THE NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

The Transition of Behavioral Health Services Into Comprehensive Medicaid Managed Care: A Review of Selected States

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Executive Summary

Many states include behavioral health (BH) services as one of the benefits administered by comprehensive Medicaid managed care organizations (MCOs), also referred to as carved-in behavioral health services. According to the 2019 Kaiser Family Foundation 19th Annual Medicaid Budget Survey, 30 states exclusively or otherwise cover BH services for adults with serious mental illness (SMI) and/or children and adolescents with serious emotional disturbance (SED) under comprehensive MCO contracts.[i,ii]

In some states that recently implemented carved-in BH benefits, the move caused significant service disruptions for consumers and caused providers to experience numerous and costly administrative processes to receive service authorizations or payments. Because of substandard rollouts, some states and MCOs had to devote attention to fixing implementation errors rather than focus on their primary objective, which is improving consumer outcomes through more effectively integrated physical and behavioral health care.

The National Council for Behavioral Health commissioned the development of this report so authors could examine carve-in implementation experiences in selected states. The National Council can use report findings to offer recommendations to state and federal policymakers so unintended negative consequences are remedied quickly or avoided entirely. Authors researched and reviewed several materials and conducted interviews with 28 stakeholders, including current and former leadership and staff from state Medicaid agencies, state and county BH authorities, state BH provider associations, BH treatment providers, a county-operated specialty behavioral health plan and a member of a state's legislature.

Authors interviewed individuals from carve-in and carve-out states to understand perspectives about current systems and planned BH reforms. Interviewees included current and former officials in Arizona, Kansas, Louisiana, New York, Ohio, Oregon, Tennessee and Washington (BH carve-in states) as well as Maryland and Pennsylvania (states where BH is carved-out of comprehensive MCOs, but administered by other types of managed care entities).

Authors reviewed and analyzed Medicaid procurement materials and MCO contracts, which make clear that states intend BH carve-in to result in: integrated behavioral and physical health care and clinical integration (Arizona); coordination of care and integration of physical and behavioral health services (Kansas); decreased fragmentation and increased integration across providers and care settings, particularly for enrollees with behavioral health needs (Louisiana); improved health outcomes and recovery, reduced unnecessary emergency and inpatient care and increased network capacity to deliver community-based recovery-oriented services (New York); integration of behavioral and physical care (Ohio); a continuum of care that integrates mental health, addiction treatment dental health and physical health seamlessly and holistically (Oregon); integrated physical delivery of physical health, behavioral health and long-term care services (Tennessee); and integrated behavioral health services that support a bi-directional delivery of care model (Washington).

However, interviews suggest that states fell short of goals in many respects. Several themes emerged from interviews – described more fully in this report – and findings revealed that payment delays and service disruptions only partly reflect the problems related to carve-in. Clearly, some of the challenges are a direct result of the planning, design and rollout of the new managed care arrangements. Other

issues are more deeply rooted. While assuring sufficient time to plan a successful implementation is key to effective integration of physical and behavioral health care, it would be a mistake to assume that implementation problems alone were at issue.

Authors observed that there are more fundamental challenges to achieving a successful model of physical health care and behavioral health care integration than a hurried implementation schedule. For example, stakeholders reported the lack of recovery-oriented measures; few, if any, measures of effective service integration with physical health care; little movement toward the level of accountability desired by states; and inadequate involvement of the state BH authority.

Authors noted other key takeaways, including that financial integration does not automatically result in effective clinical integration and that in some states, Medicaid and MCO leadership lacked the expertise in, and understanding of, BH populations, systems and services. Authors also made observations that seem to point to state Medicaid agencies' failure to address systemic barriers to ensure BH providers' effective participation in managed care, including:

- Lack of true, historical collaboration between leadership and staff from state Medicaid agencies and state BH authorities in some states.
- Lack of investment in and uneven use of health information technology (HIT) and health information exchange (HIE).
- Lack of financial reserves in BH provider organizations to manage with interrupted cash flow.
- Lack of an administrative infrastructure (even beyond HIT) within BH provider agencies to manage increased administrative demands from multiple managed care plans.

While no single solution can address all these issues, it is critical that state Medicaid agencies take stock of the already vexing BH services environment and make plans to ensure the success of sweeping reforms, even if that means making incremental changes over a longer period of time. Clearly, states will continue using managed care strategies; however, there is an opportunity for states to assess the serious implementation problems with recent carve-in rollouts and make improvements, including in states where carve-in has already occurred.

There are also opportunities for states still in the pre-implementation stages to avoid similar outcomes. The number of new states pursuing BH carve-ins may have slowed down for people with SMI, but states continue to seek more holistic approaches to address care needs of persons with SUD. Federal partners should require states to demonstrate readiness on all fronts prior to launching such significant system changes that affect vulnerable populations who are already at high risk of early mortality and increased comorbidity. Given the similarities between BH carve-in and managed long-term services and supports (MLTSS), the Centers for Medicare and Medicaid Services (CMS) should increase its monitoring of large-scale BH delivery system and financing reforms and hold states fully accountable for assured end-to-end systems testing, continuity in provider payments, service access and quality.

To ensure effective planning and smoother implementation of BH benefits carved-in to comprehensive Medicaid managed care organizations, states should:

1. Use existing data resources to document their understanding of the BH service system, including an analysis of population demographics, chronic health conditions, cost drivers and total cost of care of persons with SMI/SED or SUD, service utilization and trends and care gaps.

2. Assess current provider and service capacity and determine whether a sufficient network is available to attend to population health needs.

3. Describe and quantify outcomes to be achieved with carve-in, including health, quality of care, financial and member experience outcomes and have a formal pre-/post-evaluation plan for the implementation.

4. Collaborate with the state's BH authority and provider networks' clinical leadership to develop a clinically informed theory about how to accomplish change and confirm which evidence-based services will support desired changes.

5. Conduct internal Medicaid agency reviews of readiness across all program phases (e.g., planning, design, pre-implementation, go-live, monitoring), particularly related to requests for proposals (RFP) development, outcomes measures identification, MCO contracting, rule promulgation and handbook development.

6. Conduct external behavioral health provider readiness reviews with respect to contract negotiation, coding, claim submission and payment reconciliation abilities and be prepared to offer technical assistance and training to behavioral health providers without prior experience in managed care contracting and billing.

7. Stage implementation based on readiness and resource constraints and establish a clear communications strategy to keep members, providers and other stakeholders informed about timeframes, progress and delays.

8. Conduct and evaluate small-scale pilots (e.g., regional rollouts) to identify implementation details that may be in need of refinement or overhaul before full implementation of reforms.

9. Ensure MCO readiness by confirming appropriate governance and staffing, provider network and services adequacy, claims processing capacity, reporting capabilities and development of internal policies and procedures.

10. Institute formal end-to-end systems testing and require MCOs to report on outcomes and document services which services were not paid during testing.

11. Ensure provider readiness by assessing staffing and workforce capacity, claims submission capacity, EHRs and use of HIT/HIE.

12. Develop an oversight, monitoring and evaluation framework for program integrity and general quality improvement purposes.