Integrated Care Resource Center

TECHNICAL ASSISTANCE TOOL

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Selected Provisions from Integrated Care RFPs and Contracts: Behavioral Health

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Behavioral healthwill be a critical issue that states will need to address in their requests for proposals (RFPs) and resulting three-way contracts between the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and health plans. Historically, care for Medicare-Medicaid enrollees (individuals dually-eligible for Medicare and Medicaid) has been financed separately by the Medicare and Medicaid programs through a combination of fee-for-service and managed care models. As a result, care delivery for this population has been largely uncoordinated and has failed to maximize the benefits and financial resources of both programs–often resulting in potentially avoidable high-cost episodes of care.

This lack of coordination has been especially problematic for Medicare-Medicaid enrollees, many of whom have significant behavioral health care needs. While state Medicaid programs generally provide fairly extensive coverage of behavioral health services, those services are often provided in ways that are not well integrated with Medicaid medical services,[1] and access may be limited due to provider shortages. In addition, Medicare coverage of behavioral health services is quite limited, comparably.

IN BRIEF: States pursuing the capitated financial alignment model may need to develop requests for proposals (RFPs) to select health plans to participate in their financial alignment demonstration. They must also develop three-way contracts with the Centers for Medicare & Medicaid Services and participating health plans that will govern the demonstrations. Behavioral health care will be an integral part of these RFPs and contracts.

This technical assistance tool covers a number of key issues in the development of RFP and contract provisions related to behavioral health in five states–Arizona, Massachusetts, Minnesota, Tennessee, and Texas. It highlights variations across states and provides examples of how five states with managed care experience have addressed the following:

By developing new RFPs to integrate Medicare and Medicaid financing and benefits at the health plan level, state Medicaid agencies will have the opportunity to enhance the coordination of behavioral health care services delivered to Medicare-Medicaid enrollees. However, it will be important for the RFPs to articulate clearly the expectations for health plans to ensure that behavioral health care services for Medicare-Medicaid enrollees are truly coordinated across providers and settings of care and include all relevant benefits under both programs.

A number of states have taken significant steps in their current Medicaid managed care contracts to require health plans to improve access to behavioral health care services and coordinate those services with other services individuals are receiving. Arizona, Massachusetts, Minnesota, Tennessee, and Texas offer examples of the types of provisions and language that should be considered for inclusion in newly developed RFPs.

Guide to this Technical Assistance Tool

This technical assistance tool covers a number of key issues in the development of RFPs and contract provisions related to behavioral health (for example, coordination of behavioral health services, inclusion in care plans, training of case managers and providers). The RFPs and contracts in the five states deal with these topics in different ways and at different levels of detail. This tool highlights examples of how the five states dealt with these issues that may be useful models for other states. It draws from both RFPs and contracts, since states often incorporate detailed RFP provisions into their managed care contracts. It is not intended to be a comprehensive inventory. The contract language cited in this document is for illustration purposes only. The intent is to identify issues that should be considered and to provide examples of how selected states with extensive managed care experience have addressed those issues. Each state will want to adapt the language to its own context, programs, and goals. Each section of this tool summarizes key contract requirements, notes where these requirements can be found in the contracts, and includes excerpts of actual contract language. Links to the RFPs or contracts are provided below. States are encouraged to use these contracts for reference and adapt the sample language to their own context.[2]

- **Arizona:** Arizona Long Term Care System (ALTCS) Elderly & Physically Disabled (E/PD) Contract for Contractors, http://www.azahcccs.gov/commercial/Downloads/Solicitations/BiddersLibrary/YH12-0001/General/General_SectionA_F_YH12-0001_1_31_11FINALCLEAN.pdf.
- **Massachusetts:** Massachusetts Senior Care Options Contract for Senior Care Organizations, http://www.chcs.org/usr_doc/2010_contract.pdf.
- **Minnesota:** Minnesota Senior Care Plus Services Contract, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_156513.
- **Tennessee:** Contractor Risk Agreement State of Tennessee, http://www.tn.gov/tenncare/forms/middletnmco.pdf.
- **Texas:** Texas Health and Human Services Contract General Terms and Conditions, http://www.hhsc.state.tx.us/medicaid/STARPLUSExpansionContract.pdf.

