Benefit Design Evaluation for a Streamlined Behavioral Health Care Program

For CHP+ and Medicaid Children and Adolescents

Commissioned by the State of Colorado
Department of Health Care Policy and Financing

Care Solutions, Inc.

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Executive Summary

Introduction

Over the past two years, the Department of Health Care Policy and Financing for the State of Colorado (HCPF) has been actively engaged in researching and developing ways to more effectively purchase and administer quality health care services serving the lower income children and families of Colorado. These efforts have focused on combining: the income eligible Medicaid population; the Child Health Plan Plus program, otherwise known as CHP+; and the Colorado Indigent Care Program, otherwise known as CICP, in a delivery system that better integrates care. HCPF is interested in combining the best practices of the private and public sector in a single integrated health care delivery system, encompassing a "value based purchasing strategy." The focus of this document is to evaluate three distinct behavioral health benefit delivery system designs for best practices, as well as identify some potentially adverse consequences of each design.

The three behavioral health models to be examined are: carve-in; carve-out; and partial carve-out. The carve-in model combines physical, behavioral and pharmaceutical services under a common financing and administrative model. The health plan chosen, regardless of whether the health plan chooses to subcontract the behavioral health care services themselves, would be responsible to HCPF, otherwise known as the "Department", for all administrative, quality, data, clinical, network and performance management functions. The ultimate goal of a highly effective carve-in system is to have collaboration, coordination and integration to service and care offered to members and enrollees across all systems.

The carve-out model is a very familiar model of benefit design in behavioral health delivery. It was widely used in the late 1990's and was researched extensively for the impact on financial performance, utilization, network implications, access to care and quality. The model is flexible and able to accommodate a broad scope in benefit design.

Last is the partial carve-out model. This model is seen as combining what is believed to be best practice from the commercial managed care plans with the strength of the public sector model in providing clinical oversight for children and adolescents who have more significant behavioral health needs. The most common version often offers a basic behavioral health benefit plan, similar to a commercial model, with cases outside that benefit being managed according to an "individualized care plan" design.

The joint purchasing initiative proposed would focus on non disabled children and their families. Current literature review indicates that 12-18% of the Medicaid and CHP+ population under consideration are children and adolescents with more significant behavioral health needs that could potentially exceed a basic benefit plan. With the movement towards "individualized care plans" and allowing funding to follow consumers, the Department needs to consider a benefit design that can support an evolving best practice of "blended funding streams". This approach supports integration of funding for children and adolescents with multiple needs across child serving systems,

such as juvenile justice, child welfare, mental health, etc. This approach will help to maximize limited Medicaid/CHP+ resources and avoid duplication of services.

Main Findings

Carve-in Models:

Advantages:

- The Department would be able to manage one organization, which delivers all physical, pharmaceutical and behavioral health benefits, under one umbrella.

- There would be a single identifiable health plan for consumers and their families. The provider network would be available and accessible to all.

- In theory, it could combine and integrate behavioral and physical health care more fully to deliver more holistic, integrated individualized care.

- The Department has significant experience in managing this benefit under the CHP+ benefit plan.

- It could potentially be more attractive to commercial plans, with significant managed care experience. This offers the Department more competition and options from which to choose. Large managed care organizations often own and operate their own behavioral health care companies.

Potential Consequences

- In studies, behavioral health often is secondary to physical health in carve-in plans, both in financing and outcomes. Without well defined incentives and indicators, behavioral health performance can actually decrease.

- Carve-in designs have been shown to have difficulty being flexible in delivering an individualized plan of care. Carve-in designs have difficulty accommodating an expanded array of services, offering increased care management, involving families in significant and meaningful ways, and ensuring culture diversity in the composition of the network and providers.

- Carve-in designs often experience difficulty in maximizing multiple funding streams, such as criminal justice and child welfare, and rely solely on Medicaid/CHP+ dollars.

- Development of appropriate incentives/penalties tied to performance in behavioral health services can be more challenging to implement and oversee.

- Carve-in services, especially those in large managed care organizations, can have extensive technical expertise in the management and delivery of care. They often fall short in having the familiarity and expertise in serving populations dependent on public systems and how to best maximize financial and care resources and work well in interagency coordination.

