

**Behavioral Health-Primary Care Integration  
Collaborative  
Working Paper # 2:  
Medicaid Financing and Behavioral Health Care**

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POLICY RESEARCH GROUP

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### **About Health & Medicine Policy Research Group**

Health & Medicine is a Chicago based non-profit working to improve the health of all people in Illinois by promoting health equity. Founded in 1981 by Dr. Quentin Young, it was formed as an action-oriented policy center—nimble, independent, and focused on regional health issues. Health & Medicine's mission is to promote social justice and challenge inequities in health and health care. It conducts research, educates and collaborates with other groups to advocate policies and impact health systems to improve the health status of all people. Health & Medicine has successfully developed health policy recommendations and implementation strategies for different public and private entities, earning the trust of the legislature, advocates, the media, researchers and policymakers at all levels of government in Illinois to become the region's "honest broker" on healthcare policy matters. Learn more at [www.hmprg.org](http://www.hmprg.org).

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## **The Learning Collaborative Working Papers Series**

Recognizing that the stigma that people with mental illness face in their daily lives is also reflected in the budgets and regulations of programs that serve them, in 2015 Health and Medicine's Center for Long-Term Care Reform launched a new initiative to make behavioral health policy a priority. Our advocacy focus had for years been on moving the long-term care system for older adults and people with disabilities away from institutions and towards home- and community-based services (HCBS). Our policy analysis was therefore directed mostly at Medicaid and, in particular, on Illinois' waiver programs for HCBS. Unknowingly, this advocacy and policy focus largely left out mental health policy because, as we shall see, home- and community-based services for people with mental illness are provided under different rules and authorities.

However, recovery from serious mental illness is a life-long process, and therefore may require long-term services and supports (LTSS), just as some older adults and people with disabilities need LTSS. Programs and providers that serve the psycho-social as well as the medical needs of people with mental illness are too often siloed and marginalized within the overall health and social services system, resulting in fragmented services, exceptional challenges to information sharing and care coordination, and chronic underfunding of programs.

These factors make mental health policy a natural fit for the Center's mission, and we pursued our first major project in this area with funding from the Blue Cross Blue Shield Foundation, a behavioral health-primary care integration learning collaborative. The Learning Collaborative seeks to create a space for providers, consumers, and advocates to share ideas and information to help advance the goal of integrating behavioral and physical health care, particularly within the structure of Medicaid.

We embrace bidirectional learning, in which primary care and behavioral health providers learn from one another, and policy research informs practice as practice guides research. Through our Working Papers series, we seek to engage a broader constituency in a dialogue about the work of the Learning Collaborative. We encourage and look forward to reactions from readers--comments, criticism, stories, and ideas big and small.

## Introduction

Efforts to integrate behavioral and primary health care aim to improve overall quality of care by coordinating primary and behavioral health care providers, aligning care plans, and negotiating financial incentives to be more responsive to patient needs. This working paper will examine the role of Medicaid financing for institutional and community-based long-term services and supports as well as draw attention to the unintended consequences of various reforms and the continuing relevance of the history of Medicaid financing and service delivery for people with mental illness.

The goal of this paper is to attract expertise concerning the nature of the federal and state relationship with Medicaid, the Waivers and State Plan Amendments used to expand Medicaid coverage, and the re-advent of managed care. Through the dialogue this paper generates, we hope to engage the broader constituency of the Learning Collaborative demonstrating our interest in these important—albeit often esoteric and unattractive—issues. The economics of behavioral health care often get overlooked and our goal is to not only bring these topics to the fore, but to cultivate existing experts on various economic issues surrounding behavioral health care reform to clarify possibly confusing points of view, and to then take this information and re-express it in a generally accessible manner.

*While overall LTSS spending has shifted to majority HCBS, in fiscal year 2013 only 36% of Medicaid spending on programs for people with mental illness was for HCBS.*

We believe that by presenting our best understanding of these issues and actively seeking feedback from people with different perspectives and experience, we can inform the work of the Learning Collaborative to more effectively develop practice models and advocate for policies aimed at improving the integration of primary and behavioral health care.

Over the last 25 years, Medicaid has primarily shifted from paying for institutionalized long-term services and supports (LTSS) to allowing some flexibility to pay for home- and community-based services (HCBS). Of the \$146 billion that Medicaid spent on LTSS in fiscal year 2013, 51.3% went towards HCBS and this number is projected to reach 63% of total LTSS payments by 2020.<sup>1</sup> This new flexibility has influenced—in sometimes unexpected ways—the push to minimize the uses of institutional care and instead utilize community-based services for older adults, people with disabilities, and people with mental illness.

