Human Services and Behavioral Health Integration: A Model for Whole-Person Medicaid Managed Care

Amy D. Herschell, Ph.D., James M. Schuster, M.D., M.B.A., Donna J. Keyser, Ph.D., M.B.A., Deborah S. Wasilchak, M.A., Geoffrey B. Neimark, M.D., Sherry L. Shaffer, B.A., Matthew O. Hurford, M.D.

A comprehensive, whole-person approach to individuals' health care can be achieved by aligning, integrating, and coordinating health services with other human services. HealthChoices, Pennsylvania's managed Medicaid program, delegates responsibility for Medicaid-funded behavioral health service management to individual counties or multicounty collaboratives. County administrators' programmatic and fiscal oversight of Medicaid-funded services allows them to create synergies between behavioral health and other human service delivery systems and to set priorities on the basis of local needs. This model supports access to community-based care, integration of general medical and behavioral health services, and programs that address social determinants of health.

Psychiatric Services 2023; 74:996–1001; doi: 10.1176/appi.ps.20220478

Discussions about Medicaid policy have recently focused on how to transition to a next generation of managed care that supports whole-person health. The challenges of the transition extend beyond simply integrating general medical and behavioral health services to include intersection with other systems (e.g., justice, child welfare), reducing health disparities, and attending to social determinants of health (e.g., poverty, housing instability, food insecurity). Faced with increased enrollment; spending growth; and high levels of behavioral, general medical, and social need within the Medicaid population, state policy makers confront a complex situation that likely requires programmatic innovation as well as payment reform (1).

HealthChoices, Pennsylvania's Medicaid managed care program, offers useful insights. Pennsylvania is the fifth most populous state, with approximately 13 million residents across 67 counties. Many of Pennsylvania's citizens live in the state's two largest cities and their counties: Philadelphia in Philadelphia County, population 1.60 million, and Pittsburgh in Allegheny County, population 1.25 million. According to the U.S. Census Bureau, 81.0% of Pennsylvania's citizens are White, 12.2% are Black or African American, 3.9% are Asian, and 8.4% are Hispanic or Latino (2). The median household income in 2020 dollars was $63,627, with 12.1% of the Pennsylvania population living in poverty (2). As of October 2022, more than 3.6 million Pennsylvania citizens were enrolled in Medicaid or the Children's Health Insurance Program (3).

Within the Pennsylvania HealthChoices program, general medical health plans for Medicaid members are known as Physical HealthChoices, behavioral health plans for Medicaid members are known as Behavioral HealthChoices, and Medicaid benefits for Medicare-Medicaid dual-eligible members are known as Community HealthChoices. For Physical HealthChoices and Community HealthChoices, the state contracts directly with managed care organizations (MCOs) to manage Medicaid recipients' medical care, pharmacy benefits, and long-term general medical services and supports. Behavioral HealthChoices, however, operates under a human services integration model that gives individual counties or multicounty collaboratives programmatic and fiscal responsibility for administering Medicaid-funded mental health and drug and alcohol services in addition to other human services (e.g., child welfare, aging services,

HIGHLIGHTS

- Medicaid policies that support whole-person health are critically important; county-level integration of Medicaid behavioral health services with the funding and leadership of other human services can effectively support these policies.
- Pennsylvania's HealthChoices behavioral health program offers a model for integrating human services with behavioral health services; this program expanded access to community behavioral health services, supported general medical and behavioral health service integration, and facilitated concurrent member engagement in programs that address social determinants of health.

housing services) in each county. In this model, a behavioral health MCO contracts with one or more counties or joinder counties (i.e., counties acting collaboratively as a single unit) to support counties' management of behavioral health services and collaborates with local provider networks, community-based human services agencies, and regional general medical health MCOs. Since the introduction of the human services integration–behavioral health MCO model in 1997, Pennsylvania has demonstrated progress in expanding access to high-quality behavioral health care, integrating general medical and behavioral health care delivery, and addressing social determinants of health, all while containing costs (4). These efforts are described next and summarized in Table 1.

