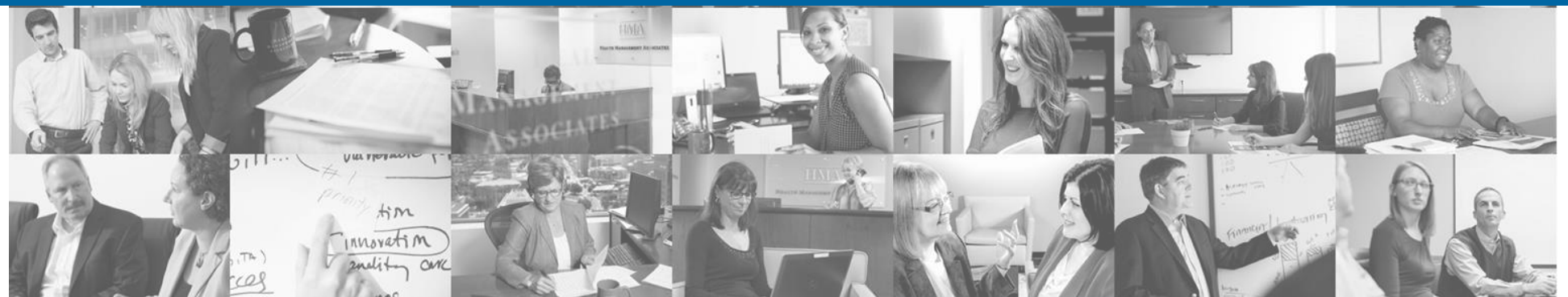
HEALTH MANAGEMENT ASSOCIATES

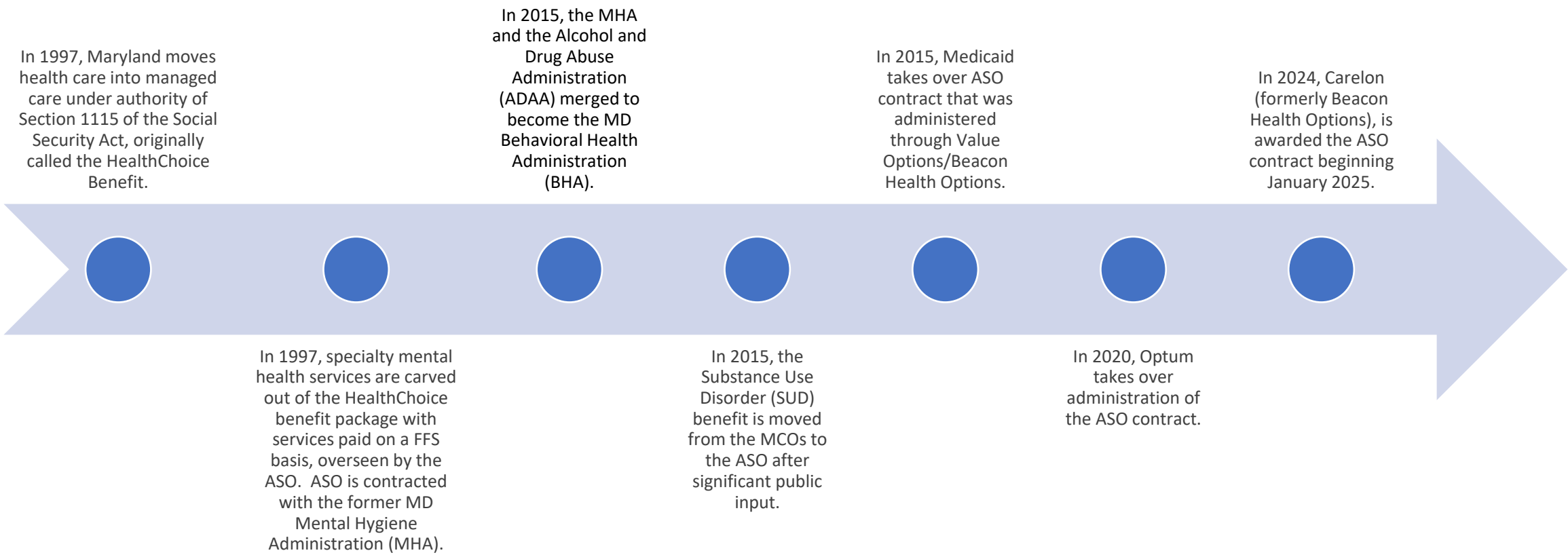
Effective Strategies for Behavioral Health Benefit Management