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<sup>1</sup> <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>

However, while overall LTSS spending has shifted to majority HCBS, in fiscal year 2013 only 36% of Medicaid spending on programs for people with mental illness was for HCBS. Enhancing services available in the communities where people live is an important prerequisite for integrating the often fragmented primary and behavioral health systems. People often receive behavioral health separately from primary health care, which leads to a break in the continuum of care, resulting in poorer overall quality of care and the exacerbation of illness. Medicaid is the main source of funding for institutional and community based LTSS, and Medicaid's role, structure, and financing are important aspects to understand if true behavioral and primary health integration is to occur.<sup>2</sup>

In any discussion of new health care policy, we need to understand how Medicaid reimbursement rates and regulations influence the actual delivery of services, and--in the case of behavioral health--the reasons for the current over-reliance on institutional and non-integrated health care. Medicaid financing and regulatory systems give rise to specific business models that too often thrive in an unbalanced environment. Stakeholders may also act to preserve their "proven" business models rather than adapt to reform agendas that may or may not take root. Proper analysis of the history, economics, and politics that created the current behavioral health system requires the input of professionals in the field, as well as people with lived experience, in order to make policy recommendations that take into account the realities of the current health care system. The complex interaction of interests of a diverse array of stakeholders on one hand, and ideas for system transformation on the other, shapes the direction of reform in often unexpected ways.

The following portions of this paper attempt to create an outline of the complications—specifically financial burdens—of implementing behavioral health care reform. We will start by mentioning a brief history of Medicaid and some of the methods used to find room to maneuver in Medicaid regulations and to increase Federal match. We will then address methods that are used to fund HCBS, and why those methods cannot be used to fund behavioral health care under the current system. This paper will then outline the difficulty in providing behavioral health care through 1915 (c) waivers. We further explain the provisions of the waiver authority, and how those provisions along with Medicaid rules prevent the use of this waiver for expanding HCBS to long-term behavioral health services. We briefly mention Illinois Rule 132 and Rule 2060/2090; the brevity of this section is intended to illicit robust discussion on all issues concerning the Illinois Medicaid HCBS authority covering behavioral health. The following sections will attempt to provide a context for the history and complexity of Medicaid funding of health care in general and specifically behavioral health, and some describe some illustrative cases of unintended consequences of Medicaid financing policy. Our discussion concludes with a look at the latest attempts to implement managed care and the promise and perils of capitation.

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<sup>2</sup> (Paradise, 2015)

Our ultimate goal with this paper is not to project definitive understanding of any of the topics discussed. If this paper is successful, we will have touched on topics that many of the Learning Collaborative members and other stakeholders have thought about, know about, or know someone who is an expert (or as much of an expert as one can be). Our conclusion is not one dictating concrete answers to any issue discussed in this paper, rather we are asking for any information—as long and complicated as people would like to offer—in order to expand our knowledge of these impossibly complicated issues.

## **The Unfinished Path to Deinstitutionalization and Recovery**

In the 1960s, deinstitutionalization aimed at shifting patients from asylums into the community. However, despite the best intentions of mental health advocates, the push for “community” based mental health care led instead to trans-institutionalization, with patients moving from large state operated psychiatric hospitals to smaller private, largely for-profit nursing homes (and also to jails and prisons). The economics of Medicaid—which explicitly restricted the use of certain institutions through the “IMD exclusion” (to be further explained later), and effectively restricted community-based services through coverage and reimbursement policies—offered opportunities for nursing facilities to successfully step into the mental health care market.

*Bringing prevention to the forefront of behavioral health care is an important step toward integration of behavioral and physical health care to achieve optimal outcomes in both.*

