

What Is Next for Behavioral Health in Managed Care?

Dave Richard

North Carolina's Medicaid reform plan legislation will continue the state's behavioral health care system of local management entities and managed care organizations for 4 years after the implementation of the 1115 waiver. Policymakers have options, including staying the course, but they must be deliberate and thoughtful in their decisions.

States continue to use different methods to manage Medicaid funding for behavioral health services. Models include carve-out managed care plans, integrated managed care, fee-for-service care, or combinations of these models. North Carolina uses a carve-out 1915(b)/(c) waiver managed by local management entity/managed care organizations (LME/MCOs) to manage services for people with mental illness, substance use, and developmental disabilities for specialty services. North Carolina covers physical health services through the fee-for-service Medicaid program [1]. Although the recently proposed Medicaid reform legislation extends the 1915(b)/(c) waiver for 4 years after implementation of this reform, it does not prescribe the structure of behavioral health care after those 4 years [2].

To evaluate the best option for the future, we must clearly define our goals for the system and specify how we will measure success. Over the past several years, the public outcry around behavioral health services primarily focused on individuals with mental illnesses in emergency departments, lack of community treatment, and the increasing opioid crisis in North Carolina. To a lesser degree, the public has raised concerns about people with developmental disabilities facing long waiting lists for support services designed to assist with community living. Underlying all of these concerns is the desire for whole-person care. Given these issues, we must strive to create a system that addresses these concerns while effectively managing costs for the state.

Continuing the Carve-Out

The carve-out model in North Carolina is designed to ensure that the people with the most significant needs have their care managed by organizations specifically designed for that purpose. North Carolina's LME/MCO system relies upon organizations with ties to local government structures (former county-based area programs) to provide services for this population. Since their inception, LME/MCOs have

achieved cost predictability for the state through the managed care process, authorized and paid for services in the benefit plan, and met the base standards established by the Department of Health and Human Services (DHHS). We have not yet achieved statewide consistency in service level or significant integration of behavioral health and physical health.

If the carve-out is to continue, we will need increased accountability around emergency department wait times, stronger outcome measures for community-based services, and continued reinvestment by the LME/MCOs in their communities. Fundamental to the success of this model is the state's ability to align outcome measures across managed care organizations that allow for shared risk.

Behavioral Health Services in Comprehensive Managed Care Plans

More states have moved to or are considering comprehensive managed care plans in an attempt to integrate care and manage costs. Possible benefits of this model are ease of whole-person care, reduced administrative burden on providers, and a clear system for beneficiaries. North Carolina's reform plan, which will have a mixture of statewide commercial plans and regional provider-led entities (PLEs), could evolve to include behavioral health funding.

If North Carolina were to consider this option, the state would need to carefully consider how to transition from the current system and determine what, if any, role the current LME/MCO structure would have in the new model. Since other states have already made this transition, we have the advantage of learning from their experiences.

Special Needs Plans

Throughout discussions around Medicaid reform, the possibility of creating plans for special needs populations has gained traction. A special needs plan would manage all of the benefits—both physical and behavioral health—for

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a targeted population. For example, we could create plans that managed all services for those with severe and persistent mental illness, as well as plans for individuals with substance use disorders.

Most often these conversations revolve around transitioning the LME/MCO system to a special needs plan, but there is also the option of including prepaid health plans (PHPs), which will consist of commercial plans and PLEs. The obvious benefit of having LME/MCOs as the special needs plan is that it allows whole-person care to be provided by organizations that have special expertise in behavioral health, thus allowing them to manage treatment for individuals with complex care needs.

Choice

As we evaluate the future of our Medicaid behavioral health system, we must consider several important items that will ultimately determine the success of our decision. As North Carolina considers how it will manage behavioral health services in the future, one key consideration is the ability of individuals to choose plans that best fit their needs. In our current waiver, individuals have the ability to choose between qualified providers. Provider choice will be standard in any future consideration, but should individuals also have the option to choose between plans?

If specialty behavioral health services are included in the statewide commercial plans and PLEs, then beneficiary choice between plans will be automatic. However, if we continue with the carve-out or create options for specialty plans, the decision of whether to allow individuals to choose between plans will be critical. There is a clear argument to be made that allowing plan choice will drive increased quality as plans and/or LME/MCOs compete for members. This strategy also has the potential to increase provider quality as providers strive to meet higher standards in order to be included in plans. The potential downside of allowing plan choice is that it could create a fragmented system in which no single organization bears responsibility for regional services and infrastructure development. Currently, the LME/MCO system has the responsibility to develop and support the state's infrastructure and to strategically align available resources to meet the needs of people in its catchment area.

Developmental Disability

Provision of services for people with developmental disabilities is included in the LME/MCO system. An advantage of this setup has been the ability to support people with dual diagnoses—both mental illness and developmental disability—through a single organization. Although we have examples where this approach works well, several barriers remain: distinct federal Medicaid funding streams, a rehabilitative approach for developmental disability versus a recovery mindset for mental health and substance use, and historical advocacy differences.