July 16, 2024



MEETING #1:
STARTING THE CONVERSATION

HISTORY OF MARYLAND'S MEDICAID BEHAVIORAL HEALTH ASO MODEL



PRIMER ON BEHAVIORAL HEALTH MANAGED CARE MODEL OPTIONS*

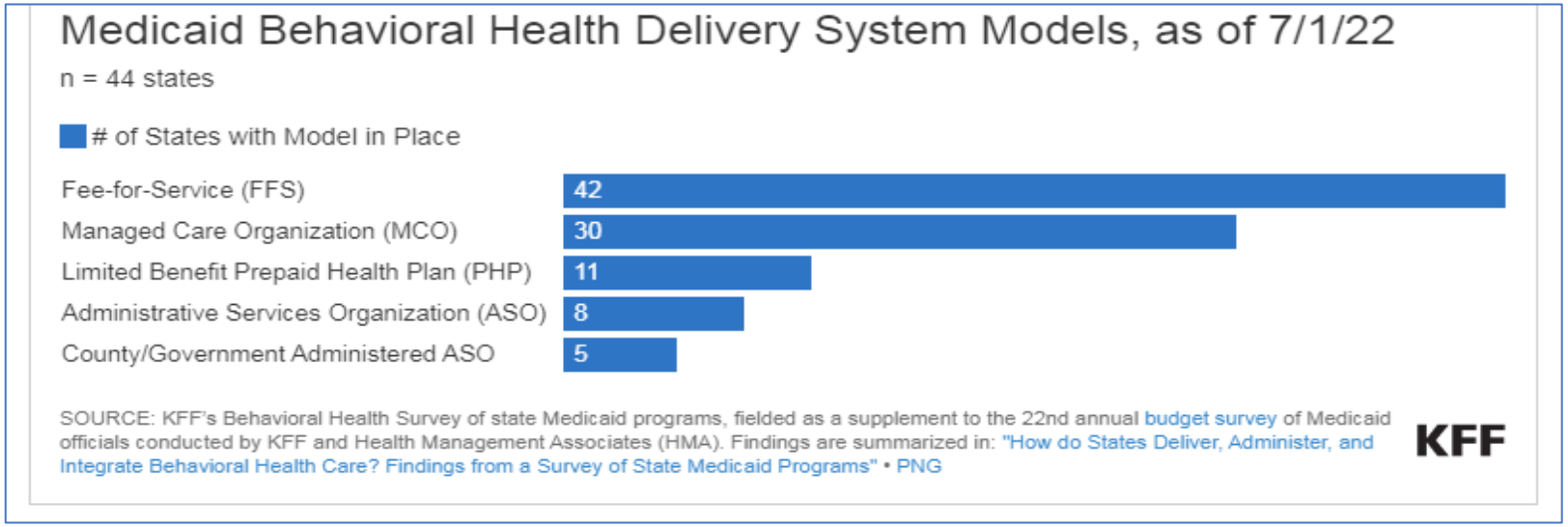
- States use a combination of fee-for-service (FFS) and managed care arrangements to deliver behavioral health (BH) care to Medicaid beneficiaries
  - Under FFS, states pay the health care provider for each service rendered, regardless of the cost, quality of the service, or the outcome
  - Under managed care, the state contracts with health plans to contract with behavioral health care providers and medical facilities to provide care for members at pre-determined rates to manage cost, utilization, and quality

- Oversight of the Medicaid behavioral health benefit is typically managed in different state agencies within the health and human services branches of government

*How do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs | KFF

PRIMER ON BEHAVIORAL HEALTH MANAGED CARE MODEL OPTIONS*

- State options for managed Medicaid BH care models include:
  - Carve in of behavioral health services into comprehensive, capitated MCO contracts (a set payment amount for each enrollee regardless of the number or type of visits)
  - Contract with risk-based limited benefit prepaid specialty health plans (PHPs) (health plans are paid per-member-per-month to cover a limited set of services)
  - Retain the FFS model but contract with public or private Administrative Service Organizations (ASOs) to deliver behavioral health services on a non-risk basis
  - Maintain some services in a FFS payment model without administrative oversight



*How do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs | KFF

Outcomes Resulting From Integration of Behavioral Health and Somatic Health Benefit Management

Notable Findings

The professional and academic literature support integration as the most effective way of providing clinical services and managing behavioral health finances.

