Integration of Behavioral and Physical Health Care for a Medicaid Population Through a Public-Public Partnership

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This article documents a unique organizational, legal, and financial partnership between a state, a university, a Medicaid managed health care plan, and a county to provide integrated mental health, substance abuse, and primary and specialty health care services to Medicaid, low-income, and indigent consumers in Washtenaw county, Michigan. Major regulatory, financial, and clinical changes were required within and among the various partners in the Washtenaw County Integrated Health Care Project. A new entity—the Washtenaw Community Health Organization—was created to implement the project. By sharing resources as well as financial risks, the state, the county, and the university have been able to provide ongoing integrated care to a vulnerable population of patients. Although resource intensive in conceptualization and implementation, the project can be viewed as a model for other states that face growing needy populations and decreasing Medicaid budgets. (*Psychiatric Services* 54:1508–1512, 2003)

Collaborators in the provision of medical care to the most vulnerable populations in our cities and states face institution-specific and systemwide threats to clinical and economic integrity. The acute uncertainties of the economy, of the regulatory environment, and of institutional viability challenge delivery systems to meet the health care needs of their communities with diminishing resources. Advances made in understanding and coordinating mental health, substance abuse, and general medical care face roadblocks due to increased numbers of poor and uninsured persons, Medicaid budget cuts, and unfavorable financial margins. The segmentation of medical, mental health, and substance abuse care that was commonplace in the United States decades ago is becoming the default of local delivery systems throughout the country as a result of a lack of resources with which to collaborate and to implement system-based change.

Most mental health services for Medicaid clients originate in one of two systems: the public, community-based organizations that have staff or contracted providers, and academic medical centers, whose service and teaching missions dictate responsibility for some portion of this population in their markets. The organizational distance between these two systems is apparent in many communities in the lack of coordination of services and funding streams. Complex developmental patterns can breed a separation of cultures, treatment philosophies, and priorities, resulting in segmentation of care and exclusion of critical parties from planning.

Under market models, the privatization of government services and the expansion of managed behavioral health care are viewed as ways of providing services more efficiently and at a lower cost. Offered primarily by investor-owned vendors, carve-outs initially demonstrated striking cost savings for private employer-sponsored health plans, with rapid extrapolation to publicly funded programs, despite arguments for the need to recognize key differences in populations and needs (1).

Of special interest are patients with serious and persistent mental illness who are treated in public programs. These individuals often have comorbid conditions such as diabetes, heart disease, or alcoholism that frequently go undetected yet complicate the care of this population (2,3). As a consequence, such patients tend to drive up the cost of care (4).

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In response to these kinds of problems, Washtenaw County, the state of Michigan, and the University of Michigan Health System (UMHS) created a public-public partnership to integrate all health care services for low-income and indigent consumers. The resultant legal entity and operational framework challenged the legacy of conceptual dichotomies between public health and personal health systems, primary and specialty care, physical and mental health services, and community and academic medicine.

In this article we describe the genesis, design, and implementation of this bold experiment in integrating care across the separate public entities. The resultant organization relied on clinical and economic models implemented in creative ways across major legal, organizational, and financial systems. The organization therefore offers a potential model for other communities faced with complex service delivery structures and growing vulnerable populations.

The value of integration

Writings on the "scholarship of integration" promote the value of making connections across disciplines, placing individual disciplines in a larger context, and teaching nonspecialists about specialties (5). Proponents of this philosophy argue that such an approach would integrate traditionally isolated disciplines, overcome the perception that interdisciplinary work is risky and professionally unrewarding, work to break down the disconnect that exists between the scientific community and the broader public, and erode the presumed authority of academic medicine over the patients' perspective (6–10).

Studies of coordinated patient care come closest to empirical tests of the concept of integration. For persons with chronic illnesses, disabilities, and poverty, the need for better integration of care is widely accepted (11,12). The potential of integration to improve the quality of care and to slow cost increases has been demonstrated in Medicare populations (13,14), in primary care settings (15), and among persons with severe and persistent mental illness (16,17). Integration also has the potential to address issues of underutilization of services, overutilization, and inappropriate utilization (18).

The importance of comanaging patients, educating providers, and improving information processes has been empirically supported, although primarily in isolated segments of the market (19–21). Lacking in the literature are prescriptions for the design and operation of integrated systems: How do multiple, competing stakeholders design a governance structure, create a legal entity, share financial risk, allocate funds, coordinate information, monitor quality, and provide cost-sensitive, high-quality care? How do health policy makers embrace integration as a guiding principle that can be used to push beyond the successes of interdisciplinary cooperation and collaboration?