Medicaid policies tend to restrict access to mental health services until an individual’s illness has resulted in disability, creating a barrier to recovery-oriented care. Furthermore these services rely on a fee-for-service payment methodology that enforces a limited menu of services, which creates a bias toward medical-model institutional care that is better equipped to handle severe mental illness under a fee-for-service model. However, dollar for dollar, HCBS has been and remains a much better deal for the Medicaid program than institutions. For example, in 2004 Illinois spent \$237,614,428 to provide services to 4,680 mental health patients in privately-funded Institutes for Mental Disease—over \$50,000 per person. In that same year, Illinois spent \$357,373,931 on community based behavioral health care for 291,080 people, or less than \$1,300 per person.<sup>3</sup> Yet in 2010, 500,000 people with mental illness (excluding dementia) still resided in Illinois nursing homes while the State budget for community-based mental health and addiction treatment services was cut by \$113 million between 2009 and 2011.<sup>4</sup> Thus, the overreliance on institutions can be explained in part by the continuing influence of a crisis-oriented medical model in the provision of mental health care, where often behavioral health issues become acknowledged and treatment becomes accessible only after a severe presentation of symptoms. This crisis-response orientation of behavioral health is in stark contract to the insistence on person-centered and preventive care in primary health care. Bringing prevention to the forefront of behavioral health care is an important step toward integration of behavioral and physical health care to achieve optimal outcomes in both.

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<sup>3</sup> Law and Disordered (Klein, 2009)

<sup>4</sup> (Grabowski, 2010) cite budget cut number (I got it from Heather’s flyer)

Person-centered, preventive services in behavioral health care is perhaps best represented by the recovery-model. Seeking to complete and expand the never fully realized deinstitutionalization policy, a new vision of a recovery-oriented mental health system looks beyond how buildings and service providers function, to how individuals function. A 2004 Consensus Statement on Mental Health Recovery published by SAMHSA defined mental health recovery as “a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”<sup>5</sup> A recovery-oriented system adapts service options and service delivery—arguably, even in an institutional setting—to the needs of individuals in recovery to support this goal, which is much better aligned with person-centered primary care medical homes.

The overreliance on institutions can be explained in part by the continuing influence of a crisis-oriented medical model in the provision of mental health care and the incomplete transformation of the system in accordance with “recovery principles.” Medicaid policies that restrict access to services until an individual’s illness has resulted in disability and pay on a fee-for-service basis for a limited menu of services that are not responsive to the needs of individual consumers are barriers to recovery-oriented transformation and create a bias toward medical-model institutional care. A truly recovery-oriented system would, in contrast, adapt service options and service delivery—arguably, even in an institutional setting—to the needs of individuals in recovery to support this goal.

Understanding the economic incentives and federal funding guidelines that support our current, more crisis-orientated system can help us work with institutions to better utilize community based care and find ways of integrating the two, often separate, health care structures. By not only addressing the issue of institutionalization but also continuing the work to integrate physical and behavioral health care, this transformation could enable better health care overall.

## THE IMD EXCLUSION

One very important categorical exclusion from federal Medicaid matching payments is the IMD exclusion. IMDs are Institutes for Mental Disease: facilities with more than 16 beds that have more than 50% of residents admitted based on a diagnoses of mental disease, which includes substance use disorders. Federal Medicaid statute prohibits federal payments for residents between 21 and 65 residing in an IMD. The intention of the IMD exclusion was to ensure that the new Medicaid program was not misused to supplant state financing for inpatient psychiatric services with new federal dollars, and to avoid creating an incentive to over-utilize those institutional services for individuals with behavioral health conditions. The impact of the IMD exclusion on access to services on the one hand—residential treatment for substance use disorder, for example—and the civil rights of individuals who may be inappropriately institutionalized without the rule, is highly controversial. Debating the merits of the IMD exclusion and various [proposals](#) to revise or repeal it is outside the scope of this paper, though we welcome comments from readers. The IMD exclusion interacts with other provisions in the Medicaid program to create unintended consequences for

<sup>5</sup> <http://store.samhsa.gov/shin/content/SMA05-4129/SMA05-4129.pdf>

## REIMBURSEMENT OVERVIEW: MEDICAID, WAIVERS, PROVIDER TAX

In this section we are going to tell an old story with a new frame. We expect many readers are very familiar with the basics of Medicaid financing, but here we will summarize that system with an eye toward the complex incentives and unintended consequences for mental health care that the structure of the Medicaid program generates, and inexorably regenerates throughout the decades.

Medicaid is a joint state and federal program, meaning the state and the federal government share both regulatory and financial obligations. The Federal government outlines various mandatory and optional Medicaid services that describe reimbursement, quality of services, type of services and eligibility<sup>6</sup>. Each state that participates in Medicaid must provide for all mandatory Medicaid provisions, and can choose some or all of the optional provisions. Each state's individual compilation of these provisions makes up the state plan, and acts as an agreement between the State and the Federal government, according to which the state share of Medicaid spending is matched by a federal share. When a state pays for Medicaid-covered services, the federal government matches a certain percentage between 50% and 83%—the Federal Medical Assistance Percentage, or FMAP--of those state expenditures. Each state's FMAP is calculated based on its median income, and federal match is *only* paid for state Medicaid services approved by the Federal government.