A rapidly growing number of states are adopting managed care models in which a single entity is responsible for both behavioral and physical health services, thus "carving-in" or integrating behavioral health services (Herman Soper, M). The literature indicates the following outcomes resulting from integration:

- Integration in Medicaid managed care was associated with **greater access** to outpatient behavioral health services for individuals with **mild and moderate mental health conditions** (2.78%) (Charlesworth, CJ)
- Access improved for individuals primarily treated in **primary care settings**, individuals with mild or moderate mental health conditions, and for **black enrollees** (Charlesworth, CJ)
- Although **cost of care was reduced slightly, access to OP services was increased** in this fully capitated model (Xiaoling X)
- Although **cost of care was reduced slightly, access to OP services was increased** in a fully capitated and integrated model (Xiaoling X)
- Studies also found that **access to inpatient level of care was increased** for individuals who moved to an integrated plan during their course of treatment relative to individuals continuously in carve-in plans (beta =.02; p=.05) (Ettner SL, et. al.)
- However, initially, individuals were less likely to access psychiatrists and other behavioral health specialists, and access did not increase for individuals with serious and persistent mental illness (Charlesworth, CJ; Frank RG.)

Outcomes Resulting From Integration of Behavioral Health and Somatic Health Benefit Management

Notable Findings

However, administering effective integrated systems of managed care requires several interim steps, and there are a variety of administrative strategies and structures that may be appropriate for Maryland:

- There are **intermediary steps** to support effective transformation from a specialty BH to an integrated system. (1) specialized clinical expertise at the health plan level; (2) state capacity for robust oversight and monitoring; (3) innovative strategies for advancing whole-person care to address beneficiaries' complex needs; and (4) mechanisms for achieving and maintaining provider and other stakeholders' support (Herman Soper, M).
- **Utilize innovative payment models** to encourage multi-sector alignment (e.g.: movement away from fee-for-service, global and value-based payment models) (Herman Soper, M; Shmerling, AC.)
- Focus on ensuring **stakeholder collaboration** and partnerships for developing the model, in developing contracting requirements with health plans, and for an ongoing feedback loop (Herman Soper, M; Shmerling, AC.)
- Increase investment in behavioral health and primary care and investments in **workforce recruitment and training** to streamline access and ensure wholistic treatment planning and care coordination (Herman Soper, M; Shmerling, AC.)
- **Increase expertise around behavioral health populations and collaboration** with providers amongst primary care, health plans, and Medicaid agencies (Smith, A.; Westfall, J. ; McConnell, K.)
- **Strengthen contracting and data analytics expertise** for performance monitoring and oversight (Lovett, L.)