EXPANDING ACCESS TO HIGH-QUALITY BEHAVIORAL HEALTH CARE

Because Medicaid is the largest single payer for behavioral health services in the United States, ensuring access to high-quality behavioral health care is a priority. Many Medicaid beneficiaries with behavioral health conditions do not seek help through traditional avenues, even though they will be at risk for worse outcomes, higher overall health care costs, and more restrictive levels of care if their conditions are not addressed early (5). Under the human services integration–behavioral health MCO model, Pennsylvania counties leverage contractual ties linking behavioral health MCOs with other human services to coordinate services across county service networks. This approach allows individuals to enroll for both social and behavioral health benefits across a wide range of sites. Counties that meet contracted clinical and fiscal standards can, if they have excess funding for Medicaid behavioral health services in a specific year, reinvest up to 3% of revenues in developing or expanding local behavioral health services and related social supports. Local reinvestment plans that fill gaps in the existing service system, test new innovative treatment approaches, or develop cost-effective alternatives to traditional services promote continuous quality improvement. Because reinvestment decisions are made locally, these plans can be tailored to meet the needs of individual communities. For example, reinvestment funding has been used to expand or enhance mobile treatment teams, peer-driven recovery support centers, behavioral health nursing home transition and diversion services, school-based team services, and psychiatric rehabilitation.

County-level oversight of behavioral health service delivery enables meaningful local stakeholder engagement in identifying community needs and developing solutions for them. When families in rural Pennsylvania counties raised concerns about the adequacy of the children's behavioral health system in those counties, a multidisciplinary group of county mental health officials, family members, providers, behavioral health MCO leaders, and educators designed and implemented a novel model of services that facilitated close collaboration between schools and providers and allowed the same providers to treat children in both home and community settings. This collaborative effort, endorsed by school personnel, improved child and family functioning and reduced externalizing child behaviors, achieved high care satisfaction ratings, and led to strong therapeutic alliances (6). Achieving these outcomes was possible because of the integration of behavioral health MCO, school district, and county resources and oversight. Similarly, local partnerships among behavioral health, early intervention, and child welfare systems have supported innovations in measurement and clinical approaches (7) to address parental depression and early childhood development. Local partnerships also have supported the widescale implementation, sustainment, and expansion of trauma-informed care networks across 23 rural counties (https://bharpsystemofcare.org/trauma-resources).

Coordinated service delivery at the county level also supports effective development of necessary resources across the state. To address the opioid overdose epidemic, state and county governments, MCOs, and local provider networks launched initiatives to increase access to and continued engagement with evidence-based treatment and community-based care, including warm emergency department handoffs, telehealth prescribing, onsite bridging interventions, and improved substance use screening. For individuals receiving medication-assisted treatment, these efforts led to lower rates of benzodiazepine use and higher rates of concurrent behavioral health service utilization (8).

INTEGRATING GENERAL MEDICAL AND BEHAVIORAL HEALTH SERVICES

Individuals with high behavioral health needs are more likely than others to have high general medical health needs. Co-occurring behavioral and general medical health conditions result in increased functional impairment and health care costs. The human services integration–behavioral health MCO model addresses these challenges at both practice and system levels. State and county agencies, MCOs, local providers, and other stakeholders have collaborated to implement a range of evidence-based integrated care practices, including screenings, engagement strategies, and shared care plans. This model supports provider networks that have partnered to promote integration through real-time information sharing, team-based care coordination, and joint approaches for assessing and rewarding high-quality care.

Numerous integrated care models now exist across the state. For example, general medical health caregivers are available in behavioral health settings; behavioral health clinicians offer services in primary care practices; and multidisciplinary primary care teams consisting of nurse navigators, wellness coaches, certified peer specialists, and certified recovery specialists are deployed. Many of these efforts have demonstrated positive clinical, quality, and cost outcomes. For example, implementation of the behavioral

TABLE 1. Key challenges, strategies, lessons learned, and monitoring metrics for the integration of human services with behavioral health services in Pennsylvania