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The Washtenaw County Integrated Health Care Project

The Washtenaw County Integrated Health Care Project, which began in 2000, is designed to deliver integrated mental health, substance abuse, and primary and specialty health care to Medicaid, low-income, and indigent consumers residing in Washtenaw County in southeastern Michigan, which includes Ann Arbor. The project offers a single point of entry to the behavioral health care system, individual case management services, and coordinated mental health and medical care provided by UMHS and the county.

Almost 8,000 lives are covered by the university's Medicaid managed health care plan in the county. In addition, the County Community Mental Health Agency serves approximately 4,000 clients with mental illness, substance use disorders, and developmental disabilities. The county's indigent program provides physical care services for an additional 1,500 enrollees through UMHS.

The organizational partners share key functional activities, such as planning, information systems, and coordinated clinical and administrative services. They also share financial resources and risk, which necessitated the creation of a new legal entity—the Washtenaw Community Health Organization (WCHO). The creation of WCHO was the culmination of negotiations, hearings, and approvals by the county board of commissioners, the county community mental health board, UMHS, the regents of the University of Michigan, the Michigan Department of Community Health, and Michigan's governor, attorney general, and legislators. The governing board was appointed in January 2000 and was legally authorized in July 2000.

Incentives for alignment

The national movement toward privatization of public services and for-profit managed behavioral care—namely, carve-outs—was viewed by many in Washtenaw County and in the state of Michigan as a blunt instrument for reducing inefficiencies in health care. Counties throughout the state had historically played both a moral and a fiscal role in the provision of services to persons with mental illness or developmental disabilities and to indigent persons. Relin-

quishing control of service delivery and management to a private entity threatened the use of publicly financed facilities and employment of the workers at those facilities. Of paramount importance was creating a line of accountability to elected officials while at the same time maintaining community and consumer voices in governance and decision making. The underlying commitment to publicly funded managed care for these patient populations led to a search for an alternative to the privatization and segmentation of care.

Early initiatives

The state laid the groundwork for the Washtenaw County Health Care Integrated Project approximately ten years ago, when members of the Michigan Medicaid population were required to choose a health maintenance organization for physical care. To counter funding fragmentation, increase flexibility in service arrangements, and enhance accountability, the Michigan Department of Community Health introduced managed care for behavioral health services in June 1996 by issuing a three-year transition plan for managed care in the state.

Goals

Among the initial goals of the project was the provision of high-quality, cost-effective care through a collaborative partnership that would enable the client to obtain coordinated access to the most appropriate services. Underlying this goal were strong beliefs in the importance of holistic health care, the role of the public health care system, and the teaching, research, and service missions of the university.

Persons with serious mental illness who use community mental health services are often hospitalized, a fact that reinforces the need for efficient coordination between inpatient care, primary care, and behavioral health care services. Participants in the project emphasized the role of preventive services in the continuum of care.

Managed care initiative

In October 1998, under authority granted by Public Act 336 of the Public Acts of 1998 (fiscal year 1999 Appropriations Act) and with the approval of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), the Michigan Department of Community Health initiated a specialty managed care program for publicly funded mental health, substance abuse, and developmental disability services. With the implementation of the managed care program, multiple sources of public funding that support vulnerable populations and specialty care services were consolidated under the authority of local county-sponsored entities.

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Under the managed program, community mental health service programs and substance abuse coordinating agencies receive Medicaid capitation payments, along with state allocations, federal grants, and other public funds, and in return are required to provide specialty services to all Medicaid recipients and designated priority populations who reside in the service area and who need such care. The community mental health service programs and coordinating agencies are at risk if the cost of providing such care exceeds the payments that the programs receive from the state for providing them.

Governance

Attorneys for the county and UMHS worked with the state to craft language that would enable legislation for the partnership between the university and the county. These efforts resulted in a successful resolution from the county board of commissioners and the university regents that approved an agreement to create a new legal entity. Subsequently, the Urban Cooperation Act gained approval from the attorney general and the governor.

The agreement states: "The County and the Regents of the University of Michigan and its University of Michigan Health System desire to establish an integrated health care delivery system to provide mental health, substance abuse, and primary and specialty health care to Medicaid, low income, and indigent consumers as defined by the Mental Health Code and Medicaid eligibility guidelines." This partnership between the university and the county required a new form of governance. WCHO was established as a ten-year partnership, governed by a 12-member board of directors, consisting of six members appointed by the county board of commissioners and six appointed by the university regents.

Both the university and the county are required to appoint at least one primary and one secondary consumer to the board. Primary consumers are health care beneficiaries, and secondary consumers are family members of the beneficiaries. With staggered appointments and a nine-vote quorum, the board structure ensures community voice as well as support from the university and the county. The board of directors is responsible for policy making, contract negotiation, budget review, and hiring and dismissal of the director.