The Process Informs the Model

EXHIBIT 1: Overview of State Behavioral Health Integrated Care Models

State	Model	Launch Date
Arizona‡	Specialty plan for beneficiaries with SMI	Apr. 2014: Maricopa County.; Oct. 2015: Greater Arizona
■ Implemented an integrated physical and behavioral health program for Medicaid beneficiaries with SMI. ■ Behavioral health services previously carved out of managed care and managed by Regional Behavioral Health Authorities (RBHA). ■ Awarded a competitive contract to Mercy Maricopa Integrated Care (or Mercy Maricopa) to serve as an integrated RBHA and coordinate behavioral and physical health services for beneficiaries with SMI in Maricopa County. ■ Following Maricopa, Arizona expanded this platform for Medicaid enrollees with SMI statewide and awarded integrated RBHA contracts in the state's rural northern and southern regions. ■ Requires Medicaid health plans that cover physical health to provide some behavioral health benefits to Medicare-Medicaid enrollees.		
Florida	Specialty plan for beneficiaries with SMI	Jul. 2014
■ Part of legislatively mandated Statewide Medicaid Managed Care, a comprehensive managed care reform that required the Agency for Health Care Administration to release a competitive procurement that allowed specialty plans (e.g., plans focused on specific populations such as individuals with HIV/AIDS, SMI, and recipients in the child welfare system) to bid on acute care contracts. ■ Magellan Complete Care of Florida selected to serve as a fully integrated specialty plan to manage Medicaid benefits for individuals with SMI in eight of 11 regions. ■ Provides all medical and behavioral health services.		
Kansas	Comprehensive managed care carve-in	Jan. 2013
■ Implemented a comprehensive managed care program via an 1115 waiver, KanCare, including all physical, behavioral, and LTSS. ■ Previously provided behavioral health services via carved-out, specialized mental health prepaid ambulatory plans through local behavioral health clinics. These clinics remain the primary source for behavioral health services, and contract with KanCare. ■ Released an RFP in 2012 to identify plans to provide "whole person care" via interdisciplinary teams; selected three plans.		
New York	Hybrid model	Oct. 2015: New York City; expected 2016 phase-in statewide
Two-part managed behavioral health reform: ■ Integrating all Medicaid behavioral health services currently provided via FFS into its mainstream Medicaid managed care plans. All 10 plans serving the New York City region manage behavioral health services internally or contract with a BHO. The rest of the state regions will phase-in during 2016. ■ These plans can apply to serve as Health and Recovery Plans (HARPs) that will offer community-based benefits to individuals age 21 and older with significant behavioral health needs. The HARPs will function as separate lines of business within each designated health plan.		
Texas	Comprehensive managed care carve-in	Sep. 2014
■ Carved-in Medicaid mental health rehabilitation and case management services into existing 19 Medicaid health plans (20 plans by November 2016) as mandated by 2013 Senate Bill 58. ■ Allows health plans to provide services in-house, or contract with a BHO. ■ Prior to enactment of SB 58, provided services via FFS by Local Mental Health Authorities (LMHAs), the state's network of community mental health centers. Plans now directly contract with LMHAs and other behavioral health entities to provide services.		

STATE STRATEGIES TO PROMOTE INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES*

	STATE EXAMPLES
Incentivize screening and referrals between primary care and behavioral health providers.	**Louisiana** requires MCOs to employ a full-time behavioral health medical director who is charged with developing training for primary care providers on specific behavioral health screening tools and collaborative care models, as well as provide all primary care providers with a current list of referral providers, including behavioral health providers, on a quarterly basis.
	Minnesota requires that managed care plans provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care clinics.
	Pennsylvania's Telephonic Psychiatric Consultation Service Program increases the availability of peer-to-peer child psychiatry consultation teams to primary care providers and other prescribers of psychotropic medications for children.
	Virginia requires its health plans to demonstrate the ability to cover specialty consultant services (e.g., telepsychiatry) to interested primary care providers and contract with network behavioral health providers that can provide assessments and other services via telehealth, as needed.
	Washington requires its plans to submit a quarterly report on bi-directional behavioral and physical health integration to the Medicaid agency

*Medicaid-Forward-Behavioral-Health-Report.pdf (medicaiddirectors.org)

STATE STRATEGIES TO PROMOTE INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES* (CON'T)

Area of Focus	STATE EXAMPLES
Advance integrated care delivery models.	CCOs bidding for contracts with **Oregon's** Medicaid program must identify and address billing and policy barriers that prevent behavioral health providers from billing for services from a physical health setting.
	Vermont implemented a hub and spoke system for supporting people with opioid use disorder.

*Medicaid-Forward-Behavioral-Health-Report.pdf (medicaiddirectors.org)

STATE STRATEGIES TO ADVANCE PREVENTION BY PROMOTING MENTAL HEALTH AND WELLBEING*

Area of focus	STATE EXAMPLES
Support mental health promotion and primary prevention.	**North Carolina** released a toolkit that provides information about resources about how to manage mental health needs during the pandemic.
Increase awareness of and linkages to other social services and supports.	**California** plans to require its health plans to conduct individual risk assessments that identify social risk factors, like lack of transportation and food insecurity.
	Massachusetts requires its plans to screen all members for their social support needs.
	Rhode Island requires its plans to refer individuals to social services and supports and monitor the outcome of those referrals.