Two of the states included in this technical assistance tool – Arizona and Massachusetts – also conducted new health plan procurements in 2012. The RFPs for those procurements can be found at these links:

- **Arizona:** AHCCCS Acute Care/Children's Rehabilitative Services RFP, issued November 1, 2012, awarded March 22, 2013, http://www.azahcccs.gov/commercial/Purchasing/bidderslibrary/YH14-0001.aspx.
- **Massachusetts:** Duals Demonstration Request for Responses from Integrated Care Organizations, issued June 18, 2012, awarded November 2, 2012, http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/120730-duals-demo-rfr.pdf.

CMS Guidance on Behavioral Health in Medicare-Medicaid Demonstrations

CMS has outlined for states and interested health plans the requirements and provisions related to behavioral health that CMS expects will be included in the demonstrations. The current guidance is on the Medicare-Medicaid Coordination Office (MMCO) web site at this link:http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html. See in particular:

- Medicare-Medicaid Financial Alignment Demonstrations—Standards& Conditions (January 2012)
- Capitated Financial Alignment Model Plan Guidance (January 25, 2012)
- Guidance for Organizations Interested in Participating as Medicare-Medicaid Plans in States Seeking to Implement Capitated Financial Alignment Demonstrations in 2014 (January 9, 2013)

There are additional resources on integrating physical and behavioral healthcare on the Integrated Care Resource Center web site at: http://www.integratedcareresourcecenter.net/hhphysicalbehavioral.aspx.

Behavioral Health Provisions in Existing Requests for Proposals/Contracts

While there are significant similarities in these contracts, the five states have adopted varying approaches in the development and delivery of behavioral health care services based on a number of factors including, but not limited to variation in the scope of services covered, the amount of resources available, and historical relationships between state agencies, non-profit support agencies, plans, and providers. In Minnesota and Tennessee, for example, most behavioral health services are included in comprehensive capitated managed care plans, while in Arizona, Massachusetts, and Texas some specialized behavioral health services are provided through separate managed care arrangements. As states consider the behavioral health provisions in these five states, they should take into account relevant differences between the programs they are developing and those in the five states covered in this technical assistance tool. To assist with this, Appendix 1 provides an overview of the major features of the Medicaid managed care programs in the five states.

1. Requirement to Provide Behavioral Health Services

All the state managed care contracts reviewed include a specific list of covered behavioral health services as well as additional guidanceon qualified providers, referral requirements, court-ordered services, and other topics.

Covered Services

- **Arizona:** Requires contracted health plans to provide medically necessary Title XIX (Medicaid) behavioral health care services to all members and requires that behavioral health needs be assessed and services provided in collaboration with the member, the member's family, and all others involved in the member's care, including other agencies or systems. (AZ, Sec. D12)
- **Massachusetts:** Requires contracted health plans to provide a "continuum" of behavioral health care that is coordinated with primary care providers and primary care teams. (MA, Sec. 2.4)
- **Texas:** Requires contracted health plans to provide covered services for the treatment of mental, emotional, or chemical dependency disorders, including all services required by state and federal law and all value-added services negotiated by the parties. (TX, Att. A, Art. 2) The Texas Medicaid program has a 30-day spell-of-illness limit for inpatient behavioral health services, but that limit is waived for adults covered under the STAR+PLUS program. In addition, the contracted health plan is required to provide the services throughout Texas with the exception of Dallas where there is a separate behavioral health managed care program (NorthSTAR) that is currently operated through Value Options. (TX, Sec. 8.1.15) Texas also requires contracted health plans to operate a Behavioral Health Hotline for emergency and crisis care 24 hours a day/seven days a week toll free, ensure that initial outpatient behavioral health visits are provided within 14 days of request, provide access to an outpatient behavioral health service provider in the network within 75 miles of the member's residence, and provide member education services, including self-referral, so members know how to obtain behavioral health services. (TX, Secs. 4.04, 8.1.3, 8.3.1, 8.1.3.2, 8.1.15.2, 8.1.15.3)

