Medicaid Managed Care 201

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Financing School-Based Mental Health Services in Medicaid Managed Care

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HEALTHY STUDENTS, PROMISING FUTURES LEARNING COLLABORATIVE
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Mental Health Technology Transfer Center Network

Funded by: SAMHSA
Focus on SBMH Financing

Literature / Document Review

Interview Series (*in process*)
- State and local (i.e., district) leaders, all 8 states in the SE region
- Sources: Medicaid, Department of Education budget/grants, non-for-profit organizations, philanthropies
- Barriers and facilitators to effectively leveraging funding sources

Survey (*planning*)
Medicaid is Key in SBMH Financing

**Medicaid** is the largest payer for behavioral health services in the U.S., including SBMH services (principally Tier 2/3 services).

Why? The “Free Care rule” changed in December 2014.

- Previously: “If you bill Medicaid, you have to bill patients and/or other payers too.” Many SBMH programs could not operate.
- Example: APEX program in Georgia starting in 2015
- Some states may need to file a State Plan Amendment to leverage?

Big trend: as of 2016, nationwide nearly 93% of Medicaid-enrolled children are enrolled in a Medicaid Managed Care plan.
When will Medicaid pay for a service?

SBMH services will be reimbursable through Medicaid if the following criteria are met:

1) Child is enrolled in Medicaid
2) Service is a covered service
3) Provider is an eligible provider
4) Setting is an accepted setting
1. Is the child enrolled in Medicaid?

A child must be enrolled in Medicaid in order for Medicaid to pay for the child’s SBMH care. 35% of kids age 6-18 are enrolled in Medicaid.

- Many children are not eligible for Medicaid.
- Many Medicaid-eligible children are not enrolled.
- Enrollment can fluctuate over time due to fluctuating eligibility or difficulty meeting administrative requirements.
- Medicaid allows for administrative billing, including payment for outreach and enrollment support activities.
2. Is the service covered by Medicaid?

While all Medicaid programs cover mental health services in general, different Medicaid programs make different decisions about which specific services will be covered and under what circumstances.

- Mandatory benefits: inpatient and outpatient hospital care, physician visits, rural health clinic services, etc.
- Optional benefits: prescription drugs, targeted case management, licensed clinical social work services, etc.
Pressure Point: Medicaid Managed Care (MMC) Plans Cover Services on Their Own Terms

Across plans, variation in terms of coverage for key SBMH services

✔️ Examples: psychotherapy services and assessment

1. Initial services may be covered with referral; sometimes requiring prior authorization
2. Covered up until a fixed benefit “cap”
3. Coverage may be extended above the cap if the provider obtains re-authorization

Plans may give little notice before making changes to coverage terms

Example: Preferred Drug List
3. Is the provider an eligible provider?

Providers must be credentialed (i.e., determined to be in good professional standing) and approved by Medicaid before their claims will be reimbursable.

- Major shortages of all behavioral health providers
  - Compounded by misallocation of staff
  - Therapist shortage has upstream impact on screening
- % providers report currently accepting any Medicaid patients.
- Some services may only be covered when provided by certain provider types (e.g., licensed *clinical* social worker vs. non-clinical).

E.g., state policy priority = academics
EPSDT is underleveraged

[822x237]EPSDT is underleveraged

3. Is the provider an eligible provider?
Pressure Point: Medicaid Managed Care (MMC) Plans Form Provider Networks Independently

**Multiple MMC plans serve the same (child) population**
- SE region (8 states): 2-17 plans statewide
- Some states (e.g., FL, MI, TX) contract with MMC plans separately for distinct geographic service areas
  - SE region: 2.0 – 5.7 plans per service area

**Complicating Coordination**
“Usually” 1 plan per child, except...

**MMC plans may subcontract out the management of beh. health benefits**
- 30-50% of MMC plans (esp. larger plans)
- Contracted to specialized behavioral health managed care companies

**State-level behavioral health (and/or prescription drug) “carve-outs”**
- 11 states’ Medicaid programs as of 2017
- State may contract directly with beh. health managed care companies (or PBMs)
4. Is the care setting acceptable?