*Medicaid-Forward-Behavioral-Health-Report.pdf (medicaiddirectors.org)

Necessary Steps and Strategies for Behavioral Health Benefit Management

This table summarizes the predominant intermediary **steps and strategies** within the professional and academic literature that contributed to effective clinical and administrative behavioral health client outcomes.

Activity	Strategy

1) Clear articulation of policy and operational goals and capacity to carry out implementation	▪ **Clearly reflect a state's policy goals**, allow plans the space to develop innovative approaches, and be very explicit on:
	  ▪ **continuity of care requirements to safeguard beneficiaries during program transitions** (e.g.: Florida's 60-day continuity of care period, during which time prior authorization requirements are waived)
	  ▪ sub-contracting – develop clear **requirements that advance coordination among entities** is important to support integrated care efforts (e.g.: New York's readiness review includes an extensive assessment of policies and procedures between health plans and BHOs around information sharing, required reporting, staffing requirements, network adequacy and integrated performance indicators)
	  ▪ **multi-system care coordination and beneficiary protections** – (e.g.: access to care standards; care coordination requirements; and collection of certain administrative data elements such as around grievances and appeals and utilization management)
	  ▪ flexibility for plans to **modify program elements to best meet enrollee needs** (Herman Soper, M)
	
	▪ **Increased expertise around behavioral health populations and collaboration** with providers amongst primary care, health plans, and Medicaid agencies, to prevent inefficient processes when transitioning policy development and oversight responsibilities to these entities (Smith, A)

Necessary Steps and Strategies for Behavioral Health Benefit Management

Activity	Strategy

2) Stakeholder engagement	▪ **Invest in strong state capacity for provider relations** can help build provider trust and involvement.
	▪ Focus on ensuring **stakeholder collaboration and partnerships** for developing the model, in developing contracting requirements with health plans, and for an ongoing feedback loop (Horvitz-Lennon, M)
	
	▪ Engage **diverse perspectives across several stakeholder groups** (Kansas hired a contractor to conduct public meetings with various stakeholder groups across the state, and collected feedback from more than 1,700 stakeholders, including consumers and their families, among others; Texas worked closely with trade organizations representing LMHAs)
	  ▪ several plans recommended a **"grassroots" approach to building community relationships** by reaching out to food banks, supportive housing organizations, peer groups, occupational training centers and other organizations.
	  ▪ seek **feedback from family members and certified peer support workforce**
	  ▪ build in additional time into program design and implementation work plans for **provider outreach and education** (Herman Soper, M)

Necessary Steps and Strategies for Behavioral Health Benefit Management, continued

Activity	Strategy

3) Provision of fiscal incentives to providers	▪ **Provide financial incentives** to achieve the benefits:
	  ▪ provide **PMPM for primary care** to provide BH screening, CCM, and other BH interventions
	  ▪ Cover **non-traditional BH** services (e.g.: faith programs, peer networks) (Westfall, J)
	
	▪ Incorporate support for **practice transformation or financial incentives** for providers to achieve the benefits of coordinated mental and physical health care (McConnell, K)
	▪ Combine financial integration with **investments in workforce** recruitment and training for primary care and BH providers (McConnell, K)
	
	▪ Provide **succinct incentives and expectations for health plans around payment and risk** (ex.: higher capitation payments to health plans, risk-adjustment methods, risk-mitigation tools, consider setting provider rates to ensure proper reimbursement, incentives for improved health plan performance) (Horvitz-Lennon, M)

Necessary Steps and Strategies for Behavioral Health Benefit Management, continued

Activity	Strategy
4) Balance network management with collaboration with MCOs (and providers)	▪ Communicate **clear expectations on penalties and rewards**, clear expectations for who is responsible for delivering each covered service ▪ Define **clear regulations and administrative processes** (ex.: regulation of medical necessity criteria, monitoring of denials to patients and payments to BH providers) (Horvitz-Lennon, M) ▪ Develop a **comprehensive system to track plan reports** and other deliverables ▪ Schedule **systematic check-ins with health plans** to ensure they are well supported and that state resources are sufficiently targeted to offer adequate support. ▪ **Ensure an adequate provider network** and encourage innovative thinking for providers to fill in system gaps ▪ **Collaborate with MCOs on provider training activities** (Herman Soper, M) ▪ Focus on ensuring **stakeholder collaboration** and partnerships for developing the model, in developing contracting requirements with health plans, and for an ongoing feedback loop ▪ **Strengthen contracting and data analytics expertise** for performance monitoring and oversight (Lovett, L)

