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Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

Impact of the Movement to Private Managed Care System for Publicly Sponsored Mental Health Care: Perspectives from Other States

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Background

Michigan's public mental health system is, once again, being threatened. Senate Bills 597 and 598, if passed, would drastically impact Michigan's Community Mental Health (CMH) system, the public Medicaid health plans (in federal terms, Prepaid Inpatient Health Plans (PIHP)], and the system's network of providers – a system that Michiganders have relied upon for years for high quality mental health care.

Abstract

Highlighted here is a sample of just some of the states – Arizona, Arkansas, California, Iowa, and Ohio – that have moved their publicly sponsored and funded (primarily Medicaid) mental health system to the private sector. Some of the themes that have presented themselves include payment delays, inaccurate payment rates, and inexplicable rejections of claims sometimes resulting in closures of providers. Also noted is the lack of expertise regarding behavioral health care on the part of private insurance companies, and the recognition that their definition of medically necessary services is vastly different from that of public behavioral health, both in direct client care and regarding services related to social determinants of health such as housing, employment, transportation, and education; and some states have cited loss of community partnerships. There have also been accusations of fraud by managed care plans.

As a result of these changes, persons served across the states discussed below have experienced reduced access to quality care due to challenges finding available providers and premature termination or reduction in services, with disparities exacerbated for BIPOC and LGBTQ+ communities due to lack of linguistically and and culturally concordant providers.

Arizona

Prior to October 2018, behavioral health care was handled by a single Regional Behavioral Health Authority for each region. In October 2018, physical and behavioral health coverage was transitioned to an integrated care structure for people enrolled in the Arizona Health Care Cost Containment (AHCCCS), the state's Medicaid program for low-income and disabled people, which brought new insurance plans into behavioral health.

A January 2019 article on Tuscon.com explains that due to this change, new contracts and reimbursement rates had to be negotiated between provider agencies and insurance companies, causing delays in claims processing, inexplicable rejections of claims, inaccurate payment rates loaded into online claims systems, and poor communication from insurance companies. This led to confusion and financial strain from local providers.

Dan Ranieri, CEO of La Frontera, a large behavioral health agency, said that they were owed more than $4.6 million in unpaid claims and services provided since the October transition. Ranieri stated, "Everybody's kind of holding on. It's kind of like living off of your retirement funds and when they're gone, they're gone. If you're a small provider with no cash, this has been really disasterous." Emily Jenkins, president and CEO of the Arizona Council of Human Services Providers, echoed this claim, noting the niche services small providers often provide and that these providers are impacted the most by payment delays. Further, Jenkins stated, "If we start losing providers, then we get into issues around access to care, issues around having an adequate network. Unfortunately, some of the smaller providers are more specialty providers, and they're often people we really need to have in the network."

Clarke Romans, executive director of the National Alliance on Mental Illness Southern Arizona, explained that the organization has heard about patients struggling to get their medications, being discharged prematurely from crisis facilities and hospitals, and getting less individualized care. He argues that the insertion of for-profit insurers into the public behavioral health care system is resulting in these problems, stating "These are the outcomes of this kind of business model of simply squeezing the providers so that a better profit margin can be maintained."[1]

Arkansas

Arkansas has four Provider-led Arkansas Shared Savings Entities, or (PASSEs): managed care organiations that contract with the Arkansas Department of Human Services to pay for and coordinate care for high-need, high-cost Medicaid beneficiaries with intellectual or developmental disabilities, behavioral health disorders or both. While PASSEs must be majority owned by health care providers, their role is similar to insurance companies, and each PASSE receives a fixed monthly amount per member from the DHS, and the PASSE then pays for care for its members.[2]

A December 2021 article in the Arkansas Democrat-Gazette explains that Empower Healthcare Solutions LLC, the state's largest managed care provider for Arkansans with disabilities, is under investigation for Medicaid fraud due to alleged fraudulent payments made by Empower to certain providers and vendors resulting in unnecessary costs to the Medicaid program. The Medicaid Fraud Control Unit found that "no provider audits were done for six months in 2019 at the direction of Empower," and that "certain providers were protected from the normal audit process." Additionally, the agency "determined credible evidence exists that $3.7 million Medicaid dollars were illegally retained and improperly reported as payment for Medicaid services in 2020,"and found a misappropriation of funds in Community Investment programs.[3]

