Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
The Pivotal Role of Medicaid in Enhancing State Services for Individuals with Intellectual/Developmental Disorders and Co-Occurring Behavioral Health Disorders: Advancing Collaborations between Medicaid, Mental Health and Developmental Disability Authorities

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Goals for the Seminar

• Identify strategies to enhance and leverage relationships between the Medicaid agency and the Mental Health, Intellectual Disabilities agencies

• Identify key factors in utilizing Medicaid to serve individual with IDD and mental health or substance use disorders

• Identify indicators for providers operating in value based purchasing or managed care environments.
What We Know

• Federal policy direction is moving to value based purchasing in the fee for service arena, as well as the managed care space
  - Even more important if the feds move forward with block granting
• Based upon industry newsletters and sessions from the National Medicaid Director’s meetings, many states are moving forward with payment reform strategies and Medicaid transformation
What We Know

- Most states are looking to form a more comprehensive, inclusive approach to using managed care to drive payment reform, have budget predictability and improve quality. IDD may have been historically carved out, but that tide tends to be shifting
  - Both state and federal dollars such as block grants, state appropriations, Medicare and Medicaid are referred to those as the public dollars
What We Know

• Public dollars are the major payer for services with people with IDD so is critical to understand the environment when serving individuals with IDD and other dual diagnosis
  – Medicare is spending for this population is increasing due to many factors
  – Medicaid is by far the largest payer for this population due to the nature of supports and services offered in the benefit plan and through home and community based waivers
What We Know

– Other “state or local” funds may supplement costs or support non covered services
– Increased availability of private insurance plans with policies that provide coverage of home and community based services
The Environment

• In addition to the movement to value based purchasing or pay for performance (p4p), individuals with IDD and other co-occurring diagnosis can present unique challenges to the health care network such as:
  – Methods of communication or interaction styles
  – Length of office visit required to achieve the outcome
  – Proficiencies in recognizing physical health symptoms while also understanding the interplay with the other diagnosis.
The Environment

- These individuals present challenges to the specialty provider behavioral health or IDD network typically serving them
  - Access to specialty providers
  - Access to trained providers
  - Rates to support the scope and duration of the needed services and supports
  - Mix of population served
The Environment

• In essence, the network of providers and support agencies may not understand the nuisances of interactions between diagnosis meaning the challenges can be more pronounced and the systems talk past each other.
What Are The Questions?

• How can the Medicaid agency be a driver of supporting people with IDD and co-occurring disorders to live healthy and productive lives as Medicaid dollars are the major payer?

• What are the roles of individuals, families and qualified providers in driving policy development with Medicaid?

• How can managed care companies be prepared to provider services and supports to individuals with co-occurring disorders?
The State Agencies

- The Medicaid Agency
  - Outline scope of delegation to the program division or
  - Have internal subject matter expertise since it is not unusual for IDD to be managed by another state agency
  - Outline clear outcomes, program objectives including non-negotiables
  - The single state Medicaid agency, by federal law, can’t render their accountability to another state agency...so, the buck stops with the Medicaid agency

- The IDD or Behavioral Health Division
  - Communicate desired outcome – don’t be as concerned about means to fund but getting the activity covered in the benefit plan
  - Be willing to compromise
  - Be willing to bring the state share as match if needed
  - How will it help or address outcomes in the Medicaid agency
Managed Care Intersection

- The new mega managed care rules establishes a definition and a framework of requirements for addressing long term care and supports
  - Recognition that long term supports is moving into managed care and that it is different than typical acute models or disease approaches
- IDD in general is a new “line of business” for managed care entities so don’t assume they understand the differences between what “we already do” and how to support people with IDD and co-occurring disorders.
  - Even though the words may be the same, the meaning and operations are not necessarily the same. For example, person centered planning
• Services for individuals with dual diagnosis are going will receive services from the “physical health plan, the behavioral health plan and most likely the HCBS waiver plan” which makes navigation and effective care coordination more challenging.

• This population will make up a small % of the managed care market however these individual’s support plans will require long term supports and be in the upper quadrant of costs.