Medicaid programs set rules that govern whether a covered service will be reimbursable only if provided in a program-approved setting.

- Outpatient (non-school-based) clinics generally an acceptable setting
- School mental health programs often facilitate transportation to/from outpatient clinics
- Schools may be an accepted care setting for some services in some states, but not others
Key Takeaways

Criteria to be met for SBMH services to be paid for through Medicaid:

1) **Child** is enrolled in Medicaid  
2) **Service** is a covered service  
3) **Provider** is an eligible provider  
4) **Setting** is an accepted setting  

Medicaid Managed Care complicates these matters in some key ways: prior authorization, terms of coverage, provider network mgmt.

Identify, measure, and act on key “pressure points” in your states.
Thank you!

Please contact me with questions

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https://mhttcnetwork.org/centers/southeast-mhttc/home
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Mississippi Division of Medicaid. https://medicaid.ms.gov/programs/managed-care/
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AGENDA

• Medicaid Managed Care Pressure Points
  – Covered Services
  – Provider Networks

• LEA Financial Assessment
  – Credentialing
  – Financial Review
  – Community Based Behavioral Health (BH) Partners
Overview

– Build sustainable relationships
– Communicate early
– Understand the policy directive from the Medicaid Agency
– Develop a comprehensive implementation plan
How do LEAs mitigate for pressure points as it relates to covered services?

**MCOs**
- MCOs are for profit entities
- MCOs will employ cost containment methodology
- MCOs must pay for medically necessary services
- All EPSDT services are medically necessary based on the individual health circumstance of the child

**LEAs**
- LEAs must write quality medical necessity statements
- LEAs must follow service request rules (prior authorization)
- LEAs must sign up for and read all MCO directives
- LEAs can pool services with other school districts to maximize services and reimbursement
How do LEAs mitigate for pressure points as it relates to MCO network independence?

Multiple plans serve the same population

LEAs must understand their numbers

- % of students in each MCO plans
- Estimate number of students that will need BH services
- LEAs must ensure that all providers are enrolled with Medicaid
- Decide financial advantage of enrolling with all available plans initially
- Estimate the fiscal impact of policy change to your program (maximize admin. claiming to offset cost)
- LEAs have closed networks as it relates to service delivery
How do LEAs mitigate for pressure points as it relates to MCO network independence?

Medicaid may subcontract out the management of BH benefits

- LEA needs to know who they are legally obligated to contract with for BH services (who will submit and pay the claims)
- LEAs have closed networks, Medicaid MCO contract will dictate LEA policy, subcontractor will have to follow those rules
- MCOs can’t develop rules that will create an access to care issue
The purpose of credentialing is to determine that the members of the LEA clinical staff are properly trained, licensed and certified to provide safe and competent care.

Steps involved in the credentialing process:
- Determine info required by the MCO
- Gather application documents
  - State license verification
  - Sanctions and exclusions verifications
  - Board certification, etc.
- Submit application
- Perform follow-up communication with MCO
Understand the Medicaid directive to the MCO as it relates to LEA credentialing and contracting process

- In SC NCQA site visits were waived
- If appropriate complete an assessment to determine which plan(s) to credential with first
- Understand how rates will be developed
  - Medicaid establishes rates or
  - LEAs negotiates rates
Financial Review

Understand your numbers

- % of students in each MCO plans
- Estimate number of students that will need BH services (determine fiscal impact if credentialing is delayed)
- Decide financial advantage of enrolling with all available plans initially
- Remember Medicaid beneficiaries have freedom of choice for plan selection
- Estimate the fiscal impact of policy change to your program
- Knowing fiscal impact will assist LEAs when negotiating rates or help educate Medicaid on rate setting impacts
LEAs do not have to deliver all services to students

- Develop relationships with local community based BH Medicaid providers (FQHCs and State Agencies)
- Community based BH providers are already credentialed with the MCOs
- Understand financial impact of outsourcing some services to community providers
  - Can fill short term needs, for example staff on extended leave
  - Can come to the school to deliver services as subcontractor or temporary employees
  - When possible, expenses should not exceed revenues
Thank You!

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