North Carolina is one of only a few states that manages mental health, developmental disabilities, and substance use services in a single system, and there is no national consensus on the best system. If we consider alternatives to the LME/MCO system, we should evaluate whether to include developmental disability services or to provide these services separately.

Supporting People With Mild Behavioral Health Needs

In the discussion of managing behavioral health and substance use care, what is often missed is that the vast majority of individuals with mental health needs are identified and treated in our physical health system, mostly in primary care settings—including pediatricians' offices. For many individuals diagnosed with conditions such as depression or attention deficit hyperactivity disorder, our primary care system is the point of contact. Thus, primary care providers must work in concert with specialty providers regardless of the managed care system. Also, it is paramount that systems provide prevention activities like early screening for substance use and that providers recognize signs of trauma in children and adults.

The potential for the greatest gains lies in the space between the specialty provider system and the primary care system. The collaborative care model, which is supported by the American Psychiatric Association, links the primary care and specialty systems and shows great promise for improving outcomes for people with mental health needs [3]. However, a serious barrier to this model is the separation of funding streams for behavioral health and physical health. Currently, we pay for psychiatry through the LME/MCO system, while primary care is funded through our Medicaid fee-for-service system. This separation of funding places a significant burden on practices, patients, and families as they try to work between 2 systems. Regardless of which management system we choose, we must create pathways that allow innovative practices to thrive.

Coordination With Public Systems

Although coordination of public resources for people with mental health, developmental disabilities, and substance use services is delegated to the LME/MCOs, multiple other public systems also impact the services provided for this population.

Counties have significant responsibility for citizens at the local level. Departments of Social Services have responsibility for child and adult protective services, which often come into direct contact with the behavioral health system. As we continue to learn more about trauma and mental health, it is becoming apparent that children who need the protection of the child services system have a significant risk of mental health issues. Often, court-ordered treatment directives clash with managed care medical necessity standards.

Local law enforcement agencies must carry out commit-

ment procedures, including serving commitment papers and transporting individuals to treatment facilities (most often hospitals), which challenges staff and funding resources. Jails across North Carolina and the United States continue to house people with mental health and substance use care needs.

Third, local education agencies report the continued need for behavioral health resources in schools to support students who struggle to learn because of mental health conditions. Schools are also on the front lines of the substance use struggle, and they need the support of the behavioral health system to succeed.

Finally, housing is critical to the success of people with severe and persistent mental illness. Providing housing for this population requires coordination and support of local housing agencies and connection to state housing resources.

These examples and others indicate that the managed care behavioral health system must coordinate with other public and private systems to succeed. The LME/MCO system was designed to take advantage of connections to the local system. In evaluating options for how behavioral health care might be provided under a future Medicaid system, the ability to improve this coordination must be a key component.

State and Local Funds

LME/MCOs manage more than \$3 billion in Medicaid and state funds. A goal of the system has always been to coordinate the management of these funds to best serve individuals. Although Medicaid is by far the largest funding stream, the flexibility of state and local funds can be critical to improving quality for North Carolinians. Any change in the system must consider the important role of non-Medicaid funds.

Path Forward

State law stipulates that the 1915(b)/(c) LME/MCO system will remain for 4 years after the 1115 managed care waiver goes into effect, although the law does not prescribe what happens next. The most likely options are continuing the system as it now exists; moving all Medicaid services, including behavioral health, to the statewide commercial plans and PLEs; or creating a new managed care platform of special needs plans to include both physical health and behavioral health services for people with severe and persistent mental illness and substance use disorders.

As we evaluate which option will be best, we must keep the following imperatives in mind. First, while almost every-

one would agree the system must improve, there is little consensus on what defines success. As a state, we need to create a realistic set of system outcomes against which we will measure success. Second, our behavioral health system has undergone multiple changes in the past 15 years, creating a sense of uncertainty for beneficiaries and providers. Any change must take into account the fragile nature of the system and assure continuity of current services for beneficiaries. Third, there is no national consensus on how to best manage behavioral health within managed care, but many options exist. North Carolina should evaluate the successes other states are having in this area and emulate those that are most likely to work in our state. Fourth, we currently include substance use and developmental disabilities in our behavioral health system. As we evaluate options, we cannot assume the current configuration is the best. Reviewing options should include careful study of each option's impact on each patient population. Fifth, prevention and support for people with milder disabilities should be a high priority. Finally, we need to clearly define how we address all issues related to behavioral health.

Ultimately, decisions about the management of our behavioral health system are about people. Any management system can work, but each option brings benefits and challenges. North Carolina must base its decisions on clear expectations, data, and the unique nature of our state. Decisions should not be made in haste or as a result of political expediency. **NCMJ**

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