Key challenges	Strategies	Lessons learned	Monitoring metrics
Expanding access to community behavioral health care	Collaborated with key stakeholders to secure federal or other funds (e.g., HRSA, PCORI, SAMHSA)[a] to supplement state resources; leveraged funding from multiple sources to increase use of medication-assisted treatment for opioid use disorder in community settings; engaged primary care physicians to treat individuals with opioid use disorder, with support from regional centers of excellence; developed value-based payment plans to incentivize use of medication-assisted treatment for opioid use disorder	County participation in prioritizing and supporting community-based behavioral health care is critical to success; ambulatory care is the backbone of a strong behavioral health delivery system, so continuing to strengthen and offer innovative ambulatory care should be prioritized; despite increased access to medication-assisted treatment, the statewide opioid use disorder death rate increased over a recent 24-month period (2019–2021), although this increase has been less than that of other states; the organizational structure and culture of most primary care practices do not support team-based treatment of opioid use disorder; disparities remain in medication-assisted treatment prescribing	Resource targeting (under Behavioral HealthChoices, more resources are spent on ambulatory services than on inpatient and residential services); number of Community Care members receiving medication-assisted treatment (increased 43% from January 1, 2018 [N=22,047], to June 30, 2022 [N=31,569]); total number of Community Care members receiving center-of-excellence services (cumulative N=16,136 from July 1, 2019—when Behavioral HealthChoices began payments for centers of excellence—to September 30, 2022); total number of agencies providing center-of-excellence services (>50 from July 1, 2019, to September 30, 2022)
Integrating general medical health and behavioral health	Integrated general medical health professionals into behavioral health care settings to establish behavioral health homes as part of recovery for individuals with serious mental illness; implemented collaborative care approaches in primary care settings and Federally Qualified Health Centers; provided training and other supports to behavioral health professionals colocated in primary care settings; incentivized integration at multiple levels (individual and system) via a pay-for-performance integrated care program supported by general medical and behavioral health managed care organizations	Behavioral health homes can enhance engagement in treatment and increase utilization of primary and specialty medical care; case managers and peers can serve as effective health navigators with appropriate training and modest nursing resources; a modest investment of resources in nursing support has a significant financial return and clinical impact; effective change requires a continuous quality improvement process and ongoing technical assistance; collaborative care codes are often not sufficient to support care outside Federally Qualified Health Centers; colocation can be successful in larger health systems but remains challenging in smaller systems	Impact of behavioral health homes on engagement in primary and specialty care (significant increases over a 2-year period, from a mean of 7.6 visits to 10.3 visits) (9); effect of behavioral health homes on cost and utilization (15% reduction in total cost and 43% increase in use of outpatient general medical services) (10); effect of behavioral health homes on important health behaviors (positively affected screening and intervention for tobacco use and hypertension, among other conditions) (11)

continued

TABLE 1, *continued*

Key challenges	Strategies	Lessons learned	Monitoring metrics
Addressing social determinants of health	Instituted routine screenings for social determinants of health by behavioral health managed care organization care managers; offered employment and vocational programs to Behavioral HealthChoices members; promoted supportive housing programs through reinvestment from capitated revenues at the county level; supported community-based partnerships to address social determinants of health through contractual requirements and with state funding	Screening for social determinants of health as a care management strategy is critical; housing is key to addressing social determinants of health, and braided payment models are needed to support housing stability; funded clinical housing has been successful but limited because of funding requirements and scarce resources for housing investments	Effect of social determinants of health care management intervention (compared with treatment as usual, the intervention was associated with fewer readmissions to substance use disorder facilities and better follow-up to aftercare) (14)

[a] HRSA, Health Resources and Services Administration; PCORI, Patient-Centered Outcomes Research Institute; SAMHSA, Substance Abuse and Mental Health Services Administration.

health home plus model, which addresses general medical health and wellness as part of recovery for individuals living with serious mental illness (e.g., schizophrenia, bipolar disorder, major depressive disorder), resulted in improved patient activation and engagement in care, increases in primary and specialty medical care visits and outpatient services, and reductions in inpatient treatment utilization and overall cost (9, 10). Behavioral health home plus providers have also improved screening and intervention for tobacco use, hypertension, and diabetes through engaging individuals in wellness coaching (11). Today, this model is offered at 65 behavioral health provider sites across Pennsylvania that serve over 10,000 individuals each year. Many behavioral health home plus model components are also applied in residential and outpatient substance use treatment facilities statewide.

Behavioral health MCOs, general medical health MCOs, and local providers have also undertaken pharmacotherapy initiatives to ensure behavioral health medications are used appropriately in the treatment of both children and adults (12). These initiatives include activities that promote metabolic monitoring for people on antipsychotic medications and improve the medication adherence of people discharged from inpatient psychiatric hospitalization (13).

As a result of these efforts, Pennsylvania ranks in the top quartile of states nationally on quality measures that rely on coordination of general medical and behavioral health, such as diabetes screening and medication adherence for persons with schizophrenia and the limited use of multiple antipsychotics among children and youths with serious emotional and behavioral conditions. Additional assessments substantiate the ability of HealthChoices behavioral health MCOs and general medical health MCOs to work together in the pursuit of positive health outcomes for Medicaid recipients (4, 9).

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have been identified as factors affecting health care access, clinical outcomes, and health care costs and are of increasing interest to Medicaid policy makers. Given the high prevalence and acuity of behavioral health issues in the Medicaid population, states are exploring strategies to address social determinants of health in health care delivery, such as using Medicaid section 1115 waivers to cover certain nonmedical services, requiring MCOs to connect Medicaid recipients with social supports, and adopting value-based payments to support social services interventions.

