ISSUE BRIEF
OCTOBER 2017

Assessing Changes to Medicaid Managed Care Regulations: Facilitating Integration of Physical and Behavioral Health Care

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ABSTRACT

ISSUE: As states consider how to effectively control Medicaid costs, many are looking to integrate behavioral and medical care, including long-term services and supports, particularly for individuals with complex needs.

GOAL: To summarize how recent federal regulations are encouraging an integrated approach to behavioral and physical health care.

FINDINGS AND CONCLUSIONS: Two recent federal rules issued in 2016 are facilitating the transition to integrated care models: the Medicaid managed care rule and the Medicaid managed care mental health parity rule. These changes may not spell the end of fragmented systems, but they certainly do not support a status quo approach to care. While the regulations do not specifically address integrated care, they should facilitate and, in some instances, encourage, state movement to integrated care for Medicaid participants.

KEY TAKEAWAYS

- Recently updated regulations for Medicaid managed care should encourage a more coordinated system of care that targets the individual's needs.
- The mental health parity rule should improve access to certain types of care and could prompt states to use more comprehensive and integrated approaches to providing care.

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BACKGROUND

Many states have Medicaid systems that separate physical, mental health, and long-term services and supports (LTSS). But the integration of physical and behavioral health care can improve quality and decrease costs, especially for people with complex health care needs. This brief explores the impact that the U.S. Department of Health and Human Services' recently updated Medicaid managed care regulations are likely to have on integrated care models.

The population of Medicaid beneficiaries with complex health care needs and high costs has a disproportionate impact on a state's Medicaid budget: 5 percent of Medicaid beneficiaries account for 54 percent of total Medicaid expenditures, and 1 percent account for 25 percent of total program expenditures.[1] As states look to change their systems to control costs more effectively, many have begun to look to integrated health care as an approach for individuals with high health care costs and complex needs, including those who receive LTSS.[2] Although there is no one model of integrated care, the most common target populations for integrated care are individuals with two or more chronic conditions, older adults, and those with moderate or severe mental health conditions.[3]

State Medicaid systems are looking to integrated care to serve not only specific high-need populations but also the broader Medicaid population. For example, Arizona merged its physical health and behavioral health Medicaid systems in 2015, initially focusing integrated care efforts on those with serious mental illness and expanding integrated care into policy decisions, purchasing strategies, and agency infrastructure.[4] Similarly, North Carolina is working toward using an integrated care model under managed care for nearly all its Medicaid population.[5]

State Medicaid systems may face barriers in moving to integrated care models more so than private health systems. In many states, health care is provided across departments with different controlling state statutes, state regulations, billing systems, operating procedures, and approved Medicaid state plan amendments and waivers. Using a managed care entity to operate Medicaid in an integrated way will not eliminate all these barriers.[6]

A number of federal laws and regulations are facilitating the transition to integrated care models (see sidebar below). We focus primarily on provisions in two key rules:

- The Medicaid managed care rule (MMC rule), parts of which went into effect in 2016, encourages comprehensive patient assessments, provides states increased flexibility regarding how to use Medicaid payments, and prompts technology and information changes that are important to integrated care models.

FEDERAL LAWS, REGULATIONS, AND PROGRAMS SUPPORTING THE USE OF INTEGRATED CARE MODELS

- **Mental Health Parity and Addiction Equity Act of 2008:** Requires more comparable access between physical and behavioral health services.
- **Affordable Care Act:** Identifies mental health and substance abuse treatment as "essential benefits" and extends requirements of the Mental Health Parity and Addiction Equity Act to small-group and individual market plans created after March 23, 2010.
- **Medicaid managed care rule:** Updates existing requirements to better reflect how states use managed care in Medicaid and support the coordination and integration of health care, promote effective forms of information-sharing, and support greater overall accountability in Medicaid and the Children's Health Insurance Program.
- **Medicaid managed care mental health parity rule:** Implements requirements of the Mental Health Parity and Addiction Equity Act for Medicaid managed care and requires states to ensure physical and behavioral health services are provided in parity in Medicaid managed care.
- **Various value-based Medicare programs:** Medicare opened the door for accountable care organizations and health homes.

- The 2016 rule implementing the Mental Health Parity and Addiction Equity Act of 2008 to Medicaid managed care (MMC mental health parity rule) further supports states in creating features and practices that are key to integrated care models and achieving related improved care quality and cost savings.[7]

Ultimately, these regulations present important opportunities for moving toward integrated physical and behavioral health.

