Michigan Association of Community Mental Health Boards

Medicaid funding consolidation:
Key themes identified in an examination of the experience of other states

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Below is a summary of the themes identified via interviews with stakeholders in, and a review of industry literature of, states across the country that consolidated, in a variety of forms, Medicaid funding for physical and some segment of mental health services. MACMHB drew much of this summary from the paper completed, in February 2016, by TBD Solutions, "Beyond Appearances: Behavioral Health Financing Models and the Point of Care" and from interviews with key stakeholders in the states which were studied. This paper will be posted on the MACMHB website (www.macmhb.org) and the TBD website (www.tbdsolitions.com) in March 2016. The TBD paper contains the full set of references and footnotes associated with this research effort.

States included in analysis

Nineteen (19) states were studied in this analysis. Those state included: Arizona, California, Colorado, Georgia, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Pennsylvania, South Carolina, Tennessee, Texas, and Washington.

Key themes identified in an examination of the experience of other states

Providers and consumers report concerns over poorly planned and executed funding consolidation efforts: Interviews with persons impacted by the funding consolidation efforts of a number of states, that did not use a deliberate stakeholder informed process, indicate dissatisfaction with the result of such consolidation. Samples from these interviews are provided in **Appendix A of this document**.

Consolidated financing does not lead to improvements; improvements result from changes at the point at which patient/consumer care is provided: Consolidating financing did not result in cost savings, improved quality of care, nor improved health outcomes for those served. What did make progress on all three of these components of the triple aim was work done at the point at which the patient/consumer receives care – integrating and coordinating care, working with high utilizers, reaching the unserved or under-served.

Shared savings/incentive programs focused on care foster integrated care are effective: Consolidating financing is not the same as integrating care. In order to ensure that improvements at the point of care flourish, savings need to be shared equitably at the service provider level. Implementing financing models that share savings and risk with service providers must thoughtfully tackle considerations related to the inclusion of high-cost patients in shared savings calculations.[i] If the purpose of integrated financing is to unite physical health, behavioral health and social services to effectively serve a complex population, then assurances need to be made which will keep dollars directed to the point of care.

Collaborative Open-Source Approach fosters rapid performance improvement: One of the frequently cited strengths of the private sector MCO model is its competitive nature. This can lead to incentives for performance, but also to a proprietary interest in information that might otherwise be used for the greater good of a population. Public care managers (PIHPs, at-risk networks of providers, and similar models) on the other hand, serve whole communities and are not in direct competition with one another for funds. This lack of competition provides an opportunity for open sharing of knowledge.

Service and administrative cost control and reductions not achieved: While interest groups may make broad statements regarding the cost savings of one financing model or another, there is not broad support for any one model in the existing research literature. A comprehensive review analyzing the cost effectiveness of the range of financing models shows inconclusive results.

Another common promise of groups promoting one model or another is that their model will achieve greater efficiencies through administrative simplification. A closer look indicates that such oversimplification of the structural impacts is not warranted by the available data.

Not all administrative costs contribute equally to patient outcomes. Quality improvement, for instance, which is often deployed from an administrative department, has a direct value for the care people receive. This is implicitly acknowledged by the formula for calculating Medical Loss Ratio (MLR), which includes spending on quality improvement activities alongside provision of services.

Other types of administrative costs are less directly related to patient outcomes. According to a report by McKinsey Global Institute, "sales and marketing alone account for one-third of total health administration expenses," a cost incurred by necessity in a private, for-profit industry. This observation is related to their additional finding that "a privately administered insurance is intrinsically more expensive."

Social determinants require that integration of care must go beyond behavioral and primary care: Given that the social determinants of health make up half of the factors that determine a person's health status, service integration and coordination needs to integrate behavioral healthcare and intellectual/developmental disabilities services with primary care and housing, employment, transportation, education, judiciary and corrections-related services, nutrition and food assistance, family support, and a range of other human services – far beyond what has been the traditional focus of the physical health care system.

The impact on total costs to a community – beyond those related to the bottom line of the healthcare payer - need to be measured: In evaluating integrated or coordinated care models, the full cost of services must be examined. When cost savings to the healthcare payer/manager are the result of inappropriate limitations on access to services or the intensity of services provided, costs increase in other domains, outside of the bottom line of the healthcare payer/manager. These domains are costs incurred by schools, law enforcement, courts, homeless and housing services providers when mental health care is limited in access or intensity.

Stakeholder engagement and deliberate approach are essential: States that implemented successful integration efforts actively engaged a wide range of stakeholders, over a prolonged period, and applied a deliberate planning, implementation, and on-going monitoring approach.

Michigan's nation leading model in light of the wide range of consolidated funding models used nationwide: At least eight distinct financing structures have been employed by states across the country, each influenced by their state's unique Medicaid service delivery and financing system.

