



Managed Care and Behavioral Health

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Questions?



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Overview of Presentation



1. Background on managed care products and their regulation
2. Delivery systems for behavioral health care services
3. Some key health care reform initiatives related to behavioral health and barriers/challenges to such reforms
4. Related developments in Medicaid and behavioral health

EXAMPLES OF MANAGED CARE PRODUCTS



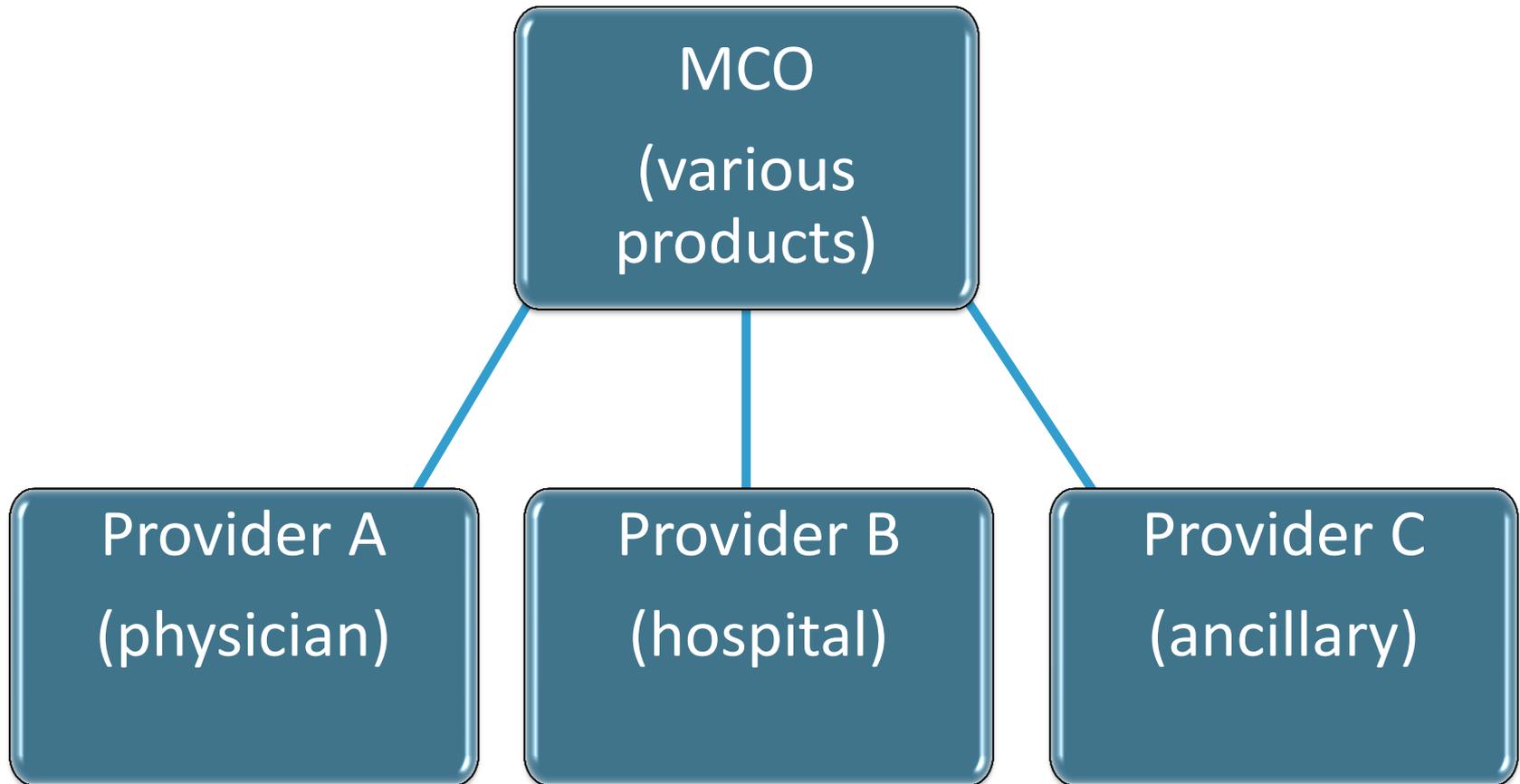
Government	Medicare Advantage	Medicaid Managed Care	FIDA	PACE
	CHIP	FHP	SNPS	MLTC
QHPS	Individual federal exchange	Small group federal exchange	Individual State Exchange	Small Group State Exchange
Commercial	Fully insured HMO	Fully insured PPO	Self funded HMO	Self funded PPO

Regulation of Managed Care Differs by Product



- These products are offered by various types of managed care organizations or “MCOs” (e.g., HMO, PPO, QHP and other payers).
- Products as well as MCOs are subject to different laws.
- This often results different legal analyses being required based on the specific product or plan at issue, for example:
 - Network access and adequacy requirements
 - Utilization management rules
 - Claims filing deadlines and prompt payment requirements
 - Appeals processes
 - Dispute resolution
 - Patient hold harmless obligations
 - Confidentiality requirements

