Organizing and Financing Mental Health Services in Medicaid

Models of Service Delivery and Financing

South Carolina Medicaid Managed Care Conference

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DMA Health Strategies
Topics Covered

► Medicaid Behavioral Health Financing Options
► State MHA and Medicaid Options
► Design a plan!
► Other state agency spending
► Goals of financing models
► Conclusions
Federal policy requires single state authorities for State Plans and Block Grants but federal agencies have permitted, and to some degree encouraged, multiple strategies for organizing and financing behavioral health services.

Over the last two decades, state efforts to expand federal revenue in mental health and other services have led to a patchwork of approaches to fund state shares for federal match.

Across the country “providers” include private, county and state organizations funded with global budgets, capitation, case rates, FFS and cost reimbursement.

In the last fifteen years, managed care approaches have further confounded the financing structures with carve-ins and carve-outs, statewide and regional/county plans.

The result? No state is alike – there is wide variation in structure and practice patterns.
Why is there such variation?

- Agency structure for MHA and Medicaid
- Child and Adult system structure
- County role
- Medicaid managed care design
  - None – e.g. FFS
  - Disease Management? Colorado, Wyoming
  - Waiver: Integration, partial integration or carve-out
- Provider Financing methods
- Other state Agency Spending
- Innovations
Current Issues and Future Directions

► Mental health spending in Medicaid has grown in absolute terms but it has declined from 12% in 2001 to 9.8% in 2003

► Medicaid MH spending seems to be a problem because:
  → Medicaid accounts for 21.5% of state budgets (AL – 11.6% and ME – 31%)
  → High growth rate of ER spending
  → High usage of inpatient
  → Rapid growth of pharmacy spending esp. children
  → Lack of coordination between physical and behavioral

► New Targeted Case Management and Rehabilitation Option rules will force significant changes

► 1915i State Plan option may be used by some states for significant reforms

► Expect more managed care initiatives to seek greater flexibility

► Expect more integrate health care efforts; BHOs will develop and market new physical health related initiatives
Models for Medicaid Managed Behavioral Health Care
Regional Behavioral Health Carve-Out

Examples include:
- California
- Michigan
- Arizona
- Washington State
- North Carolina
Integrated Behavioral Health Plans

Examples include:
- Often SCHIP and TANF only
- Nevada
- Minnesota
- MA Choice of MCOs or PCC Plan – Acute Care only

Managed Care Organization (HMO)
- Providers

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- Providers
Examples include:

- Massachusetts PCC
- Iowa
- New Mexico
- Pennsylvania Counties
- DC and Philadelphia
Carve-Out w/ASO

Examples include:
- San Diego
- Some Michigan Counties
- Tampa
- Colorado Health Networks
SMI State Carve Out

Examples include:
Vermont
New York
Maine
Delaware
SMHA and Medicaid Financing Approaches
Massachusetts

Department of Mental Health – Strategic Planning Framework

EOHHS

Mental Health Authority

SMHA

Central Office

Area Office

MHBH

Interagency Coordination & System Oversight

Purchasing, Licensing & Service Standards

Service Quality Evidence Based Svcs.

Admin/Mgmt Services

Strategic Actions

Organization

Draft – 12/20/04
Michigan

CMS Federal Match

SAMHSA

General Funds

State Match

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MI Department of Community Health MH/SA Administration

- Capitation Payments for Medicaid
- GR
- Block Grant

County MH Program

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Many are Prepaid Inpatient Health Plans; Many Counties are Consolidating

County MH Program

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State Hospital

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Health Plans
MH Benefit
20 Outpt.visits; No Inpt.

Psych Pharmacy
Carve-Out (reconciled to Health Plans

$$

County MH Program

$$$
County based system of Mental Health services – most counties directly deliver the majority of services

State Mental Health Authority oversees the allocation of Short-Doyle “grants” to the counties for indigent and for state match of Medi-Cal Rehab services – tagged to motor vehicle licensing

Medi-Cal managed care was implemented in two “waves”- Inpatient and Outpatient. State funds capped to counties in global budget.

Counties continue to submit FFS bills for Medi-Cal inpatient and Rehab services for the federal share.

Medi-Cal MCOs include pharmacy, now anti-psychotics are carved-out.

More than $1B in new state revenue under the Mental Health Services Act
* Medi-Cal Billing by Counties is for 50% Federal Share only. Counties have the match. County EPSDT spending is 90% matched by state and federal.
Pennsylvania

CMS Federal Match

SAMHSA

Physical Health $

MH Funds

State Office of Mental Health

County MH Programs

Health Plans

Psych Pharmacy

Health Choices
County Capitation Rates
- Experience-based
- Surplus rolls over with reinvestment plan;
- Reserve requirements

Provider Grants

Provider FFS (MA)

State of Mental Health

County Allocation Grants – Adult/Child - GF; PATH; Other

Health Choices: County Right of First Opportunity: Capitation

State Hospitals

State Office of Mental Health

County Funds?