Risk sharing

To provide care in the most cost-effective manner, financial incentives are aligned through risk sharing, based on actual service use and financial data from the 1998–1999 fiscal year. A total of $55 million per year has been dedicated to WCHO—$44.5 million from community mental health and substance abuse grants

and $10.8 million from UMHS. WCHO is responsible for providing a risk arrangement to cover losses and established a risk pool of $2.6 million funded through cost savings. Should there be excess funds beyond risk reserves, WCHO must reinvest the savings in services.

Operations

The operations of WCHO are supported by a joint medical director, shared administrative staff, a central information system, a joint substance abuse service, and combined children's and adult services. Critical to the success of the organization is its functional rather than hierarchical structure. The system reinforces the role of the consumer in its service line design. The roles of the county's behavioral health case managers and the university's care managers—or "health navigators"—are combined to capture the advantages of each.

Information technology

WCHO expanded an existing electronic record system at UMHS that uses a secure Web browser to provide access to all clinical and laboratory records. With state funding, this system is also available in the county-based community mental health clinics. This integrated record allows clinicians and other community mental health care providers to communicate with primary care providers and specialists elsewhere in the system. The entire system is protected to ensure confidentiality and security of records.

The state has also funded a data warehouse for administrative, financial, and clinical information. This system enables managers and researchers to track current and longitudinal costs and patterns of physical and mental health care use by several variables, such as diagnosis, procedures, and site of care.

Barriers to integration

Despite the consensus on the importance of integrated care, many barriers arise in its implementation. In Michigan, legal and political barriers have been established to protect public beneficiaries and public funding, some of them linked to federal guidelines on Medicaid services.

Legal and political barriers

The preexisting legal and political framework in the state directly or indirectly reinforced the separation of mental health, substance abuse, and primary care services. The establishment of legal relationships between a county entity and a state-funded university thus invited scrutiny by the attorney general as well as by those responsible for the fiscal health of the participating organizations.

The enactment of the Michigan Mental Health Code in 1974 created the legal framework for the devolution of authority and funding for specialized mental health and developmental disability services from the state to county-sponsored community mental health service programs. Changes to the code were needed to permit successful private bidders on managed care contracts to assume statutory duties reserved exclusively for county-sponsored entities. An amendment was needed to allow Washtenaw County to organize and operate a community health service program jointly with UMHS. Legislation was introduced in February 1999 (Senate Bill 1006) amending the Mental Health Code to allow the new organization to serve as the community mental health board for Washtenaw County, with final enactment ten months later.

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The Department of Community Health renegotiated its waiver from the Centers for Medicare and Medicaid Services to allow community mental health service programs to continue to receive behavioral health funding without competitively bidding for the contracts.

Organizational barriers

Institutions involved in the project were accustomed to being aligned with each other on matters of public good. However, the project required a level of sharing that had previously been unheard of in the community. The clinical and provider records were made available across providers and across enrolled patients. Funding relationships and professional referral patterns were reconfigured. All in all, the integration required a melding of cultures. The university-based environment is one of physician dominance, provider independence, and clinical authority. The public sector had always had consumer representation and public accountability.

The county needed guarantees that public patients would not be viewed as guinea pigs for research. Despite the existence of the university's own institutional research review board, a WCHO review committee was constituted to oversee the recruitment of public clients or use of their data for research projects.

Discussion

Individual states are now engaged in many experiments to bring managed care principles and practices to the public sector. Whether these models can apply to low-income, chronically ill, and disabled populations remains to be seen. Newer models of managed care that use disease management concepts and chronic care management programs also have a place in public-sector approaches. This is especially true for Medicaid: persons with severe mental illness or developmental disabilities constitute a high and growing proportion of Medicaid enrollees and account for an even greater proportion of costs (22). Efforts to coordinate and integrate

physical health care with services for mental and substance use disorders have shown promise in improving quality, especially for persons who have chronic illnesses (23).

This integrated model can meet with powerful barriers in the public sector. The historical separation of physical and behavioral services is embodied in completely different funding streams, governmental structures, and cultures. These new systems, of necessity, will reflect the unique constellation of local and state forces. In Michigan, the Washtenaw Integrated Health Care Project is one such model. Like any local solution, WCHO brought together local partners and resources, but with the advantage of a progressive county public system and a university that is committed to serving the community. Shared resources and shared financial risk were important, but shared values and commitments to the public were critical. The state government was in this case both an advocate and a facilitator, and the project would not have succeeded without the active involvement of its agents.

The creation of this new entity is only the beginning. Future efforts will be guided as they were in the past by rigorous research into the costs and benefits of shared clinical programs, further integration of physical and behavioral services, and characteristics of legal and risk-sharing partnerships. It is our hope that more effective systems of care that improve quality of care for public patients while better managing resources will result. ♦

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