BASIC DELIVERY SYSTEM FOR MANAGED CARE

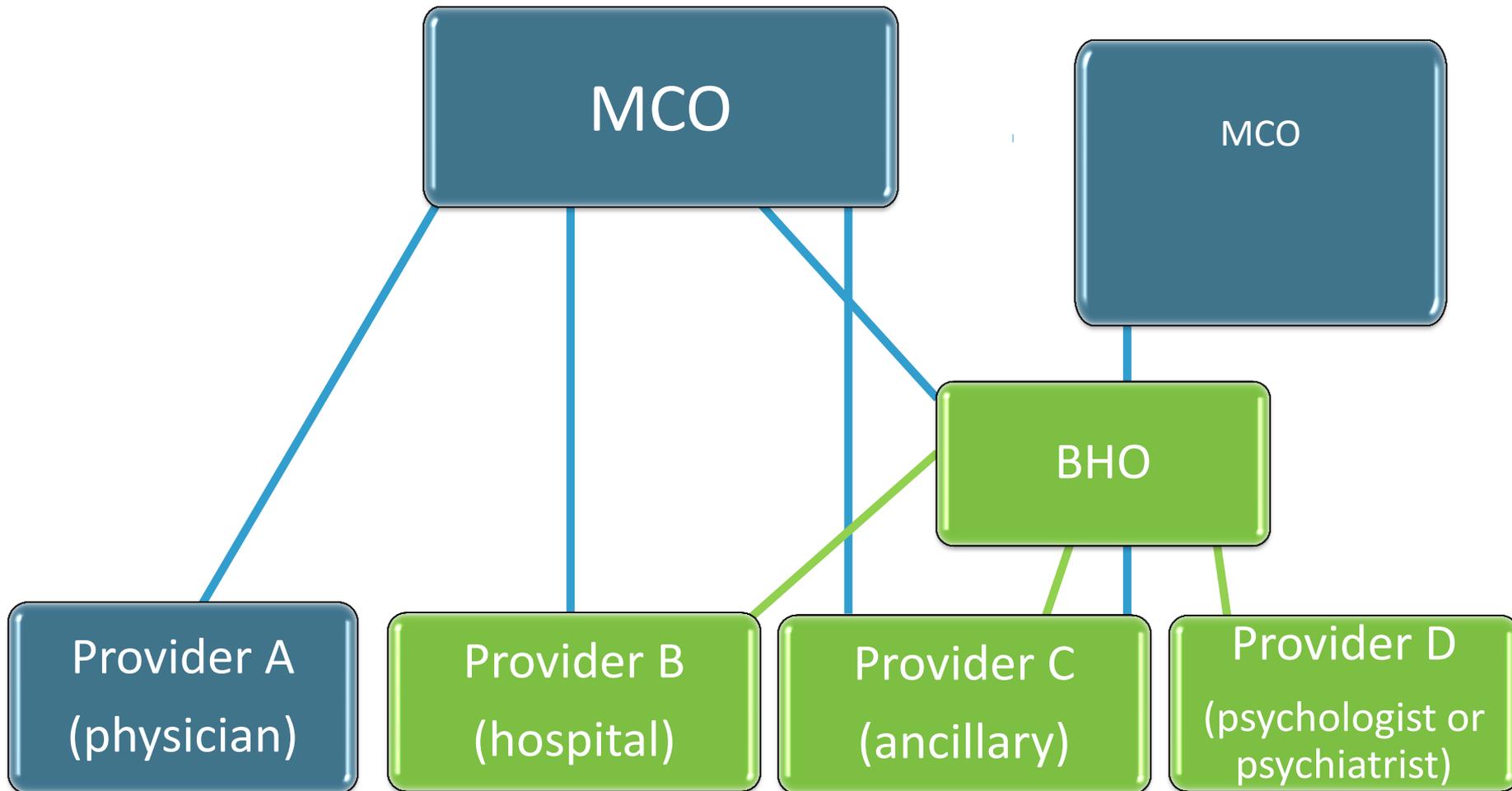


Delivery Systems for Behavioral Health



- Behavioral health services are often “carved out” of an MCO’s agreements with providers and provided and managed by a specialized behavioral health organization (“BHO”) (BHO may be affiliated with the MCO or not)
- BHOs often have their own network of providers with separate agreements, pay behavioral health claims and perform utilization management for such services
- BHOs likely have multiple MCO clients accessing their networks, which makes consistency of contract terms with all MCOs difficult
- Thus applicable law varies by product and payer (MCO and BHO) and
- Contract terms also vary by product and by payer (MCO and BHO)

MCO AGREEMENTS FOR MEDICAL AND BEHAVIORAL SERVICES



Behavioral Health Delivery Systems



- So providers who provide both medical and behavioral health services (e.g., a hospital) may have different agreements apply to services provided to the same individual: one agreement for medical services and another agreement for behavioral health services

- The terms of both agreements are likely to be different, for example:
 - Policies and procedures such as clinical criteria, prior authorization and eligibility verification
 - Claim filing deadlines (e.g. 90 versus 180 days)
 - Reimbursement terms

Behavioral Health Delivery Systems



- Term and termination provisions (e.g., providers may end up being in network for medical services but not in network for behavioral health services for same population and vice versa)
- Dispute Resolution (arbitration versus litigation)
- Patients presenting with both medical and behavioral health conditions at same visit present unique challenges:
 - which agreement applies?
 - where to submit a claim?