Carve-out Models

Advantages

- The Department has extensive experience managing these models under the Medicaid benefit. The Behavioral Health Organizations (BHOs), formerly known as the Mental Health Assessment and Service Agencies (MHASAs), deliver behavioral health care under the current Medicaid model in a carve-out design.

- Carve-out models in most states tend to be able to cover an expanded array of services and offer a more individualized plan of care.

- Carve-out services, especially those provided by nonprofit and government Managed Care Organizations (MCOs), were seen as having greater expertise and familiarity in providing care for those with behavioral health disorders who are dependent on the public system.

- Carve out services are more likely to use non risk-based financing and case rates, while carve-in models often use capitation, a riskier form of financing and one not as preferred by providers.

- Flexible, braided funding options, such as combining Medicaid, juvenile justice and child welfare funding to provide behavioral health care services for children and their families, has been shown to be more easily accomplished in carve-out systems.

- Improved accountability for children's behavioral health care has been shown to be significantly greater in carve-out systems.

Potential Consequences

- Carve-out models can be "isolated" from the other care delivery systems. Delivery fragmentation and lack of coordination is cited as a major problem in Colorado's behavioral health care delivery system currently.

- While carve-out models often do well in serving children/adolescents with serious behavioral health disorders, those with mild/moderate behavioral health problems are often seen within the physical health system, schools, etc. or not at all.

- It is not yet clear whether potentially interested health plans would take a carve-out behavioral health model into account when deciding to participate and if this would negatively impact their interest in provided care services.

- Coordination with physical health systems would be affected if program design and incentives are not aligned and present in a carve-out design. Behavioral health pharmaceutical dollars are not tied to behavioral health delivery, so impact of cost and quality may not be realized.

- Carve-out models need properly designed performance incentives and penalties to assure quality delivery of services.

Partial Carve-Out Model

Advantages

- Partial carve-out models can be designed to take advantage of the best practices of both carve-in and carve-out designs. The benefit design could potentially maximize the strengths of large commercial managed care organizations in delivering a basic benefit package, while utilizing the expertise of non profit and government managed care organizations to deliver behavioral health care services to children with more serious behavioral health disorders.

- A partial carve-out model could take advantage of the "value based purchasing strategy" that a commercial health plan might be looking for, but provide a strong safety net for children and adolescents that require more extensive and individualized behavioral health services. It could potentially provide more Medicaid cost containment, by increasing oversight of complex cases.

- A partial carve-out model could more carefully oversee the service delivery system for more serious behavioral health care services to avoid duplication between child serving agencies.

Potential Consequences

- The "Core" and "Core Plus" benefit structure would need to be clearly defined to assure a smooth and clear transition between the two benefit packages. Limited financial resources would need to be carefully evaluated to assure appropriate funding of care in both arenas.

- Data information systems would have to be carefully designed to assure appropriate performance measures, incentives and penalties. Data could be potentially more difficult to gather from two significantly different providing organizations.

Conclusion

Each of the benefit designs discussed is not without advantages and disadvantages. In whatever benefit design is chosen, it is crucial to have the benefit of involvement in planning and implementation of stakeholders who are knowledgeable about children's behavioral health care, such as family members, other child serving systems and behavioral health providers. States that have had success in implementing best practices around children's behavioral health services have developed broad spectrum approaches, including early identification, prevention services and individualized care plans in the treatment of chronic illness.

The carve in approach has been used successfully in Colorado with the current CHP+ (Child Health Plan Plus) program, while the current Medicaid program utilizes the MBHO (managed behavioral health organization), which is a carve out program utilizing the community mental health centers as the primary delivery system. The Department will need to carefully evaluate which model will best suit the joint behavioral health purchasing system. The design chosen will need to have the following components to be successful:

- Coverage to provide an expanded array of behavioral health services with a flexible benefit design and an individualized plan of care.
- Management of care with broad, psychosocial medical necessity criteria.
- Development of a system of incentives/penalties tied to performance in providing and delivering behavioral health care services.
- Strategies for clarifying responsibilities for paying for services across child serving systems.
- Improvement in accountability for and quality of children's behavioral health care, including monitoring of access to initial care, access to extended care for more serious disorders, waiting lists, interagency coordination, etc.
- Assessment of the adequacy of rates for behavioral health services.