[1] https://tucson.com/news/local/tucson-mental-health-providers-owed-millions-in-unpaid-claims-after/article_87a91de8-258e-5275-ad05-734311af8cbf.html

[2] https://insurancenewsnet.com/oarticle/arkansas-investigates-managed-care-company-in-medicaid-fraud

[3] https://www.arkansasonline.com/news/2021/dec/03/arkansas-largest-disbility-care-firm-under/

California

California has 58 county-run mental health plans which provid mental health services to adults with serious mental illness enrolled in Medi-Cal, and individuals must meet certain criteria to qualify for these services. Prior to 2014, those who did not qualify for county specialty mental health services had to receive outpatient services through primary care physicians or Medi-Cal fee-for-service providers. In 2014, services were expanded for Medi-Cal members who experience mild-to-moderate mental health conditions, and managed care plans (MCPs) became responsible for providing these services, resulting in Medi-Cal mental health car being delivered through two separate systems.

Because "access to non-specialty mental health services is critical for the approximately one in five Medi-Cal members who may encounter mental health symptoms in any given year," most of whom experience milt-to-moderate symptoms, the California Pan-Ethnic Health Network published a report focusing on "examining the extent to which Medi-Cal members can access non-specialty mental health services through MCPs," while highlighting disparities in access experienced by BIPOC and LGBTQ+ communities. Data in this report shows that "most BIPOC communities have low access rates for non-specialty mental health services," and access in LGBTQ+ communities "is so low that publicly available data shows no stratification by Sexual Orientation and Gender Identity (SOGI)." Through interviews with primary care physicians, noted several themes, including "poor awareness of the non-specialty mental health benefit among PCPs and members," "challenges finding available mental health providers," "challenges finding language concordant mental health providers and ensuring quality language," and "finding mental health providers with cultural concordance."

CPEHN also discovered that both Medi-Cal Members and PCPs found navigating the Medi-Cal managed care website to be confusing. Upon conducting a test to evaluate the degree of accessibility of these websites, important findings included "long and difficult searches requiring multiple clicks," "confusion over the appropriate 'product' to choose," and "limited language access on the MCP sites and in the mental health provider listings."[4]

Michelle Cabrera, Executive Director of County Behavioral Health Directors Association of California, discussed the importance of expertise in behavioral health care, something the state does not have, and the ways in which the public health field as a whole doesn't prioritize behavioral health as much as it should. Additionally, Cabrera expressed that because health plans don't have expertise in behavioral health care, the result is holes in coverage for patients experiencing mild to moderate mental illness and a lack of recognition for the functions necessary to improving public mental health which fall outside of insurance. Reduction of staff with expertise in behavioral health care leaves the state unable to examine the strength of the public system due to lack of advocacy. With pressure from managed care plans, this allows the state to lean on privatization, resulting in managed care plans that are unsupervised in clinical, financial, and policy aspects. These health plans also fail to consider the social determinants which impact mental health.

Cabrera also noted the significant partnerships between public behavioral health care agencies and law enforcement, social services, hospitals, etc. which become negatively impacted with a move to a private market.

[4] https://cpehn.org/assets/uploads/2021/09/Medi-Cal-Managed-Care-Plan-Mental-Health-Services_September-2021-1.pdf

Iowa

In November 2015, Iowa handed over management of its $5 billion Medicaid program to private insurers.

The state started out with three insurers, however in July of 2019 UnitedHealthcare backed out due to lack of profit. Because there are only two private insurers, providers have found it difficult to hold them accountable. Providers have experienced accreditation delays in addition to staffing shortages.

Knowledgeable observers within the Iowa system explained that while the public behavioral health care system has a history of outcome measures, the private system has not yet developed that, leading to a lack of qualitative and quanitive outcome measures. Further, the definition of medically necessary services differs greatly between the public and private structures, with little consideration for social determinants such as housing, employment, transportation, and education on the private side. Particularly notable is the impact on quality care for patients. Due to lack of expertise regarding behavioral health, there is often premature termination of services or a reduction in services for patients experiencing mental illness once an improvement is noticed.

Additionally, limited coverage by private insurers leads to public tax dollars underwriting private profits and picking up the costs of unmanaged care. For example, Medicaid only pays for a patient's stay in a mental health institution or residential care facility up to a certain number of days, after which the cost becomes the responsibility of the county, so there is an absence of incentive to provide long-term services. This limited coverage in in congruence with an absence of understanding for how social determinants impact mental health recovery outcomes results in greater costs to taxpayers.