Additional Guidance

- **Minnesota:** Requires MCOs to include Medicare assessments, long term care consultation (LTCC) assessments to determine access to HCBS services and home care services. (MN, Sec 6.1.3(1) The state also requires that the LTCC assessment include questions from the Omnibus Budget Reconciliation Act (OBRA) screening Level I. If an enrollee is determined to have a diagnosis of mental illness or developmental disability and requires nursing facility care, the MCOs must refer the enrollee to the local agency for further OBRA Level II screening before admission. (MN, Sec. 6.1.11 (E))[3]
- **Tennessee:** Requires a contracted health plan to establish a behavioral health advisory committee that is accountable to the health plan's governing body to provide input and advice related to behavioral health services. (TN, Sec. 2.24.2)

Sample Contract Language: Requirement to Provide Behavioral Health Services

Arizona (Section D12)

"The Contractor shall provide medically necessary Title XIX (Medicaid) behavioral health services to all members in accordance with AHCCCS policies and 9 A.A.A.C. 28, Article 11."[Contract lists all covered services including, but not limited to, these examples:]

- Behavioral health case management services (with limitations)
- Emergency behavioral health care
- Individual, group and family therapy and counseling
- Opioid agonist treatment
- Psychosocial rehabilitation (living skills training; health promotion; supportive employment services)

"Behavioral health needs shall be assessed and services provided in collaboration with the member, the member's family and all others involved in the member's care, including other agencies or systems. Services shall be accessible and provided by competent individuals who are adequately trained and supervised. The strengths and needs of the member and their family shall determine the types and intensity of services. Services should be provided in a manner that respects the member and family's cultural heritage and appropriately utilizes natural supports in the member's community."

Qualified Providers

- **Minnesota:** Requires that mental health services be provided by qualified mental health professionals and directed at rehabilitation of the member in the least restrictive clinically appropriate setting. (MN, Sec. 6.1.23) Depending on the type of qualified mental health professional, certain licensure and/or educational and training requirements must be met. (MN, Sec. 245.462 subd. 18(1) through (6) for adults and MN, Sec. 245.4871, subd. 27(1) through (6) for children)

Sample Contract Language: Qualified Providers

Texas (Section 8.1.15.1, Attachment B-1)

"The HMO must maintain a Behavioral Health Services Provider Network that includes psychiatrists, psychologists, and other Behavioral Health Service Providers. To ensure accessibility and availability of qualified Providers to all Members in the Service Area, the Provider Network must include Behavioral Health Service Providers with experience serving special populations included in the STAR+PLUS program. Such special populations include children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities."

Referral Requirements

- **Tennessee:** Prohibits a contracted health plan from requiring primary care physician referral to access behavioral health services. (TN, Sec. 2.14.4.4)

Sample Contract Language: Referral Requirements

Texas (Section 8.1.15.2, Attachment B-1)

"The HMO must maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.

The HMO must permit Members to self-refer to any Network Behavioral Health Services Provider without a referral from the Member's PCP. The HMO's policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such self-referral to BH services.

The HMO must permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and must provide the Member with information on accessible Network Providers with relevant experience."

Court-Ordered Services

- **Minnesota, Tennessee, and Texas:** Include specific procedures for the provision of court-ordered behavioral health services. For example, Minnesota requires a contracted health plan to provide all court-ordered mental health services that are also covered services under the contract, provided the services are ordered by a court of competent jurisdiction and based upon a mental health evaluation performed by a licensed psychiatrist or a doctoral-level licensed psychologist. In Texas, plans may not limit services, including behavioral health services required under court order; however, plans may participate in the preparation of a care plan developed by DFPS prior to court submission. (MN, Sec. 6.1.23(X); TN, Sec. 2.7.2.9; TX, Sec. 8.1.15.7))

2. Coordination of Behavioral Health Services

All of the states reviewed include provisions in their contracts specifying that behavioral health services must be coordinated across providers, settings of care, and relevant agencies.

Use of Case Manager

- **Arizona:** Requires that contracted health plans ensure that member behavioral health services are appropriately provided, documented in member records, and tracked by a case manager. (AZ, Sec. D12)
- **Minnesota:** Requires contracted health plans to make available targeted case management services to adults with mental health issues, including optional models for individuals with serious and persistent mental illness. Case management includes development of a specific care plan. (MN, Sec. 6.1.23)

