Fiscal Impact of the Behavioral Health Integration Model

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Overview

• Review of JCR outline

• Timeline for JCR development and review

• Fiscal impact of Behavioral Health Integration model
JCR Outline

• Detail how the new model will address various goals
• Outline how services for the uninsured, and Medicaid-ineligible services, will be provided
• Discuss the role of existing local planning agencies and State administrative support
• Outline how services outside the current Medicaid, mental health and substance use grants will operate
• Evaluate the current outcome measures, and detail how they will need to be improved and/or expanded
**JCR Outline**

- Evaluate current rate-setting methodologies and determine what changes should be made to those methodologies
- Discuss whether or to what extent the current array of statutory substance use disorder treatment programs should be consolidated into a single block grant
- **Evaluate the fiscal impact of the model**
- Anything else the Department wishes to add
JCR Timeline

• Writing — in process

• Stakeholder review and comment period — approximately five days

• Due date: December 1
Fiscal Impact of the Behavioral Health Integration Model
Key Areas of Responsibility for ASO

Medicaid Covered Benefits
- Continue to administer Medicaid specialty mental health services
- Administer Medicaid substance use disorder services

Uninsured and Non-Medicaid Covered Benefits
- Continue to administer mental health services to the uninsured and benefits not covered under the Medicaid program
- Administer outpatient substance use disorder services to the uninsured population ("services that would be covered by Medicaid if a person were enrolled in Medicaid")
- Pre-authorize all residential substance use disorder treatment
  - Locals determine payment process for residential providers
Other Potential Drivers of Cost

• Medicaid Expansion under Affordable Care Act
  – Impact not unique to behavioral health integration
  – Primary Adult Care (PAC) recipients have already been receiving outpatient behavioral health services
  – PAC recipients will now be eligible for full benefits

• Uninsured / Non-Medicaid Programs and Services
  – Continued need for services not covered by Medicaid or Qualified Health Plans
Estimating ASO Cost Using Current ASO (~1.5% of the cost of the service benefit)

<table>
<thead>
<tr>
<th>Specialty Mental Health Populations</th>
<th>$ Millions</th>
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</thead>
<tbody>
<tr>
<td>Populations</td>
<td>FY 2011</td>
</tr>
<tr>
<td>Uninsured</td>
<td>$19.8</td>
</tr>
<tr>
<td>Medicaid—State-Only Covered Services</td>
<td>$44.1</td>
</tr>
<tr>
<td>Medicaid—Covered Services with Federal Match</td>
<td>$591.3</td>
</tr>
<tr>
<td>Total</td>
<td>$655.2</td>
</tr>
<tr>
<td>Cost of ASO Contract</td>
<td>$9.97</td>
</tr>
<tr>
<td><strong>Percentage of Service Cost</strong></td>
<td><strong>1.5%</strong></td>
</tr>
</tbody>
</table>

*FY 2013 is not complete—providers have 12 months to bill.*
Defining Substance Use Carve Out

- The Department is working on defining the substance use disorder procedure codes and diagnoses that will be covered under the ASO.
- For inpatient and outpatient hospital services, our goal is to focus on certain revenue codes where the primary diagnosis is related to substance use.
- MCO will still be responsible for medical issues resulting from long-term substance use disorders, e.g., cirrhosis of the liver.
Medicaid Tracks Expenditures on Outpatient Substance Use Services

Medicaid Outpatient Substance Use Spending, FY 2012

<table>
<thead>
<tr>
<th>Program</th>
<th>Non-Pharmaceutical</th>
<th>Pharmaceutical</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-service</td>
<td>$3,903,248</td>
<td>$811,092</td>
<td>$4,714,340</td>
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<tr>
<td>HealthChoice</td>
<td>$43,912,586</td>
<td>$13,700,388</td>
<td>$57,612,974</td>
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<tr>
<td>PAC</td>
<td>$27,915,033</td>
<td>$9,822,942</td>
<td>$37,737,974</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$75,730,867</strong></td>
<td><strong>$24,334,422</strong></td>
<td><strong>$100,065,289</strong></td>
</tr>
</tbody>
</table>

Note: Expenditures do not include lab services.
MCO Rates Will Be Adjusted

• Downward adjustment will be applied to the rates paid to the MCOs
• Adjustment will be determined by actuaries
• Calculations will take place during the 2015 rate-setting process, which begins February 2014
Lost Rate Stabilization Funds

- Fund collects monies from a two percent tax on MCO revenue
- This tax is not applicable to ASO arrangements
- A carve-out of substance use disorder services therefore lowers the tax revenue collected by the State related to the premium tax on MCO revenue
Proposed Allocation of Risk-based Performance Measures

• Up to 10% of the ASO contract could include risk-based performance measures
• Proposed allocation breakdown:

<table>
<thead>
<tr>
<th>Allocation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationally-recognized consumer outcome measures</td>
<td>25%</td>
</tr>
<tr>
<td>Other State-specific consumer outcome measures</td>
<td>25%</td>
</tr>
<tr>
<td>Customer service metrics</td>
<td>30%</td>
</tr>
<tr>
<td>Provider service measures</td>
<td>20%</td>
</tr>
</tbody>
</table>
New Activity: ASO Will Administer Some Substance Use Services For Uninsured

- Outpatient services will be pulled out of the local grants provided by the ADAA
  - Services that would be covered by Medicaid if a person were enrolled in Medicaid
- ASO will manage these services for both the uninsured and Medicaid enrollees, allowing the same organization to make service determinations for all populations
New Activity: ASO Will Authorize All Residential Substance Use Treatment

- Local jurisdictions will be able to choose whether they would like to pay for residential services
  - These services are not entitled to federal matching dollars under Medicaid
- ASO must approve these services regardless of what option the local jurisdiction selects
Improving Quality of Care and Bending The Cost Curve

- The goal of the new Behavioral Health Model is to improve quality of care by:
  - promoting better continuity of care
  - ensuring prior-authorizing/service placement criteria is applied consistently across populations
  - providing more accountability through risk-based performance measures and other initiatives
  - aligning incentives across the system

- This will also result in lower service costs, *e.g.*, fewer hospital readmissions
# Summary of ASO Costs

<table>
<thead>
<tr>
<th>Areas Impacting Overall Costs</th>
<th>Impact</th>
</tr>
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<tbody>
<tr>
<td>Specialty Mental Health Services Medicaid and Non Medicaid</td>
<td>Neutral – Already Under ASO</td>
</tr>
<tr>
<td>Medicaid Substance Use Services</td>
<td>New Cost</td>
</tr>
<tr>
<td>Outpatient Substance Use Treatment Uninsured</td>
<td>New Cost</td>
</tr>
<tr>
<td>Residential Substance Use Treatment – Prior-authorization</td>
<td>New Cost</td>
</tr>
<tr>
<td>Lost Revenue from Rate Stabilization Fund</td>
<td>Lost Revenue</td>
</tr>
<tr>
<td>Medicaid MCO Rate Adjustment</td>
<td>Cost Offset</td>
</tr>
<tr>
<td>Improving Quality of Care and Bending the Cost Curve, e.g., lower readmissions</td>
<td>Savings</td>
</tr>
</tbody>
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Questions