. Providers and advocates also cited quarterly provider "problem-solving" meetings with the Bureau as a key indication of the state's willingness to communicate and collaborate. Although providers appreciated the availability and willingness of the state and MCOs to communicate, some mentioned that they sometimes felt like a "little fish in a big pond," since behavioral health services were carved into managed care contracts. They observed that behavioral health providers now are competing with a wide range of other providers for attention from and prioritization by the Bureau and MCOs.

Data can enhance coordination and inform policy decision making. Providers and state associations cited the benefits of using data to drive care and advocate for

system change. One provider, for example, requested to be notified by the MCOs when a patient was admitted to an emergency department so as to tailor care more appropriately. At the association level, the Tennessee Association of Mental Health Organizations has established a data warehouse that member provider organizations populate with data from all client payers. Data from the warehouse have been used in advocacy efforts with MCOs and local legislators.

Provider competition generated by integration of behavioral health services into managed care contracts is both beneficial and challenging. The introduction of multiple MCOs has encouraged competition among provider organizations; in turn, this has encouraged efficiency and innovation at the provider level. Providers now must compete to secure MCO contracts and demonstrate an ability to provide quality care at competitive rates. Although most providers indicated that, on balance, competition among providers has been a positive outcome of the integration of benefits at the plan level, it has also caused a great deal of upheaval. Some providers found it necessary to merge or affiliate to remain competitive in a managed care environment. Some suggested that affiliation occurred to increase the ability to negotiate with and demonstrate service capacity to MCOs. Competition may also have somewhat diminished collaboration between community behavioral health agencies. To describe the current reality of competition and collaboration, one respondent said “We’re all in this together, separately”.

The complexity of contracting with multiple MCOs using different billing systems, service definitions, and financing arrangements presents administrative challenges for providers. Provider and consumer respondents viewed contracting with multiple MCOs as a challenge that has required them to learn and adapt. Providers, for example, mentioned that billing and payment practices vary widely among the MCOs. One provider noted that for case management, one MCO pays a daily rate, one a monthly, and one in 15-minute increments. Providers likewise mentioned ambiguous contract language and the broad service definitions established by the state as a challenge. Whereas providers understand and appreciate the need for flexible language to permit provider and MCO innovation, some also suggested that it is important to strike a balance between giving MCOs enough flexibility to establish service definitions that meet their needs and enough specificity in service guidelines to prevent room for interpretation. Respondents said that billing codes traditionally used by MCOs do not always fully capture the complexities of behavioral health services-- particularly team-based services. A distinct and ongoing challenge has been educating MCOs. Providers noted that MCOs might not be as familiar with specialty behavioral health services as would specialty managed BHOs regarding the types and nuances of behavioral health services and ensuring that they establish policies accordingly.

Other state policies and practices should be considered and amended to facilitate provider coordination. Several providers mentioned that challenges associated with same-day billing of physical and mental health services create barriers to service integration, particularly for providers that wish to provide co-located behavioral and physical health services; they strongly recommended that same-day

billing be both permitted and achievable. Tennessee permits same-day billing and, along with MCOs, is working to adjust data and billing systems to accommodate billing for physical and behavioral health services on the same day. Such reengineering has taken time, however. In addition, primary care health codes are not necessarily included in MCO contracts with behavioral health providers, so if the latter would like to administer physical health services, they must participate in additional negotiation with the plan to include the necessary codes.

UNDERSTANDING INNOVATIVE STATE SYSTEMS THAT SUPPORT COORDINATED SERVICES FOR INDIVIDUALS WITH MENTAL AND SUBSTANCE USE DISORDERS

Reports Available

Improving the Coordination of Services for Adults with Mental Health and Substance Use Disorders: Profiles for Four State Medicaid Initiatives

HTML <http://aspe.hhs.gov/report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-profiles-four-state-medicaid-initiatives>

PDF <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-profiles-four-state-medicaid-initiatives>

Illinois Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Louisiana Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Massachusetts Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Tennessee Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

State Strategies for Coordinating Medicaid Services and Housing for Adults with Behavioral Health Conditions

HTML <http://aspe.hhs.gov/basic-report/state-strategies-coordinating-medicaid-services-and-housing-adults-behavioral-health-conditions>

PDF <http://aspe.hhs.gov/pdf-report/state-strategies-coordinating-medicaid-services-and-housing-adults-behavioral-health-conditions>

State Strategies for Improving Provider Collaboration and Care Coordination for Medicaid Beneficiaries with Behavioral Health Conditions

HTML <http://aspe.hhs.gov/basic-report/state-strategies-improving-provider-collaboration-and-care-coordination-medicaid-beneficiaries-behavioral-health-conditions>

PDF <http://aspe.hhs.gov/pdf-report/state-strategies-improving-provider-collaboration-and-care-coordination-medicaid-beneficiaries-behavioral-health-conditions>

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Office of Disability, Aging and Long-Term Care Policy
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Washington, D.C. 20201
FAX: 202-401-7733
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