Necessary Steps and Strategies for Behavioral Health Benefit Management, continued

Activity	Strategy
5) Identify metrics to assess improvements in healthcare access, quality, and outcomes	▪ Incorporate **clear process and outcome reporting metrics**, such as: ▪ Utilization of services ▪ Inpatient MH visits ▪ Outpatient MH visits ▪ Primary care visits ▪ ED visits (all visits) ▪ Readmissions after MH hospitalizations ▪ Total costs for enrollees with SMI ▪ Total spend for members who have chronic conditions, as well as either a MH and or SUD diagnoses; tracking spend over time with increased supports ▪ MH screenings and follow-up ▪ HEDIS - follow up with BH professional after BH hospitalization ▪ SDOH factors (ex. rates of arrests, employment, homelessness) (Niles and Olin, 2021)

Examples of Metrics

EXHIBIT 2: Examples of State Performance Measures

State	Quality/Performance Measure Examples
Florida Florida Specialty Plan-Specific Performance Measures[13]	■ Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotics ■ Diabetes monitoring for people with diabetes and schizophrenia ■ Cardiovascular monitoring for people with cardiovascular disease and schizophrenia ■ Adherence to antipsychotic medications for individuals with schizophrenia
Kansas KanCare Evaluation Final Evaluation Design[14]	■ Number/percent of: » Adults with serious and persistent mental illness (SPMI) who were homeless at the initiation of Community Supports and Services (CSS) and experienced improvement in their housing status; » KanCare members diagnosed with SPMI whose employment status increased » Members using inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services ■ Healthy Life Expectancy measures for persons with SPMI: includes indicators of prevention (e.g., screenings, vaccinations, preventable emergency visits) and treatment/recovery (e.g., diabetes management, HbA1C testing; eye exams, blood pressure)
Arizona Mercy Maricopa RFP: Performance Measures for SMI Members Receiving Physical Health Care Services[15]	The plan must meet and sustain Minimum Performance Standards in several areas, including but not limited to: ■ Inpatient and emergency department utilization ■ Hospital re-admissions ■ Follow-up after hospitalization after 7 and 30 days ■ Access to primary care and behavioral health providers ■ Comprehensive diabetes management ■ Use of appropriate medications for people with asthma ■ Flu shots for adults

QUESTIONS

- We've outlined 5 necessary steps for behavioral health benefit management. Are we missing any critical steps?
- What are the strengths and challenges of the current behavioral health ASO model in Maryland?
- How might a different behavioral health management model address the challenges of the current system?
- If the state were to consider changes to the current ASO model, what would be the major challenges to implementing a different model?
- What role would your agency or organization play in implementing a different model, and how would this impact your current operations?