Because federal matching payments bring additional resources into the state Medicaid budget, there is a strong incentive to maximize that federal revenue stream—one even hears the term FedRevMax to describe this strategy. While federal dollars are important sources of financing for medical and social services, the maximization of federal match can drive resource allocation at the expense of sound policy. With regards to behavioral health care much of the treatment does not follow the same principles of the traditional medical model. Behavioral health care is often not as simple as sitting in a doctor's office, and can require significant time planning and even trying to get into contact with a patient –little of which is covered by Medicaid and therefore available for federal match.

One obvious example is the lack of supportive housing for people with mental illness and substance use disorders. The federal government will not allow Medicaid matching payments for housing, but expenditures on emergency room visits are matched. Providing housing, in most cases, would do more to stabilize an individual and support their recovery than intermittent ER visits, and at less cost to Medicaid. The system of state expenditure

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<sup>6</sup> (Substance Abuse and Mental Health Services Administration, 2013)

and federal matching payments strongly dis-incentivizes unmatched state expenditures, however, making payments for housing a very difficult sell to state leadership.

Later in this paper we will encounter other examples of federal match-driven policy, especially when Medicaid providers themselves pay portions of the ‘state share’ to generate federal match. This is a complex topic and our goal is not an exhaustive policy review but a high-level overview of its relevance to the day-to-day experience of service providers and recipients, as well as to policy-makers and would-be reformers. We welcome comments from readers on risks and opportunities presented by federal revenue maximization strategies

## 1915 (C) WAIVERS

Many services are enumerated as mandatory covered services in Title XIX the Social Security Act (SSA), which governs Medicaid. There are also sections of the SSA that define rules for optional services that states may choose to include in their Medicaid programs. If states comply with federal rules for those optional services, they can receive federal match on the costs.

Sections 1915 (c)-(k) of the Social Security Act create options for states to expand Medicaid coverage of HCBS as alternatives to institutional care. In Illinois, 1915(c) waivers are a major vehicle for providing HCBS. We have nine different HCBS waivers that expand services to older adults, people with physical disabilities, traumatic brain injuries, HIV/AIDS, or developmental disabilities. The goal of these waivers is to reduce over-use of costly institutions for long-term care. Waivers are *not* an open-ended commitment from the federal government to finance home- and community-based services. There are two main ways that 1915(c) waivers control eligibility and costs. First, to target individuals at the most risk of institutionalization, a functional eligibility limit is set at an “institutional level of care,” meaning that assessments of a waiver service recipients must indicate impairments that would require nursing home care in the absence of waiver services. This eligibility restriction is another barrier to preventive care, as individuals must become so functionally impaired that they require a nursing home before they can access other, community based services that could provide the supports for

### Broken Incentives: when I produce the value and you accrue the savings

The IMD exclusion has the unintended consequence of interfering with budget neutrality of HCBS programs for people with mental illness. This is just one example of a general problem facing efforts to ‘reward value’ in health care. Community-based behavioral health providers may produce value in the form of cost-effective treatments that support individual recovery while reducing utilization of costly services like inpatient hospitalization and nursing home placement. But the savings they produce are often accrued by a different entity, and a different payer. In some cases the hospital cost that is saved accrues to Medicare, while the cost of the community intervention was paid for by Medicaid. In other cases the savings accrue to the correctional system when arrests and incarceration are prevented by effective mental health care. But those savings are not re-invested across the silos of Medicaid agencies and Departments of Corrections. This disconnect is a serious barrier to innovation and value-based payments.

recovery that would reduce or eliminate the need for such intensive and costly services in the future. Delayed intervention is a problem throughout the long-term care system and not only in behavioral health.

*We welcome input from readers on HCBS waiver policies, alternatives to waivers, and research on preventive services for older adults and people with disabilities who use LTSS.*

The second limitation on waiver services is the budget neutrality provision that requires that expenditures on HCBS do not exceed what the State would have spent on institutional services. For older adults and people with non-psychiatric disabilities, waiver services that prevent an institutional placement may pay for themselves by saving the money Medicaid would have paid for a skilled nursing facility or state operated developmental center.