Health Reform Initiatives Related to Behavioral Health Services



- The Affordable Care Act mandates coverage of behavioral health services as an “Essential Health Benefits” for private plans and Medicaid plans (includes mental health and substance use disorder treatment for most plans)
- The Mental Health Parity and Addiction Equity Act (MHPAEA) essentially requires behavioral health benefits be treated the same as medical health benefits with respect to:
 - financial requirements (such as copays and deductibles)
 - quantitative treatment limits (such as visit limits)
 - non-quantitative treatment limits (such as medical management)
 - Medicaid /CHIP final mental health parity regulations are due tomorrow - expected to require parity regardless of the delivery system (e.g., managed care, alternative benefit programs); goal is to create consistency between commercial and Medicaid markets
- Population health and value based payment are both reforms that require coordination of medical and behavioral health services, e.g., ACOs, PCMHs

Impact of Health Reform Initiatives on Behavioral Health Services



- Medicaid expansion has resulted in increased provision of behavioral health services – the expansion population has significant behavioral health needs
- Some states are still transitioning Medicaid or Medicaid expansion population to managed care - 80% of all Medicaid is now under managed care (some are going in other direction, e.g. Connecticut)
- Some states are in the process of “carving in” behavioral health to managed care for the first time (although BHOs may be used, e.g., New York)
- Increased number of Medicaid waivers and demonstration projects: as of September 2015, there were 55 approved section 1115 demonstration projects in 18 states, many involve behavioral health services
- Increased federal level regulation of Medicaid managed care – e.g. CMS proposed a broad reaching rule in May 2015 that seeks to better align Medicaid managed care with commercial and Medicare markets

Unique Challenges Related to such Health Reform Initiatives



- Two hallmarks of health care reform - care coordination and the integration of primary care and behavioral health care - are proving more challenging due to:
 - Fragmented regulation and delivery systems for medical versus behavioral health care
 - confidentiality requirements that are much more stringent for behavioral health services
 - another level of coordination among regulators, plans and providers is needed in order to integrate mental health and substance use disorder treatment since they have historically been regulated differently
 - difficulty in measuring quality improvement and cost savings for value based payment for same reasons
- Compliance with the mental health parity law is also proving challenging for similar reasons

Medicaid and Behavioral Health



- Medicaid is the single largest payer for mental health services in the United States and increasingly plays a larger role in reimbursement for substance use disorder services (especially given Medicaid expansion).
- Utilization and spending by Medicaid for enrollees with behavioral health diagnoses by basis of eligibility (2011):
 - Enrollees with a behavioral health diagnosis: **9.86 billion**
 - Total Medicaid spending for enrollees with a behavioral health diagnosis: **\$131.18 billion**
 - Enrollees with a behavioral health diagnosis as percentage of all enrollees: **20%**
 - Spending for enrollees with a behavioral health diagnosis as a percentage of spending for all enrollees: **48%**

Medicaid and Behavioral Health



Utilization and spending by Medicaid enrollees with behavioral health diagnoses by basis of eligibility (2011) (cont'd):

Total Medicaid spending per enrollee(medical, behavioral, health and long-term services and supports):

\$13,303: Enrollees with a behavioral health diagnosis

\$3,564: Enrollees with no behavioral health diagnosis

Source: Medicaid and CHIP Payment Commission

Medicaid and Behavioral Health



- Given all this, many states have pilots and initiatives in place to improve access to, and the quality and cost of, behavioral health services
- Taking NY as an example (since approximately 1/3 of New Yorkers have Medicaid for their health care needs), there are multiple Medicaid managed care projects involving behavioral health services:
 - DSRIP which allots approximately \$8 billion in incentive payments for provider based projects, some of which are based on integrating primary care and behavioral health
 - “Health and Recovery Plans” (HARP) for severely mentally ill (SMI) or SUD Medicaid patients as of October 2015 which offers home and community based services to address the social and non health-care related challenges that accompany behavioral health
 - FIDA IDD product expected

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Upcoming Webinars

Behavioral Health Crash Course Series



- **Investments in Behavioral Health: Drivers and Outlook**

April 5 at 2:00 - 2:15 p.m. ET

Purvi B. Maniar

To register, please visit: <http://www.ebglaw.com/events/>

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