APPENDIX

Source	Research Summary	Take-away
Charlesworth CJ, et al. Use of behavioral health care in Medicaid managed care carve-out versus carve-in arrangements.	Compared differences across BH enrollees using claims data from two different Medicaid entities in the Portland area.	Integration of physical and BH in Medicaid managed care was associated with greater access to outpatient behavioral health services, particularly for individuals with mild or moderate mental health conditions and for black enrollees. • Relative to the carve-out group, individuals in the carve-in group were more likely to access outpatient behavioral health, primary care physicians, psychologists, and social workers and less likely to access psychiatrists and behavioral health specialists. • Access to outpatient behavioral health visits was more likely in the carve-in arrangement among individuals with mild or moderate mental health conditions (compared to individuals with severe mental illness) and among black enrollees (compared to white enrollees).
Frank RG. Behavioral health carve-outs: Do they impede access or prioritize the neediest?	Summarized the Charlesworth, CJ et. al. study and examined differences between care in a carve-out versus carve-in arrangement by examining rates of treatment for behavioral health problems in each type of organizational setting and further examining the composition of service users under the two organizational schemes.	Study found that: 1) the probability of having an outpatient behavioral health visit, among people treated for a mental illness, is greater for the population under carve-in arrangements; 2) the increase stems from greater use of behavioral health services by people with mild to moderate illnesses and people of color; and 3) the types of clinicians seen were less likely to be specialists in behavioral health.
Herman Soper, M. Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators.	Assessed five state models (AZ, FL, KS, NY, TX) that use different approaches to integration. Key factors of success or failure in all states include level of stakeholder involvement in designing and implementing new model to ease transitions; balancing oversight with collaboration from state health plans; and advancing clinical integration between physical and behavioral health with cross-system accountability for patients.	Initial requirements should clearly reflect a state's policy goals, allow plans the space to develop innovative approaches and be very explicit on: • continuity of care • sub-contracting • care coordination and beneficiary protections • Integrated approach at the plan level • clear performance metrics for all partners
McConnell, K, et al. The effects of behavioral health integration in Medicaid managed care on access to mental health and primary care services—Evidence from early adopters	Compared changes in two counties (Clark, Skamania) in Washington State that transitioned to financial integration in 2016 to 10 counties that maintained carve-out models, combined with qualitative analyses of 15 key informant interviews. The transition to financially integrated care had relatively little impact on primary care providers, with few changes for enrollees with mild, moderate, or no mental illness. They noted that it may create some administrative simplification for enrollees.	Financial integration of behavioral and physical health in Medicaid managed care did not appear to drive clinical transformation and was initially disruptive to behavioral health providers with no sustained changes after the first year. Suggested incorporating support for practice transformation or financial incentives to achieve the benefits of coordinated mental and physical health care. Transition to a financially integrated care model led to enrollees with SMI experiencing a slight increase in access to primary care, but no sustained changes in the use of ED or IP services for mental health care.

Source	Research Summary	Take-away
Horvitz-Lennon, M, et al. Is Carve-In Financing of Medicaid Behavioral Health Services Better than Carve-Out.	Meta-analysis of multiple studies of systems moving from carve-out to carve-in. Research shows mixed results - Medicaid BH carve-outs were associated with lower use of psychiatric IP services and lower total costs for enrollees with SMI, BUT this was inconclusive in terms of effects on outpatient BH services and the quality of care. Increased use might not reflect greater access to psychiatrists, might just be capturing primary care providers and nonspecialists.	Implementing an integrated/carve-in model alone is not adequate to achieve financial, organizational, or clinical integration. To be effective, the article identified multiple critical design features: • "requires an incremental, stakeholder-engaged process“ • clear expectations on penalties and rewards, clear expectations for who is responsible for delivering each covered service • succinct incentives and expectations for health plans around payment and risk (ex.: higher capitation payments to health plans, risk-adjustment methods, risk-mitigation tools, consider setting provider rates to ensure proper reimbursement, incentives for improved health plan performance) • clear regulations and administrative processes (ex.: regulation of medical necessity criteria, monitoring of denials to patients and payments to BH providers
Lovett, L. Integrated Managed Care Organizations Fail to Outperform Carve-Outs in Behavioral Health Access.	Summarized McConnell KJ, et al. study and reaffirmed that integrating BH services did not improve access to and utilization of services.	Affirmed that financial integration alone does not boost BH access and quality - states may need to consider additional measures. Carve-ins result in improved administrative efficiencies but do not impact clinical outcomes • “States aiming for clinical integration may need to combine financial integration with investments in workforce recruitment and training and strengthen contracting and data analytics expertise for performance monitoring and oversight”
McConnell KJ, et al. Access, Utilization, and Quality of Behavioral Health Integration in Medicaid Managed Care.	Study to assess the effect of transitioning to IMC in WA using claims-based measures for enrollees in WA's Medicaid MCO. Conducted separate analyses for enrollees with SMI, enrollees with MMI, and enrollees with no mental illness. Also conducted interviews with key stakeholders to gather qualitative data.	Integration results in improved administrative efficiencies but does not impact clinical outcomes. • For individuals with SMI, the number of outpatient behavioral health visits averaged 805.6 visits per 1,000 member months in carve-out programs. After the integrated managed care model, that number fell by 33.9 days. However, that number was not statistically significant • Allow states to layer additional training, incentives, and supports onto a single accountable plan. • Combine financial integration with investments in workforce recruitment and training and strengthen contracting and data analytics expertise for performance monitoring and oversight.
Westfall, J. “Carve In” Mental Health and Substance Use Treatment.	Compared data on overall Medicaid spending vs spending on BH and SUD Medicaid spending.	Concluded that carve-outs function to limit access to services due to provider network inadequacy especially to rural and underserved communities. However, “integration” must mean more than just network management of physical and behavioral health. Effective integration strategies: • pay primary care providers and practices to administer BH treatments • provide PMPM for primary care to provide BH screening, CCM, and other BH interventions • cover non-traditional BH services (e.g.: faith programs, peer networks) • make access to to MH and SUD treatment a no-wrong door process • cover a primary care visit and a counseling visit at the same site on the same day