Coordination with Other Providers and Agencies

- **Arizona:** Requires health plans to ensure communication between the case manager, primary care provider, and behavioral health providers and that care is coordinated with other agencies and involved parties. (AZ, Sec. D12)
- **Massachusetts:** Requires coordination with the Department of Mental Health for individuals with serious and persistent mental illness as well as coordination with other support services as appropriate. (MA, Sec. 2.4, Subsec. D)
- **Tennessee:** Requires the provision of mental health case management services that include the member, member's family, legally appointed representatives, primary care physician, care coordinator, and other agency representatives. (TN, Sec. 2.7.2.6; see also Attachment 1) Contracted health plans in Tennessee also are responsible for ensuring and monitoring the continuity and coordination between covered physical health, behavioral health, and long-term care services and ensuring collaboration

between relevant providers. (TN, Sec. 2.9.9) Tennessee specifies how contracted health plans must ensure communication between mental health providers and substance abuse treatment providers as well, and encourages contracted health plans to contract with behavioral health safety net providers. (TN, Secs. 2.9.10, 2.11.7)

- **Texas:** Requires contracted health plans to ensure primary care providers coordinate with behavioral health service providers, and includes additional requirements to ensure that the care of newly enrolled members with a history of treatment for behavioral health services is coordinated. (TX, Secs. 8.1.15.4, 8.1.15.21) Texas also requires contracted health plans to coordinate with the local mental health authority and state psychiatric facility regarding behavioral health services for members committed by a court of law. (TX, Sec. 8.1.15.8)

Sample Contract Language: Coordination with Other Providers and Agencies

Tennessee (Section 2.9.9 and 2.9.10.1)

"As provided in Section 2.6.1 of this Agreement, Contractor shall be responsible for providing a full continuum of physical health, behavioral health, and long-term care services. The Contractor shall also be responsible for ensuring continuity and coordination between covered physical health, behavioral health, and long-term care services and ensuring collaboration between physician health, behavioral health, and long-term care providers."

"The Contractor shall ensure communication and coordination between mental health providers and substance abuse providers..."

3. Required Behavioral Health Staff Positions

Two states require contracted health plans to have specific mental health professionals on their staff.

- **Arizona:** Requires a contracted health plan to have a "Behavioral Health Professional" on staff. This person must devote sufficient time to ensure that member behavioral health care needs are coordinated. (AZ, Sec. D25)

- **Texas:** Requires contracted health plans to have a qualified individual serve as the Medical Director. The Medical Director, or his/her designee, must possess expertise with behavioral health services or have ready access to such expertise to ensure timely and appropriate medical decisions for members during or after hours. (TX, Sec. 4.04)

4. Inclusion of Behavioral Health Services in Care Plan

Some states specifically require contracted health plans to ensure behavioral health issues are addressed in a member's care plan.

Involvement of Behavioral Health Professional

- **Arizona**: Requires contracted health plans to have policies and procedures in place requiring involvement of a behavioral health professional in the development of a care plan. (AZ, Sec. D12)

Involvement of Enrollee

- **Tennessee:** Requires contracted health plans to ensure that all members receiving behavioral health services have individualized treatment plans. Individualized treatment plans must be completed within thirty calendar days of the start of treatment and be updated every six months. (TN, Sec. 2.7.2.1) Furthermore, Tennessee includes very specific requirements related to member involvement in the development and implementation of care plans, including documentation of member involvement. (TN, Sec. 2.18.10)

Sample Contract Language: Involvement of Enrollee

Tennessee (Section 2.18.10)

"[The Contractor shall require that] all behavioral health treatment plans document member involvement. Fulfilling this requirement means that each treatment plan has a member/family member signature or the signature of a legally appointed representative on the treatment plan and upon each subsequent treatment plan review, where appropriate, and a description of how this requirement will be met; The requirement that member education materials include statements regarding the member's, parent's, or legally appointed representative's right to involvement in behavioral health treatment decisions, their ability to choose and change service providers, and a description of how this requirement will be met; The requirement that provider education materials regarding the rights of members, parent(s), or legally appointed representatives to be involved in behavioral health treatment decisions and a description of how this requirements will be met; A description of the quality monitoring activities to be used to measure provider compliance with the requirement for member, parent, or legally appointed representative in behavioral health treatment planning."

5. Training of Case Managers and Primary Care Providers

Several states require contracted health plans to train specific personnel and/or network providers on identifying behavioral health issues.