The human services integration–behavioral health MCO model enables Pennsylvania counties to address gaps in the social safety net for Medicaid recipients. Through contractual ties and by blending county, state, and federal funding streams, county human services agencies can facilitate the integration of traditional and nontraditional services and supports to assist community members in need. County agencies can provide support for a range of basic needs (e.g., supplemental nutrition, utility and cash assistance, supportive housing, education and employment opportunities, transportation) and connect Medicaid enrollees to cross-sector resources (e.g., child welfare agencies, aging services, intellectual and developmental disability supports, early intervention services, veterans' services, legal and justice agencies, school districts). Similarly, one behavioral health MCO, working collaboratively with counties, developed an intervention that directly addressed social determinants of

health when Medicaid enrollees were in a hospital or rehabilitation setting; compared with treatment as usual, the intervention was associated with fewer readmissions to substance use disorder facilities and better follow-up to aftercare (14). In 2021, Pennsylvania enacted contractual managed care requirements and funding to support community-based partnerships, leading to comprehensive planning around individuals' basic and human service needs. Counties also receive money directly from the state to pay for services not covered by Medicaid, such as housing, employment, vocational supports, child care, nutrition, and transportation. County oversight of multiple funding streams allows community leaders to allocate funding in the best interests of their constituents.

Pennsylvania counties have also used reinvestment funds to expand or develop new programs to address social determinants of health for constituents with mental health conditions. One urban county reinvested over $17 million into supportive housing programs for youths transitioning from child welfare, juvenile justice, or mental health housing to independent apartment living. Another initiative expanded permanent supportive housing for adults with serious mental illness at risk for long-term institutional care and offered budgeting, home maintenance, landlord communication, short-term financial aid, and housing choice voucher (Section 8) application assistance services.

CONTAINING COSTS

Pennsylvania's focus on integrating health and human services at the county level has led to an overall shift from more expensive and more restrictive inpatient care to less expensive and less restrictive community-based care, such as mobile treatment and peer support (4). This shift, supported by the stabilization and enhancement of the behavioral health workforce, has produced cost savings by decreasing the total cost of care and inpatient spending (4). Indeed, although the price of services has increased, cost savings have still been realized. For example, over a recent 10-year period (2011–2021), the national Consumer Price Index increased 3.1% annually for health services (15). During that same time, per capita spending for Medicaid-funded behavioral health services decreased 0.7% annually in 41 Pennsylvania counties (Community Care Behavioral Health Organization, 2021, unpublished data). Despite concerns that carve-out models lead to higher administrative costs, the human services integration–behavioral health MCO model has maintained administrative expenses as a percentage of revenue at the same levels incurred by general medical health MCOs (4).

NAVIGATING THE ROAD AHEAD

Pennsylvania's experience offers reason for optimism that effective whole-person care and cost containment can coexist in a Medicaid behavioral health managed care program. In fact, from 2019 through 2022, Mental Health America ranked Pennsylvania among the top eight states for addressing mental health and substance use (https://mhanational.org/issues/2022/ranking-states). This high ranking—based on national survey data measuring communities' mental health needs, access to care, and treatment outcomes—likely occurred in part because of the success of Behavioral HealthChoices. If the integration of human services and behavioral health services is prioritized, then a coordinated approach to service delivery, meaningful stakeholder engagement, and opportunities for local reinvestment can follow, resulting in positive outcomes for states, communities, and Medicaid beneficiaries.

The human services integration–behavioral health MCO model works well in Pennsylvania because the state government delegates many social services interventions to individual counties. This approach supports localized efforts that maximize cultural, demographic, and regional strengths and resources. Although the human services integration–behavioral health MCO model may not be a good fit for other states, related efforts focused on standardizing requirements for high-quality integrated service delivery and outcomes, building connections between behavioral health and human services agencies to enhance access and address social needs, and promoting integrated care approaches may offer opportunities for improvement.

AUTHOR AND ARTICLE INFORMATION

Community Care Behavioral Health Organization (Herschell, Schuster, Wasilchak, Neimark, Shaffer, Hurford) and Center for High-Value Health Care (Keyser), UPMC Insurance Services Division, Pittsburgh. Send correspondence to Dr. Herschell (herschella@upmc.edu). Marvin S. Swartz, M.D., and Steven Starks, M.D., are editors of this column.

The authors gratefully acknowledge the contributions of our state and county partners. They also appreciate the time and effort of Amanda Maise, M.S.P.H., who carefully proofread and edited the manuscript before submission.

These views represent the opinions of the authors and not necessarily those of UPMC Insurance Services Division.

Dr. Neimark owns stock in Pfizer, Plandaí Biotechnology, and Tonix Pharmaceuticals. The other authors report no financial relationships with commercial interests.