SUPPORT FOR INTEGRATED CARE IN THE MEDICAID MANAGED CARE RULE

The changes to the MMC rule were intended to, among other goals, support the coordination and integration of health care, promote effective forms of information-sharing, and support greater overall accountability in Medicaid and the Children's Health Insurance Program (CHIP).[8] The MMC rule also includes some universal features, such as health risk assessments for beneficiaries, that should promote integrated, comprehensive approaches to care. Integrated care relies heavily on quality care coordination, and the MMC rule made significant changes in this area that align with integrated care principles.

The MMC rule also made other changes that support integrated care models, such as the following:

Improved health information technology. One of the principles behind the MMC rule update is that "all individuals, their families, their healthcare and social service providers, and payers should have consistent and timely access to health information in a standardized format that can be securely exchanged among the patient, providers, and others involved in the individual's care."[9] The requirements in the MMC rule should facilitate the communication necessary for integrated care models.

Changes to payment calculations. The MMC rule broadened the language around rate-setting processes and medical loss ratios to be more inclusive of services needed to ensure integrated care, such as care coordination and case management, in the development of capitation rates.[10]

Implementing value-based purchasing. The MMC rule established mechanisms for states to require managed care entities to implement value-based purchasing models for provider reimbursement. Value-based payments could provide incentives for providers to work with complex care patients. However, if these payments are not structured appropriately, there could be adverse consequences to patients, especially those who need significant care to maintain health stability.

Availability of services and network adequacy standards. The new standards in these areas recognize that more individuals with complex care needs are enrolled in Medicaid managed care and that they likely need access to a variety of specialists. The MMC rule requires states to consider the characteristics and health needs of the covered population and to consider the availability of technology-based services. These requirements may facilitate an integrated care system through an appropriately tailored network and recognition of the role of nonoffice visit services, which may include patient follow-up activities.

Another important feature of the MMC rule related to integrated care is the requirement that states factor in the ability of providers to ensure accessibility for both physical and mental disabilities. Although federal nondiscrimination requirements have always prohibited discrimination, this requirement may cause a state to more closely examine the provider network's ability to meet the needs of the covered population. Other features, such as time and distance standards, will hopefully address some of the access issues, including access to specialists, that may act as barriers to integrated care.

The shift toward using managed care for populations with complex health needs and the rise in using care coordination for more than just primary care, both of which are tied to integrated care models, were cited as prompts for the care coordination changes in the MMC rule. Some of the most important changes in the MMC rule are related to care coordination. The changes were supposed to strengthen the role of the care coordinator, ensure more accurate and timely data gathering and sharing, and include beneficiaries with LTSS needs, including those with chronic health conditions, in the service planning process.

The MMC rule changes related to care coordination also included changes to initial screens of an individual's health risks as well as comprehensive assessments and the creation of treatment plans for certain populations. Care coordination is central to integrated care, and the MMC rule changes in this area facilitate integrated care through the new requirement for initial screens, expanding the populations for which comprehensive assessments and treatment plans are required, improving access to information, and ensuring smoother transitions of care.

WHEN WILL THE MEDICAID MANAGED CARE RULE CHANGES TAKE EFFECT?

In early 2016, the U.S. Department of Health and Human Services updated the Medicaid managed care regulations for the first time in over a decade. The regulations became effective July 5, 2016, but the implementation of several elements is staggered. This means states and managed care entities will continue to make changes to implement the new rule in coming years, including setting network adequacy standards and establishing beneficiary support systems. The rule includes other changes to support state efforts around integrating physical and behavioral health care, value-based payment models, and population health, including social determinants of health.

MEDICAID MANAGED CARE MENTAL HEALTH PARITY RULE: DRIVING DECREASED FRAGMENTATION

The MMC mental health parity rule does not prohibit states from carving out mental health care from physical care, which is the practice in many states. However, it may incentivize moving away from such models and toward integrated care.

Under the MMC mental health parity rule, if individuals are served by a Medicaid managed care organization (MCO), then all their benefits — medical and surgical care as well as mental health and substance use disorder services — must be provided in parity, even if the organization does not manage all the benefits. If the MCO provides all the benefits available to those individuals, such as in an integrated care model, then it performs the parity compliance analysis as opposed to the state Medicaid agency. If a state uses an MCO to provide an integrated care model, it may avoid the administrative burden related to the complex mental health parity analysis that would otherwise be necessary if Medicaid services were provided through multiple mechanisms. However, the state must still oversee the delivery of benefits in compliance with parity and make any contract changes where necessary.

In general, the requirements of the MMC mental health parity rule regarding services may also help drive integrated care by increasing access to mental health and substance use disorder services. Importantly, the rule requires that states also ensure that LTSS are provided in parity. LTSS have long been treated separately from other services, but the inclusion of LTSS should drive states toward integrated care to make compliance simpler. Overall, the MMC mental health parity rule should decrease siloes and encourage a more comprehensive approach to an individual's care.