That process breaks down for community-based mental health services. As we have seen, institutions for people with mental illness—IMDs—are not reimbursed by Medicaid. Therefore, a Medicaid dollar spent on HCBS for an adult is not a Medicaid dollar saved from institutional care, because Medicaid wasn't paying for the institutional care in the first place. Mental health HCBS providers cannot 'count' the cost of IMDs in their budget neutrality calculation, making 1915(c) waivers unworkable except for some services for children (because Medicaid does pay for certain institutional care for individuals under 21 years old).

*There is evidence that increased flexibility in budget neutrality requirements can facilitate expansion of community-based alternatives to institutions.*

Functional eligibility and budget neutrality provisions of 1915(c) waivers are barriers to providing community-based mental health services. However there is evidence that increased flexibility in budget neutrality requirements can facilitate expansion of community-based alternatives to institutions. The experience with 1915(c) waivers for people with developmental disabilities shows clear benefits of just that type of flexibility. In 1987 a federal budget reconciliation act loosened some of the budget neutrality provisions for services pertaining to individuals with developmental disabilities, and as a result many 1915(c) waivers have since been used to cover services for people with developmental disabilities. This policy change incentivized waivers that covered HCBS for children and adults with developmental disabilities as alternatives to institutionalization, but no such incentive has been created for HCBS for people with mental illness. Thus in 2011 71.7% of the \$38 billion spent on 1915 (c) waivers went to providing HCBS for people with developmental disabilities, and only 0.3% went to pay for services for people with mental illness and severe emotional disturbance<sup>7</sup>. Despite the enormous barriers, some

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<sup>7</sup> (SAUCIER, 2013)

states do use 1915 (c) waivers to expand HCBS for people with mental illness—both Connecticut and Montana use a 1915 (c) waiver for people over 22 with mental illness—however, most 1915(c) waivers for people with behavioral health conditions pertain to children, who are not subject to the IMD exclusion.<sup>8</sup>

Unlike 1915(c) waivers, the lack of a budget neutrality provision makes the state plan amendments—1915(i)-1915 k)—seem more conducive to expanding mental health care to Medicaid recipients. An added benefit of 1915 (i) waivers, as revised under the Affordable Care Act, over 1915(k) is in some cases people can receive services without meeting “institutional level of care” requirement. This enables the Medicaid funding of HCBS services for early intervention that hold promise to prevent disability and eventual entry into an institutional setting. Furthermore, 1915(i) allows for flexibility on the “rehab” optional provision of Medicaid, facilitating Medicaid billing of “case management” to reimburse for the vital, but often unbillable, outreach and logistical aspects of community care, including locating and engaging with patients and setting up meetings with providers, that are so important to facilitate access to care for people with serious and persistent mental illness.

### **RULE 132 and Rule 2060/2090**

In Illinois, Medicaid mental health services are provided not through waivers (as many other disability services are) nor the more flexible 1915(i) state plan option, but through the Medicaid Rehabilitation Option. Further separating mental health care from other publicly administered health care services, Medicaid Rehabilitation Option services are not regulated by the Medicaid agency, the Department of Healthcare and Family Services, but are instead governed by the Department of Human Services, Division of Mental Health (DMH) through the often-disparaged Rule 132.<sup>9</sup> Substance Use Disorder treatment services are provided under yet another separate authority, Rule 2060/2090, administered by DHS’s Division of Alcoholism and Substance Abuse (DASA). Rule 132 and Rule 2060/2090 offer broad lists of services (including HCBS) billable under Medicaid and therefore eligible for federal match; the added benefit of being authorized under a state plan amendment means there is no budget neutrality agreement for Medicaid expenditures under Rule 132 and Rule 2060/2090. However, Rule 132 and Rule 2060/2090 are notable—even in the confounding world of Medicaid policy—for their tortuous complexity. Some of the problems with these rules cited by providers are duplicative licensure and certification requirements and overly-burdensome, uncoordinated contracting, documentation and compliance processes.<sup>10</sup> Within the DHS-administered mental health care system, the

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<sup>8</sup> (Families USA, 2012)

<sup>9</sup> (Substance Abuse and Mental Health Services Administration, 2013)

<sup>10</sup> See, for example: <http://www.law.uchicago.edu/files/file/Medicaid-reform-cbha-comments-dec-2010.pdf>

shortcomings of Rule 132 and Rule 2060/2090 services are a barrier to innovation and quality improvement. The separation of SUD services in a different rule adds to this complexity, with practical consequences for providers and patients—for example, a DMH-licensed Rule 132 provider may not be licensed by DASA to bill for SUD services covered by Rule 2060/2090.