- **Arizona:** Requires contracted health plans to train case managers and providers to identify and screen for members' behavioral health needs. (AZ, Sec. D12)
- **Tennessee:** Requires contracted health plans to develop provider education and training materials to ensure that physical health and long-term care providers know when and how to refer members who need specialty behavioral health services and vice versa. (TN, Sec. 2.9.9.4)
- **Texas:** Requires contracted health plans to provide training to network primary care providers on how to screen for and identify behavioral health disorders, the health plan's referral process, and clinical coordination requirements. (TX, Sec. 8.1.15.4)

Sample Contract Language: Training of Case Managers and Primary Care Providers

Texas (Section 8.1.15.4, Attachment B-1)

"The HMO must require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.

The HMO must provide training to network PCPs on how to screen for and identify behavioral health disorders, the HMO's referral process for Behavioral Health Services, and clinical coordination requirements for such services. The HMO must include training on coordination and quality of care, such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.

The HMO shall develop and disseminate policies regarding clinical coordination between Behavioral Health Service Providers and PCPs. The HMO must require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement must be specified in all the Provider Manual."

6. Network Availability of Behavioral Health Services

Tennessee and Texas both specify network requirements.

- **Tennessee:** Requires contracted health plans to ensure access to behavioral health providers and includes tables listing services that must be available as well as geographic and time for admission/appointment requirements. (TN, Attachment V)
- **Texas:** Requires contracted health plans to maintain a behavioral health services provider network that includes psychiatrists, psychologists, and other behavioral health service providers. Such providers must have experience serving special populations, including persons with disabilities and the elderly. (TX, Sec. 8.1.15.1)

7. Inclusion of Behavioral Health Requirements in Quality Improvement/ Monitoring Programs

Several states include behavioral health services in their quality improvement programs as well as financial incentive programs.

- **Arizona:** Requires that contracted health plans' quality improvement programs include monitoring of a primary care provider's referral to, coordination of care with, and transfer of care to behavioral health providers. (AZ, Sec. D12)
- **Minnesota:** Sets forth specific quality standards, including assuring adequate access and providing face-to-face contact once per month. (MN, Sec. 6.1.23)
- **Tennessee:** Includes the behavioral health HEDIS measures in its quality improvement incentive payment program. (TN, Sec. 3.10.3)
- **Texas:** Requires contracted health plans to integrate behavioral health into their Quality Assessment and Performance Improvement (QAPI) program, including a process for monitoring, evaluating, and improving the quality and appropriateness of behavioral health services. (TX, Sec. 8.1.7.5) Texas also requires inclusion of review of behavioral health services in utilization management. (TX, Sec. 8.1.8)

Sample Contract Language: Inclusion of Behavioral Health Requirements in Quality Improvement/Monitoring Programs

Texas (Section 8.1.7.5, Attachment B-1)

"The HMO must integrate behavioral health into its QAPI Program and include a systematic and on-going process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members. The HMO must collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care."

Appendix 1: Major Features of Programs for Medicare-Medicaid Enrollees in Selected States

State	Program Name and Start Date	Population Covered	Total Number of Full Benefit Medicare-Medicaid Enrollees in the State (2009)[a]	Number of Medicare-Medicaid Enrollees in Integrated Plans/ Programs[b]	Number and Name of Plans[c]	Benefits Covered	Geography	Medicaid Enrollment
Arizona	Arizona Health Care Cost Containment System (AHCCCS) (1982)	All Medicaid beneficiaries, including duals	126,826	32,816 (1/2012)	8: APIPA, Bridegeway, CareFirst, Health Choice, Maricopa Health Plan, Mercy Care, Phoenix Health Plan, University Family Care	Acute care	Statewide	Mandatory
	Arizona Long-Term Care System (ALTCS) (1989)	All Medicaid beneficiaries needing nursing home level of care, including duals		6,466 (1/2012)	3: Mercy Care, Bridgeway, Evercare Select	Acute and LTSS	Statewide	Mandatory
Massachusetts	Senior Care Options (SCO) (2004)	Duals and Medicaid-only beneficiaries age 65+	253,025	24,175 (4/2013)	5: Commonwealth Care Alliance, Evercare, NaviCare, Senior Whole Health, Tufts Health Plan	Acute and LTSS	Statewide	Voluntary
	PACE	Age 55+ and needing nursing home level of care		2,562 (7/2011)	6: Elder Service Plan (4 plans), Summit Elder Care, Uphams Elder Service Plan	Acute and LTSS	Boston area	Voluntary
Minnesota	Minnesota Senior Health Options (MSHO) (1997)	All Medicaid beneficiaries age 65+, including duals	141,141	35,573 (3/2013) Includes non-duals	8: Blue Plus, Health Partners, Itasca Medical Care, Medica, Metropolitan Health Plan, Prime West, South Country Health Alliance, UCare	Acute and LTSS	Statewide	Voluntary
	Minnesota Senior Care Plus (MSC+) (2005)	Medicaid beneficiaries age 65+, including duals; duals get Medicare through FFS		12,917 (3/2013) Includes non-duals	8 (same as MSHO)	Acute and LTSS	Statewide	Mandatory (alternative to MSHO)
	Special Needs Basic Care (SNBC) (2008)	All Medicaid beneficiaries age 18-64 with physical disabilities, including duals		37,634 (3/2013) Includes non-duals	5: South Country Health Alliance, Medica, Metropolitan Health Plan, PrimeWest Health, UCare	Acute and most (but not all) LTSS	Statewide	Voluntary
Tennessee	TennCare CHOICES (2010)	Age 65+ or 21+, in nursing facility, needing nursing home level of care, or at risk of institutionalization	191,279	None	3: United Healthcare Community Plan,BlueCare, Amerigroup	Medicaid acute and LTSS	Statewide	Mandatory