In an article in The Gazette, disability advocate Jenn Wolff stated, "Iowans were made more vulnerable by privatization," and insisted that reducing services for disabled Iowans will not improve their health and will raise costs for managed-care organizations. Additionally, "People are getting sick, they are having more physical symptoms and more mental health issues because of their level of stress."[5]

In an article in Iowa Starting Line from October 2020, disability advocate Eric Donat stated, "People aren't getting services in a timely basis. Providers, when they provide services, are not getting fully paid or they're not getting paid at all and they're pulling out of programs. And that's why people with disabilities aren't getting their services."[6]

In July 2020, Auditor of State Rob Sand released a report on a survey of healthcare providers about the ways in which Medicaid is administered. The following are some of the key findings:

- 51.5% of respondants felt privatization had been harmful to quality of care; 6.1% felt it had been beneficial.
- 54.0% of respondants felt privatization had been harmful to access to care; 9.9% felt it had been beneficial.
- 41.1% of respondants are dissatisfied or extremely dissatisfied with MCOs impact on providers ability to provide services to Medicaid patients; 26.5% of respondents are satisfied or extremely satisfied.

[5] https://www.thegazette.com/health-care-medicine/five-years-of-managed-care-in-iowa-state-says-medicaid-has-stablized-but-patients-disagree/

[6] https://iowastartingline.com/2020/10/29/iowa-disability-advocates-want-their-voices-heard-this-election-and-beyond/

- When presented with 3 positive impacts privatization may have had on their business, over 2/3rds of respondents instead chose "other" and then stated no positive impacts or stated a negative impact.
- Within the substantial majority of providers that believe policies, procedures, and guidelines have become more strict under MCOs, they believe by a 5-to-1 margin that the restrictions are inappropriate. Just 2% of all respondents believed new restrictions were appropriate.[7]

Ohio

In January of 2018, the Kasich administration expanded the way behavioral health services could be coded, adding more than 100 new codes to the system. In July of 2018, Ohio transitioned from a fee-for-service model to a system in which providers submit claims to insurance plans.

An October 2018 article on Cleveland.com discusses a handful of behavioral health facilities that have had to close their doors due to changes in treatment for Medicaid patients, and points to processing and reimbursement delays putting financial strain on providers.

One of these facilities, Northeast Ohio Behavioral Health Center, was waiting on nearly $40,000 in Medicaid claims to be paid by managed care plans when it was forced to close and lay off 30 employees. Dr. Robin Tener, a clinical psychologist and the executive director of Northeast Ohio Behavioral Center, stated, "I didn't want to dump 400 clients into our mental health system; I wanted to continue to see them. It wasn't enough."

Additionally, two other Canton facilities said that the changes to behavioral health contributed to closing or sale, and according to Lori Criss, CEO of The Ohio Council of Behavioral Health and Family Services Providers, centers around the state are laying off employees and cutting services.[8]

In a January 2020 article on Cleveland.com, the following complications with the state's information technology system were noted:

- The system allows duplicate member identifications, potentially resulting in paying a managed care plan more than once for the same person.
- The system isn't tracking whether it is properly submitting all required IRS forms.
- Errors caused hundreds of privacy lapses in which Medicaid enrolees received mail for other enrollees, and enrollees have ben able to access the portals of other members.
- The system auto-populates new browser windows when a case worker does not close a prior case file, which can result in the wrong data uploaded into a case file.
- County workers report that the Ohio Benefits system is causing some individuals' applications for benefits to disappear.
- The system allows multiple ways of inputting data, which can cause problems when assessing and aggregating data.

John Corlett, a former Ohio Medicaid director and president of the Center for Community Solutions, a health care think tank, stated, "It just doesn't sound like the system is working. They say they're faced with 1,100 system defects, and because of those defects, they say they have to do 1,765 workarounds. That means the case worker has to do a manual process when they encounter a defect. That creates a lot of

[7] https://www.auditor.iowa.gov/reports/file/62327/embed

[8] https://www.cleveland.com/metro/2018/10/ohio-mental-health-care-centers-making-tough-decisions-on-changes-to-medicaid-payments.html

extra work for county case workers. This is probably part of the challenge with why we've seen so many people drop off the system."[9]

[9] https://www.cleveland.com/open/2020/01/state-reveals-12-billion-ohio-benefits-system-riddled-with-defects-a-year-out-from-medicaid-work-requirements.html