In the context of integrated primary care and behavioral health services, the separation and complexity of Rule 132 and Rule 2060/2090 is especially problematic. For people with non-psychiatric disabilities, services analogous to those covered under these rules are covered by 1915(c) waivers. Thus there is an administrative fragmentation between 1915(c) services for most recipients of LTSS and state plan option services for people with mental illness. The specialized and Byzantine bureaucracy of Rule 132 and Rule 2060/2090, administered outside of the Medicaid agency that operates waiver programs, creates an especially pernicious silo that strengthens the marginalization of behavioral health services within the health care delivery system. Policy interventions to make Illinois Medicaid LTSS more integrated and person-centered, such as the now-defunct Path to Transformation 1115 waiver, often primarily target 1915(c) waivers for reform, leaving the uncomfortable impression of behavioral health as an afterthought.

*We are looking for experts on rule 132 and Rule 2060/2090, both critics and advocates. The seemingly separate bodies of expertise surrounding Medicaid waivers and DHS Rule 132 and Rule 2060/2090 create a constraint on mutual understanding, collaboration and systemic reform.*

## **PROVIDER TAXES**

So far we have examined methods for providing Medicaid services to various eligible populations. Now we turn to methods of financing Medicaid services. As we have seen, Medicaid is a partnership in which the federal government and each state government pay a share of the costs. Provider taxes emerged as a method to increase federal Medicaid flowing into state budgets by arranging for Medicaid *providers* to contribute to the *state* share of Medicaid. A hospital, for example, can pay a per-bed tax to the state and if the state uses that tax revenue for Medicaid services, that Medicaid spending will generate federal matching funds without additional state budget expenditure. Provider taxes have evolved over time in a push and pull of state creativity and federal rule-tightening. But the large amount of Federal matching funds that provider taxes continue to bring in create an incentive for states to preserve this revenue stream. As a result these taxes have become an inextricable part of the Medicaid system in many states, including Illinois. For example the

Illinois hospital assessment program alone generates about \$1.5 billion in additional annual federal payments.<sup>1112</sup>

Although the word ‘tax’ may imply that providers would resist this arrangement, the additional money in the Medicaid system generally makes provider classes that are subject to these taxes, primarily hospitals and nursing homes, winners from the tax. If providers did balk at extending a provider tax, the State Medicaid budget would be left with a sizeable hole. This creates policy distortions, as preserving revenue from the tax becomes a higher priority than other policy goals.

Federal regulations limit the use of provider taxes to simply “recycle” Medicaid dollars endlessly (provider taxes must be broad based, uniformly imposed, capped at 5.5%, and not “hold harmless” the taxed providers). However, while these rules may mitigate the policy distortions that provider taxes create, they do not eliminate them. In fact, the federal rules can exacerbate this incentive by restricting provider taxes to certain classes of providers, which includes nursing homes and ICF/MRs, but not HCBS providers, as taxable provider classes. A Lewin Group report for the State of Missouri highlighted the “skewed cost-benefit calculations for otherwise good policy actions,” such as reducing hospital and nursing home utilization, that result from overreliance on provider taxes.<sup>13</sup>

## **Managed care for behavioral health**

Provider taxes, like any tax, can become structurally complex, but at their core they are a fairly straightforward federal revenue maximization strategy. A more programmatically ambitious and operationally challenging Medicaid financing strategy is capitated managed care. In an attempt to curb growing health care costs, Medicaid is increasingly attempting to harness the profit motive by using capitation and privatization to incentivize the reduction of unnecessary procedures and support high value treatment.<sup>14</sup> Capitation is designed to replace fee-for-service reimbursement with a more flexible system with better incentives for quality, cost-effective care.

In Illinois, capitated managed care in Medicaid is fairly new, and mandatory managed care programs have only been dominant in the last few years. If this system works as policy makers expect, capitated managed care should accomplish three goals: 1) improved health

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<sup>11</sup> (National Conference of State Legislatures, 2014).

<sup>12</sup> (ilga.gov)

<sup>13</sup> (Group, 2010)

<sup>14</sup> (Dianne Hasselman, 2014))

care services for Medicaid enrollees, 2) lower costs and budget predictability for the State, and 3) profit for the MCOs.

Under capitation, the State Medicaid agency pays managed-care organizations (MCOs) a per-person-per month rate based on an actuarial analysis of historical fee-for-service payments. MCOs agree to provide care coordination functions, meet quality standards, and abide by other contractual requirements for things like network adequacy and consumer protections. But the capitated payment methodology offers flexibility to provide services that are not covered under traditional Medicaid and to pay providers in different ways, like value-based purchasing or shared savings arrangements. The classic example is the case of Medicaid patients during a heat wave. Fee-for-service Medicaid will pay for the emergency room visits and hospitalizations for heat stroke. Managed care organizations have the option of paying for air conditioners for the most at risk plan members, preventing a crisis for the member and avoiding hospital costs for the plan.