Closure Funds

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Tennessee

- TennCare blends all behavioral health funding – Medicaid, Block Grant, etc.
- State hospitals are included in plan except for forensic units. Rates are well below market
- West and East Regions are carve-outs managed by Magellan – one risk based the other administrative services only
- Central region went carve-in this year with a choice of plans
New Mexico - Before

Interdepartmental Behavioral Health Purchasing Collaborative (IBHPC)

State Agencies Currently Purchasing Behavioral Health Services

DOC (COM COR) → DOH (BHSD) (OSH) → CYFD → ALTCD → HSD (MAD) (TANF) → PED (Spc Ed Hlth Svc Voc Rehab) → DFA (DWI) → DOT

5 RCCs → AAAs → 3 MCOs → Schools → Counties → Providers

DDPC → Governor’s Office → HPC → IAD

State Facilities

New Mexico Human Services Department

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New Mexico - After
Design a Plan!

So let’s design a plan for children….

► Your Medicaid and Mental Health Departments are separate or don’t talk much. When they do talk they speak a different language.

► Medicaid wants to encourage integration of health and mental health benefits, but …. Mental Health wants control and access to community services from their state hospitals. Social Services want everything just the way it is now

► You’re all concerned about the ability of health plans to manage the most needy populations in Medicaid – e.g. disabled adults, children in state custody, yet…. these are the highest cost recipients and their quality of care is the most questionable

► State staff want direct access to services when needed and Judges will continue to place kids directly unless someone can tell them to stop

► Providers think they know how to manage care because they have been under a fixed budget for the last twenty five years, but no one really knows how many people they are serving across their programs.
Here are the kids in the public system:

- Mental Health Authority
- Juvenile Justice Agency
- Child Welfare Agency
- Medicaid and SCHIP Expansion
- Separate SCHIP Programs
- Income Eligible Children
- Foster Children
- Incarcerated Children
- Children with SED
- Children with Disabilities
- Schools
Mental illnesses, like substance use disorders, have an extraordinary impact across all sectors of government.

While state Mental Health Authority and Medicaid spending have been a focus for much research, the growing use of prisons for people with mental illness and the disruption caused by mental illnesses in our schools and communities have focused attention on spending and utilization in other agencies.

NASMHPD Research Institute: Other State Agency Study” began in 2004 and expanded with a second round of states in 2006.

This focus on Other State Agencies is in fact a major focus for SAMHSA Transformation Grants.

Mental Health Authorities can and should take a lead in coordinating policy across these different funding streams.
Montana Adult Utilization

SFY 2007 Unduplicated Medicaid and MSH Adult Recipients Receiving Selected Service Types

- Indiv Counseling: 5,791
- Med Mgmt: 2,234
- Targeted Case Mgmt: 3,590
- Group Home/Foster Care**: 2,030
- 23 Hr. Obs: 2,857
- PRT/Inpatient**: 785
- Misc: 9,095
- MSH: 13,898
- Psych Med: 601
- Other State Plan: 601

AMDD Medicaid
Montana Adult MH Expenditures

SFY2007 DPHHS Adult MH Expenditures* by Source

- State MH Institutions: 37%
- AMDD Medicaid: 33%
- Other State Plan Medicaid: 20%
- Mental Health Services Plan: 7%
- Voc Rehab: 4%

Total = $98.8 Million
Fiscal Year 2002:
Total Mental Health Spending Estimates

- **DCYF**
  - (Includes DCYF Medicaid)
  - $101,624,165

- **DMHRH**
  - (Includes DMHRH Medicaid)
  - $83,262,984

- **DHS**
  - OTHER
    - $49,764,017
  - Rite Care
    - $16,823,493

- **School Based Health Centers**
  - N/A

- **DOC**
  - $1,000,000
SMHA or County contracts with providers in the majority of states are grant or cost reimbursement arrangements.

Medicaid funds are generally fee for service (some limited use of case rates).

Sometimes these are offset against SMHA grants depending on the service.

For most states there is little, if any, provider competition outside of the urban cores. Community mental health centers or their equivalent are the dominant organizations.

Reimbursement includes cost settlement, cost reimbursement, negotiated rates, class rates, and in some services case rates.
What are we funding? What do we want to fund? How do we get there?

- Integrated health and behavioral healthcare
- Care is consumer and family driven - Person centered or wraparound planning
- Excellent and evidence based care - More effective services
- Reduced disparities – increased equity in health care delivery
- Promoting Recovery: Use of peer support and flexible funding
- Increased screening and early mental health care
- Increased research and use of technology
- Safety in services
- Efficiency – avoiding waste and unnecessary services
- Timely services – reducing waits and delays

Consolidation of goals from The President’s New Freedom Commission Report and the Aims of the Institute of Medicine Crossing the Quality Chasm Report
Disease Management

- Chronic Illness Management and Disease management approaches
  - Define the target population
  - Develop/adopt evidence base guidelines
  - Adopt collaborative practice models for primary and behavioral health
  - Develop and implement patient self management education
  - Implement reporting, process and outcome measures

- The clinical effectiveness of disease management is clear but its ability to control costs is not

- Ultimately, the keys to success lie in improving provider quality and increasing the knowledge and capacity of consumers for self direction
Conclusions

► Successful financing reforms can move the system toward our goals. For some systems this could mean a shift from grants to FFS reimbursement. For other systems it could mean competitive procurements.

► Ultimately, money should be able to “follow the person” and providers should be incentivized to manage “population” or community health rather than treating illnesses.

► There are a variety of system and organizational structures that states can use to achieve these goals.

► Regardless of structure, successful states have:
  ➔ Developed clear policies and strategies working effectively with stakeholders;
  ➔ been effective contract managers and;
  ➔ used procurements and incentives effectively to move the system forward.
Thank you.

Questions?

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