• States establish the managed care requirements through the RFP process.
Managed Care Intersection

- States are responsible for the Contracts with the managed care plans and the monitoring of the plans
  - The question is, how are the needs of these individuals addressed through RFP development, contract requirements and monitoring?
  - This is an area that families and individuals can have a role and inform the process
Considerations for Managed Care Long Term Care and Supports (MLTSS)

- How will health care be coordinated with specialty services or supports?
  - The role of the case manager in HCBS services
  - The role of the care coordinator in the managed care environment

- Since each state’s managed care plans are different, comparison to other states can be challenging.
  - Review the state ffs benefit plan and the HCBS waiver before going into managed care.
  - Managed care does allow for the flexibility of adding services either through “in lieu of services” or B-3 services. Are there services that support individuals with co-occurring diagnosis?
Considerations for managed care long term care and supports (MLTSS)

- CMS historically has pushed for quality measures that support ADA, Olmstead and other HCBS quality measures
  - What are the required metrics or pay for performance indicators? Are the measures acute based or long term care.
- Does the RFP or contract writing and review include staff who are experts in the area? What role did the IDD experts play?
- Are there mechanisms for the use of “savings” achieved by lowering institutional admissions and returning individuals in the community in expanding access to and quality of home and community services?
Considerations for managed care long term care and supports (MLTSS)

- Is there a way to modify the perceived or real institutional bias through the 1115 waiver?
- How will transition from ffs be handled:
  - For individuals?
  - For providers?
    - studies show that consumers have little difficulty in the switch – providers tend to have more difficulty
- Are there continuity of care provisions?
  - Transfer of provider to network
  - Transfer of authorization to new entity
- Will there be standardization among MC entities?
  - Administratively
  - Programmatically
The North Carolina Experience

• Designate a champion from the Medicaid agency and the Division administering behavioral health and IDD
• Establish a relationship and operating protocol
• Understand roles and responsibilities of each agency since they may inherently conflict
• Are the outcomes shared or one-sided?
• Meet regularly with set agenda and status reports
• Document, document, and document
North Carolina Experience serving individuals with IDD and other dx

• To give visibility to the uniqueness, a clinical policy was written to recognize the population

North Carolina Experience Serving Individuals with IDD and Other Behavioral Health DXs

• Every population served will want special attention to their area of services and supports.
• From a lesson learned perspective, IDD has a strong advocacy presence embracing specialty services and supports for the individual with IDD and behavioral health challenges as a priority.
Lessons Learned

• **Cost**
  
  • *It is important to know the true costs for serving these individuals. Cost could and probably will be different than the billing rate or allowable fee schedule.*
  
  • *Providers must develop or access the infrastructure to perform cost analysis for risk based or pay for performance contracting*
  
  • *Knowing that may lead to individual case rates or other funding arrangements*
Lessons Learned

• One manage care organization (MCO), Vaya Health, in NC has completed an analysis of serving individuals with IDD and MH. Cost run about 20% more than the IDD only population

• Results:
  • Dual Diagnosis: $64K per year   ID Only: $48K per year
  • Using a t-test, we found this difference to be highly significant
  • This supports everyone in the group’s experience that serving these people with significant challenges is considerably more expensive
  • More importantly, it was a random sample, so it is much more generalizable to other populations

• Extrapolation:
  • With the relative cost difference as a starting point, we extrapolated across the US using Braddock’s State of the States data and National Core Indicators prevalence data for Dual Diagnosis for a state-by-state analysis
  • Over $8.5 Billion spent annually for extra cost of Dual Diagnosis in US
Lessons Learned

• **Infrastructure**
  
  • *Electronic Health Record (EHR) and Health Information Exchange (HIE)*
    
  • Where is your state in requiring the sharing of data?
  
  • How is your state addressing whole person care through data sharing in means other than paid claims data?
  
  • *Plan on activities to develop the infrastructure or provide guidance on how to obtain the required support.*
Lessons Learned

• Workforce Development
  • Behavioral health, IDD and physical health providers and practices will require training and consultation
  • This is a specialty area and should be treated as such.
  • Use of evidence based practices or evidence informed practices are one way to drive effective and efficient care and supports.
Lessons Learned

• The first area to address is the acceptance and belief that people with IDD can and do have behavioral health conditions just like other individuals.

• Conduct a gap analysis to determine what training is required

• Prepare a training plan with dates and resources (people and funds) identified to carry out the plan
In Summary

- Serving individuals with IDD and mental health or substance use disorder is a special needs population whose:
  - Providers and practices required specialized training
  - The provider network should have the capacity to accurate diagnose and provide effective and efficient treatment and supports
  - The cost of care and supports is typically more expensive than supporting those individuals with out co-occurring dx.
  - The cost and quality of care is impactable!!
In Summary

- Given the type of interventions and supports utilized, these individuals usually obtain services through various parts of the Medicaid program such as managed care waivers, ffs state plan services, HCBS waivers, and state/local dollars.
- As a result of the above, it is critical that the individual have an coordinator of care and supports, utilizing a efficient care coordinator or case manager to assist in the true single plan.
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