*Creative contracts between MCOs and health care providers can emphasize quality quantity of services.*

This basic model is important for behavioral health as well. Fee for service (FFS) billing systems do not provide a method to bill for many of the services that patients with mental illness or substance use disorder require. As implied in the name, fee-for-service providers can only bill for actual authorized services they provide, which tend not to include staff time it takes to locate and engage patients, other necessary logistical steps required for recovery-oriented treatment, or physical health interventions that occur during a behavioral health-coded encounter. Some of these “support” services, like outreach and engagement with patients, are necessary because without them, direct treatment becomes difficult or impossible. Other services that are covered under FFS Medicaid may include restrictions that make them a poor fit for patients with co-occurring mental and physical health conditions. For example, the FFS methodology that requires primary care providers to bill for 15-minute visits is a major barrier to integrating behavioral health into primary care services, where additional screenings and brief interventions during the primary care encounter necessitate longer visits. Capitated managed care, in theory, allows reimbursement for the provision of support services as well as direct treatment.<sup>15</sup> Ideally managed care would allow MCOs to use their capitated payments to contract with providers for the services that their members need to stay healthy and in recovery (and out of hospitals and nursing homes) as opposed to relying on the restrictive guidelines of fee-for-service billable codes.

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<sup>15</sup> (Joshua M. Wiener, 1998)

Capitated managed care, however, can be deep or shallow. If it reaches deep into the actual health care delivery system, beyond the State-MCO relationship, MCO-provider contracts, supported by smart capitated rate setting and effective pay-for-performance quality measures, can shift on-the-ground practice. Creative contracts between MCOs and health care providers can emphasize quality treatment over the quantity of treatment that FFS incentivized. Furthermore following a reimbursement model based on quality standards can lead savings to from reduced hospitalization and nursing home placements which can then be re-invested in more cost effective community-based providers.<sup>16</sup> This can help nudge the mental health care system away from crisis-response (and even in that regard the current system is inadequate) and toward recovery. By shifting payment systems away from FFS, managed care and capitation could help correct the reliance institutions in mental health care.

However, without changes in state administrative processes to shift from the fee-for-service role of paying providers directly, to the new role of overseeing managed care contractors, the dysfunctions of fee-for-service will continue to hold back system change. Under fee-for-service, State agencies performed the key function of provider payment review. In mandatory managed care areas in Illinois, that responsibility currently falls on MCOs who take on risk for health spending through capitation. In some ways the adaptation of State operations to that new assignment of risk and responsibility is the 'limiting reactant' in the transformative potential of managed care. On one end of the spectrum of possibility, the State can use capitation simply to ensure greater budget predictability but maintain legacy fee-for-service rules that hold back changes for providers and consumers on-the-ground. On the other, more ambitious, end of the spectrum, the State can examine those rules and processes, revising them to shift from fee-for-service payment review to monitoring quality and holding MCOs accountable to their contract requirements. The latter case allows MCOs more flexibility in how they pay providers while, maintaining a level of accountability to the State for the quality of services they provide to their members.

The current evidence for quality improvement and cost control from capitated managed care is mixed.<sup>17</sup> The "promise" of managed care that we have perhaps optimistically referred to here is still unfulfilled, and the ability of the State to monitor, regulate, and improve on the performance of MCOs is crucial to realizing the benefits and mitigating the risks of shifting so much responsibility to private contractors. We at Health and Medicine contend that the most effective role for the State to play is to monitor MCOs' performance and carefully withdraw from its provider payment review role. The State should identify

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<sup>16</sup> (National Health Care Purchasing Institute, 2002)

<sup>17</sup> (Dickson, 2015)

MCO strategies that work to improve outcomes and incentivize their broader adoption, while at the same time detecting and responding to signs of fraud and abuse.

Under the current form of managed care a sort of vicious cycle appears to have arisen in which experiments with outcomes-based, non-fee-for-service payments are thwarted by outdated rules, thus perpetuating the very problem managed care was introduced to fix. In areas of the State with mandatory managed care, the State pays capitated rates to MCOs, which then contract with, and also pay providers. In many cases, providers simply bill MCOs just as they billed the State under fee-for-service. However, one goal of Medicaid managed care in Illinois was to encourage new, outcomes-based payments between providers and MCOs. However, instead of supporting providers and MCOs to take the initiative to experiment with creative reimbursement methodologies, the state often stymies these attempts using legacy fee-for-service rules.