Source	Research Summary	Take-away
Shmerling AC, Gold SB, Gilchrist EC, Miller BF. Integrating behavioral health and primary care: a qualitative analysis of financial barriers and solutions.	Characterizes financial barriers and solutions for the integration of behavioral health in primary care at the practice and system levels through semi-structured interviews between March-August of 2015 with 77 key informants.	The current system is fragmented with inadequate baseline reimbursement, and it hinders progression toward integrated behavioral health and primary care: • Funding is needed both to support integrated care and to facilitate the transition to a new model • The model must move away from fee-for-service toward a global and value-based payment model • Future policy efforts must focus on ensuring stakeholder collaboration, multi-payer alignment, and increasing investment in behavioral health and primary care
Xiaoling Xiang, et al. Impacts of an Integrated Mediaid Managed Care Program for Adults with Behavioral Health Conditions: The Experience of Illinois	Assessed the impact of the Integrated Care Program (ICP), a new Medicaid managed care model in Illinois, on health service utilization and costs for adults with behavioral health conditions.	After the SMART Act (which impacted to control FFS group), ICP enrollees had increased outpatient and dental services utilization without significantly higher costs. The relative increase in utilization was due primarily to decreased utilization in the restricted FFS group after the SMART Act. By the end of the study period, the ICP group had 13.3 more all-cause primary care visits, 1.5 more emergency department visits, and 1.4 more dental visits per 100 persons per month relative to the FFS program. A fully-capitated, integrated managed care program has the potential to reduce overall Medicaid costs for people with behavioral health conditions without negative effects on service utilization.
Smith, A., et al. The Transition of Behavioral Health Services Into Comprehensive Medicaid Managed Care: A Review of Selected States	Examined various states' (Arizona, Kansas, Louisiana, New York, Ohio, Oregon, Tennessee, Washington) experiences around implementing a carve-in model for behavioral health care, as well as states that maintain a carve-out model to understand perspectives of the current systems. (Maryland and Pennsylvania). Authors conducted interviews with state officials and conducted a review of Medicaid procurement materials and MCO contracts to help determine the intended goals of a BH carve-in.	Financial integration does not automatically produce effective clinical integration. Systemic barriers still exist for behavioral health providers in terms of their participation in managed care – ex. lack of investments in HIT and HIE. Ensure there is expertise around behavioral health populations and their related systems and services amongst MCOs and Medicaid agencies, to prevent inefficient processes when transitioning policy development and oversight responsibilities to these entities.
Ettner SL, Xu H, Azocar F. What Happens When Employers Switch from a "Carve-Out" to a "Carve-In" Model of Managed Behavioral Health? J Ment Health Policy Econ. 2019 Sep 1;22(3):85-94.	Examined how specialty BH care patterns change when employees and dependents are moved from a "carve-out" plan to a "carve-in" plan by linking insurance claims, eligibility, plan and employer data from 2008-14 for three Optum employers who dropped their carve-out contracts but retained their carve-in plans.	Relative to individuals continuously in carve-in plans, those who were transitioned experienced significant increases in inpatient utilization (beta =.02; p=.05) and patient inpatient costs (beta =2.35; p=.01) and decreases in day treatment (beta =-0.01; p=.02). Carve-outs may use day treatment to reduce inpatient care so that increased inpatient utilization post-transition reduced demand for day treatment.