Received September 19, 2022; revision received November 21, 2022; accepted December 19, 2022; published online March 20, 2023.

REFERENCES

1. Williams E: Medicaid Enrollment & Spending Growth: FY 2021 and 2022. San Francisco, Kaiser Family Foundation, 2021. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2021-2022. Accessed Jan 12, 2023
2. QuickFacts: Pennsylvania; United States. Washington, DC, US Census Bureau, 2022. https://www.census.gov/quickfacts/fact/table/PA,US/PST045222. Accessed Feb 20, 2023
3. Medicaid & CHIP in Pennsylvania. Baltimore, Centers for Medicare and Medicaid Services. https://www.medicaid.gov/state-overviews/stateprofile.html?state=Pennsylvania. Accessed Feb 20, 2023
4. Highland JP, Clark A, Manderson L: Long-Term Performance of the Pennsylvania Medicaid Behavioral Health Program. Portland, ME, Compass Health Analytics, 2010. http://www.akleg.gov/basis/get_documents.asp?session=29&docid=63755

5. Walker ER, Cummings JR, Hockenberry JM, et al: Insurance status, use of mental health services, and unmet need for mental health care in the United States. Psychiatr Serv 2015; 66:578–584
6. Herschell AD, Schake PL, Hutchison SL, et al: Evaluating the effectiveness of a statewide school-based behavioral health program for rural and urban elementary-aged students. School Ment Health 2021; 13:743–755
7. Herschell AD, Shaffer SL, Wallace NM, et al: Hybrid implementation effectiveness trial: home-based intensive family coaching to improve outcomes for Medicaid-enrolled preschoolers. Evid Based Pract Child Adolesc Ment Health 2021; 6:246–261
8. Schuster JM, Loveland D, Parthasarathy M, et al: Reducing problematic benzodiazepine use among individuals enrolled in methadone treatment programs. J Addict Med 2016; 10:202–207
9. Schuster J, Nikolajski C, Kogan J, et al: A payer-guided approach to widespread diffusion of behavioral health homes in real-world settings. Health Aff 2018; 37:248–256
10. Highland J, Nikolajski C, Kogan J, et al: Impact of behavioral health homes on cost and utilization outcomes. Psychiatr Serv 2020; 71:796–802
11. Brar JS, Maise AA, Schake P, et al: Implementing a learning collaborative for population-based physical and behavioral health integration. Community Ment Health J 2021; 57:1361–1373
12. Edelsohn GA, Karpov I, Parthasarathy M, et al: Trends in antipsychotic prescribing in Medicaid-eligible youth. J Am Acad Child Adolesc Psychiatry 2017; 56:59–66
13. Hutchison SL, Flanagan JV, Karpov I, et al: Care management intervention to decrease psychiatric and substance use disorder readmissions in Medicaid-enrolled adults. J Behav Health Serv Res 2019; 46:533–543
14. Hutchison SL, Herschell AD, Edwards JF, et al: Care management intervention to address determinants of health for individuals with multiple behavioral health readmission. Prof Case Manag 2022; 27: 47–57
15. 12-Month Percentage Change, Consumer Price Index, Selected Categories. Washington, DC, Department of Labor, Bureau of Labor Statistics, 2022. https://www.bls.gov/charts/consumer-price-index/consumer-price-index-by-category-line-chart.htm. Accessed Feb 17, 2022

Call for Policy Article Submissions

Topic: Behavioral Health Workforce Shortages

Psychiatric Services is pleased to call for policy article submissions. Twice per year, the *Psychiatric Services* Policy Advisory Group will select a high-priority policy topic. Submissions should provide a critical analysis of the topic and present a balanced overview of potential policy strategies at the federal, state, tribal, or local levels. Authors should take care to avoid making overtly political or partisan claims. Please see below for additional information about how to submit a manuscript for consideration.

The first high-priority policy topic will be behavioral health workforce shortages. Specific issues to address may include team-based care, telehealth, collaborative and integrated care models, peer roles, insurance acceptance, and scope of practice.

Additional information

- Articles may be submitted as either a Policy Review (4,000–6,000 words) or an Open Forum (1,600 words).
- Authors should follow the format requirements for the article type being submitted as outlined in the journal's author guidelines (ps.psychiatryonline.org/ps_ifora)
- When submitting a manuscript for consideration, authors should mention the solicitation and policy topic in a cover letter as part of the submission.
- All submissions will undergo the journal's standard peer review process.
- Submission deadline: December 30
- Authors are invited to send questions about this call for policy article submissions to psjournal@psych.org.