Here is just one example, based on conversations with a behavioral health care agency. An MCO agreed to pay the agency a case rate to provide services to people with severe and persistent mental illness who were the highest utilizers of ERs and hospitals. The case rate included the costs of outreach and patient engagement services that would not be billable under FFS Medicaid. The agency agreed to report the services it delivered, the costs, and outcomes to the MCO. However, the agency also continues to report its billable services to the Department of Human Services.

*The right question is, “Does this payment arrangement produce improved outcomes for Medicaid members?”*

If this double reporting was merely an additional administrative burden on providers, it would not be a major, system-level concern. A deeper problem arises when the State compares the case rate the MCOs pay to the behavioral health agency to the *billable* services delivered by that agency. The total dollar amount of billable services is likely to be less than the total dollar value of the MCO case rate, because the MCO rate includes a larger package of services than what is billable under fee-for-service. This is precisely the kind of flexibility envisioned by capitated managed care, absent any evidence of collusion and fraud, the right question for the State to ask about this discrepancy is, “Does this payment arrangement produce improved outcomes for Medicaid members?” Yet, the State still primarily orients itself toward payment review, not quality monitoring. As a result, the State questions the case rate and may penalize the MCO by refusing to cover significant portions of the case rate cost as a covered medical expense.<sup>18</sup> We miss a greater

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<sup>18</sup> Illinois requires managed care plans to meet a minimum medical loss ratio (MLR)—the percentage of capitation payments spent on services for members (rather than administration and profit). The State and MCOs negotiate over what costs are included in the MLR and which are not. We are arguing that the risk that costs associated with

opportunity for system change when the State acts as a short-sighted watchman over Medicaid expenditures without fulfilling what should be its new role in managed care to oversee and support changes in provider-level payment and service delivery. If the State continues to see some of the “creative” medical expenditures as illegitimate, MCOs may stop allowing creative partnerships with providers because of the risk associated with paying for both actual service costs combined with the penalties from the state for unaccepted costs.

To be clear, the administrative changes necessary to support flexibility and innovation without opening the door to fraud and abuse are not easy. Furthermore, the rigorous collection and analysis of accurate claims, encounter, and outcome data is a necessary a step toward the transformation to recovery based-models of integrated care.<sup>19,20</sup> If no current, accurate data exists to determine if the new and “improved” system is actually working, any innovative payment system will simply be dysfunctional in a new way. This illustrates a critical issue with the capitated payment system used by Illinois’ managed care programs: in order to measure the quality of managed care the State is paying for, better data collection and a method to discern what quality care actually means is imperative.

Any health reform effort is going to be built on a foundation of historical policy and practice that won’t be easily altered. Health & Medicine believes that integration of behavioral health and primary care is a priority for health reform, and we see opportunities and risks in moving to test new models of integration in Illinois. In particular we see possibilities for dynamic new partnerships between payers and providers, encouraged in Medicaid by a careful implementation of managed care. We welcome responses to this section from payers, providers, and consumers with experience and expertise in managed care.

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case rates and other non-fee-for-service payment arrangements will be rejected from MLR calculations can be a barrier to innovation in MCO-provider contracts.

<sup>19</sup> (Adamopoulos, 2014)

<sup>20</sup> (Sweeny, 2015)

## **Conclusion**

Policy advocates need to understand the unintended consequences of federal reforms, Medicaid rate adjustments and rule amendments, and the expansion of managed care in order to avoid inequitable shifts in control of funds and resources. . However the problem, as we have come to see, is that this healthcare system and the methods used to pay for services is inconceivably complex, and with every bit of understanding comes a multitude of complicated questions. Yet this is not to say understanding health care/Medicaid finance in Illinois is not worth attempting. Implementing innovative policy and supporting effective treatment methods requires that health policy advocates must understand the economic incentives and financial viability of any desired program. This paper sketched out a few historical examples and current challenges related to Medicaid financing, complex interactions of interests and ideas, and unintended consequences of reform. Our goal is to call upon those in our learning collaborative and their extended networks to elucidate parts of this complicated health care payment structure and simplify it to the extent that it can—at the very least—be used to further policy goals, and at best—to educate the general public to allow people to better utilize services and understand the system they are a part of.