State	Program Name and Start Date	Population Covered	Total Number of Full Benefit Medicare-Medicaid Enrollees in the State (2009)[a]	Number of Medicare-Medicaid Enrollees in Integrated Plans/ Programs[b]	Number and Name of Plans[c]	Benefits Covered	Geography	Medicaid Enrollment
	PACE	Age 55+ and needing nursing home level of care		317 (7/2010)	1: Alexian Brothers	Acute and LTSS	Selected counties	Voluntary
Texas	STAR+PLUS (1998)	SSI/disabled Medicaid beneficiaries not in nursing facilities, including full duals	394,205	43,000 (2010)	5: Amerigroup, Molina, Superior Health Plan, HealthSpring, United Healthcare Community Plan	Medicaid acute and LTSS; Medicare services provided separately	Selected counties	Mandatory
	PACE	Age 55+ and needing nursing home level of care		984 (7/2011)	3: Bienvivir Senior Health Service, Jan Werner Adult Day Care Center, La Paloma	Acute and LTSS	Selected counties	Voluntary

NOTE: Appendix 1 prepared by J. Libersky and J. Verdier, Mathematica Policy Research. Main source: J. Verdier, J. Libersky, and J.Gillooly. "Integrating Care for Dual Eligibles in New York: Issues and Options." New York, NY: NYS Health Foundation, February 2012.

a. Number of Full Benefit Dual Eligibles, as confirmed by the Medicare Enrollment Database from Medicaid Analytic eXtract (MAX) 2009 Validation reports.
b. Number of duals enrolled in PACE programs is from CMS Managed Care Program Summary Report, July 1,2011. Numbers enrolled in other integrated plans/programs are from Mathematica analysis of May 2012 state Financial Alignment Demonstration proposals, state web sites, and CMS SNP Comprehensive Reports.
c. Mathematica analysis of contracted plans. Number of plans is current as of May 2013.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees and other high-need, high-cost Medicaid beneficiaries. The state technical assistance activities provided within the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit **www.integratedcareresourcecenter.com.**

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Endnotes

[1] Allison Hamblin, James Verdier, and Melanie Au. "State Options for Integrating Physical and Behavioral Health Care." Integrated Care Resource Center, October 2011.
[2] Additional documents that may be useful to reference are (1) the Arizona Marketing Outreach and Incentives Policy at http://www.azahcccs.gov/shared/Downloads/ACOM/ACOM.pdf and (2) the Texas Uniform Managed Care Manual (UMCM) at http://www.hhsc.state.tx.us/medicaid/umcm.
[3] States may want to include language suggesting that plans coordinate with the Preadmission Screening and Resident Review (PASRR), which is a federal requirement that all nursing facility applicants be evaluated for mental illness and development disability and then offered the most appropriate setting for their needs. PASRR requires a Level I screen and a more in-depth Level II screen. More information is available at http://www.pasrrassist.org/resources/introduction-pasrr.