CONCLUSION

Integration of physical and behavioral health care may not be a primary driver, or end result, of the MMC rule or the MMC mental health parity rule. These rules, however, facilitate the provision of integrated care for Medicaid managed care populations. While its impact is uncertain, the MMC rule is designed to create a more coordinated, comprehensive system of care that targets the needs of the individual. It also provides opportunities for states seeking to use payment to promote integrated care models.

The mental health parity rule will likely affect access to all types of care and cause states to evaluate the care that patients receive in a more comprehensive, and perhaps integrated, way. However, the lack of clear standards for integrated care, much less proof of long-term cost savings or improvement in outcomes, is something states need to consider when contemplating a move to this care delivery model.

NOTES

[1] Centers for Medicare and Medicaid Services, *Improving Care for Medicaid Beneficiaries with Complex Needs and High Costs* (CMS, n.d.).

[2] About one-third of Medicaid spending currently goes to LTSS, with this spending likely to rise as the population continues to age. Medicaid accounts for about 60 percent of LTSS expenditures nationwide. LTSS includes institutional care such as nursing homes and community-based services, like home health aides, that help a person continue to live in the community with the assistance they need. M. Favreault, H. Gleckman, and R. Johnson, *How Much Could Financing Reforms for Long-Term Services and Supports Reduce Medicaid Costs* (Urban Institute, Feb. 2016), p. 2.

[3] M. Maruthappu, A. Hasan, and T. Zeltner, "Enablers and Barriers in Implementing Integrated Care," *Health Systems & Reform,* Sept. 2015 1(4):250–56. These groups are targeted for integrated care because they "have been consistently demonstrated in the literature to consume the highest amount of resources and require the most coordinated care and, as such, pose a high economic burden." Ibid.

[4] D. Bachrach, P. M. Boozang, and H. E. Davis, *How Arizona Medicaid Accelerated the Integration of Physical and Behavioral Health Services* (The Commonwealth Fund, May 2017).

[5] The North Carolina Medicaid agency has proposed a Section 1115 Demonstration Waiver that will move a system that currently uses primary care case management for physical health and prepaid inpatient health plans for behavioral health services into comprehensive managed care using an integrated care model for nearly all Medicaid beneficiaries. North Carolina Department of Health & Human Services, *NC Medicaid Transformation* (NC HHS, n.d.).

[6] Common barriers to integrated care include: 1) technology issues associated with the accessibility of health care data and electronic health records to necessary parties, lack of information uniformity, and coordination issues; 2) reimbursement models that primarily value diagnostics as opposed to treatment and other services necessary for integrated care, such as care coordination, patient outreach, and follow-up activities; 3) an insufficient provider network; and 4) institutional and administrative problems created from long-standing separation or "siloes" of care types leading to various methods of administration as well as cultural and training issues (particularly with incorporating behavioral care into other types of care). D. J. Cohen, M. M. Davis, J. D. Hall et al., *A Guidebook of Professional Practices for Behavioral Health and Primary Care Integration: Observations from Exemplary Sites* (Agency for Healthcare Research and Quality, March 2015); and M. Maruthappu, A. Hasan, and T. Zeltner, "Enablers and Barriers in Implementing Integrated Care," *Health Systems & Reform,* Sept. 2015 1(4):250–56.

[7] Medicaid and Children's Health Insurance Programs; Metal Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans; Final Rule, *81 Fed. Reg.* 18390, Mar. 30, 2016 (to be codified at 42 C.F.R. pts. 438, 456, and 457). See also Centers for Medicare and Medicaid Services, *Frequently Asked Questions: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP* (CMS, Oct. 11, 2017).

[8] Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, *81 Fed. Reg.* 27498, 27834, May 6, 2016 (to be codified at 42 C.F.R. pt. 438).

[9] Ibid., 27649.

[10] Ibid., 27523, 27528; and 45 C.F.R. § 438.8(e)(3). The new regulations count "activities that improve health care quality" as services.

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Editorial support was provided by Maggie Van Dyke.

ACKNOWLEDGMENTS

The author is grateful for the support for this work provided by the Commonwealth Fund.

The author also would like to recognize valuable information provided in interviews by the Centers for Medicare & Medicaid Services; Center for Medicare and Medicaid Innovation; National Association of Medicaid Directors; Pennsylvania Department of Human Services; Oregon Health Authority; California Department of Health Care Services; America's Essential Hospitals; Association for Community Affiliated Plans; Bazelon Center for Mental Health Law; Legal Services of Eastern Missouri; and Western Center on Law & Poverty.

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