Michigan's approach should reflect the fact that Michigan is where most states are trying to move:

- using a **risk-based managed care approach** for behavioral health and intellectual/developmental disability services

- **integrating, into a single system, the Medicaid benefits system of all four major mental health populations**: adults with mental illness; children/adolescents with emotional disturbance; adults, children, adolescents with intellectual/developmental disabilities; adults, children, adolescents with substance use disorders

- managing the **broadest array of proven practices** that include **traditional and non-traditional services** to address an array of **social determinants**

Appendix A:
Below are excerpts and summaries of interviews with stakeholders in states that did not use a deliberate and stakeholder informed process when they consolidated Medicaid financing.

Minnesota: "The carve-in isn't a model that rewards best practices- it's basically the old FFS model. It puts you on this treadmill, where if you don't want to go broke, you have to have productivity expectations, have case managers see so many clients per day, rather than be able to go and focus more on wellness and outcomes. It rewards units of service."

California: While people will talk about funding consolidation in California, the state actually added a previously non existing benefit called "mild/moderate" mental illness which means a diagnosed condition with no significant functional impairment to the benefit managed by the private Medicaid HMOs (Note: This form of consolidation has been the Michigan Medicaid financing model since 1998)

Texas: The Texas Behavioral Health Integration Advisory Committee's (BHIAC) July 2015 report identified a number of challenges that enrollees and providers face in the managed care setting. Highlights include:

- Providers often encounter administrative burdens when navigating multi-payor delivery systems. In Texas, HHSC administers managed care programs through 19 different MCOs – many of which have different credentialing, contracting, and claims processes.

- Many of the private managed care organizations (MCO) subcontract with behavioral health organizations (BHO), which often have different credentialing, contracting, and claims payment processes.

- Private Managed Care Organizations and private Behavioral Health Organizations have been slow to adopt alternative payment methodologies that promote value over volume and integration over duplication. MCOs and BHOs generally pay for mental health services such as counseling, physician visits, mental health TCM, and mental health rehabilitation through the traditional, fee-for-service model. Under this payment approach, many services provided in an integrated setting are not reimbursed, such as provider-to-provider communication, phone conversations with members, services provided my multiple provider in the same group on the same day, and member navigation and coordination.

- Texas has a shortage of behavioral health providers willing to accept managed care payment rates, creating access to care challenges.

Colorado: "With the carve-out model, we were able to do an amazing job with reducing hospitalizations, saving the state money, and pumping the money back into services for consumers."

"Carving in behavioral health may or may not have any impact on our communities' attempts to integrate at a clinical level. Sometimes carving in and carving out do the same thing. If you want true and robust integration, the policies and payment arrangements for the mental health benefit must be seen and measured on the ground in the practice."

South Carolina: Only substance use disorder (SUD) providers (considered the 301 system in SC) are paid via the private Medicaid MCO system. The vocal concerns of stakeholders ensured that services to persons with mental health (not substance use disorder) needs were retained in a focused specialized system.

Since the consolidation of SUD, the prior authorization system used by the MCOs has made access to residential services difficult – given the cumbersome and time consuming nature of this process and the high service denial rate.

While the former payment system recognized and supported the use of a number of Evidence Based Practices, the MCO staff are not familiar with these practices nor their benefit to the client.

Pennsylvania: "Integration doesn't have to happen at the payment level; that's irrelevant. What's important is what you're requiring at the local level"

"Lots of money was coming off the top at the MCO level (for-profits), then profit administration at the next level. By the time the money got to a provider, there was even less left over."

Tennessee: "Integrating financing at the MCO is not a magic bullet to get providers to integrate"

Massachusetts: Stakeholders from Massachusetts, a private PHP model state, report that many community mental health providers are closing their outpatient practices because of inadequate reimbursement rates and insufficient business, cutting off one branch of services to save the provider as a whole. This survival strategy has resulted in a shortage of outpatient providers.

Furthermore, payment restrictions have not evolved at the pace of innovative service delivery. Antiquated models can interfere with newer care models that result in improved outcomes. For example, in many states, two types of services cannot be billed in the same day

New Jersey: Similar to Massachusetts, stakeholders report that many local mental health providers closed their outpatient practices because of inadequate reimbursement rates and insufficient business, cutting off access to a modality of services in order to keep the rest of the providers' operations intact.

Arizona: Some states report difficulty in finding provider partners for care integration efforts. The challenge often arises when there are a separate set of incentives at the care level, regardless of financing model. For instance, primary care providers prioritizing their own quality and outcome measures may resist integration when they perceive that a specialty population has a detrimental effect on their incentives. In Arizona, some integration efforts have had a negative impact on patients, as primary care providers discharged some individuals from their practices after discovering they had a serious mental illness. These primary care providers expressed concern that these patients would negatively impact their outcome-based incentives.