Medicaid Realignment: Boon or Bane for Behavioral Healthcare?

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Reports are now available from a growing number of states about major efforts to realign Medicaid programs. Almost always, the impetus is financial, i.e., the need to contain costs; sometimes, it also has ideological overtones, e.g., the desire to alter population coverage, to convert the program to a block grant, to create an omnibus waiver, etc. A key question for us in each of these proposals is how behavioral healthcare would fare under these changes. Here, I would like to explore some of the features of these proposals and their implications for behavioral healthcare.

Contracting Medicaid Out to a Managed Healthcare Entity. Although we can expect that all Medicaid benefits will be managed in the future, two very important distinctions need to be made. First, it is very important that behavioral healthcare funds remain carved out, i.e., Medicaid funds for behavioral healthcare services remain separated from Medicaid funds for healthcare. This will assure that these funds will not be reallocated either deliberately or inadvertently to healthcare services. Second, it also is very important that management be done by an entity that has direct experience with behavioral healthcare service delivery. This may be a new not-for-profit entity specifically created for this purpose by a state behavioral healthcare association, a national or regional managed behavioral healthcare entity with a proven track record, or some combination of the two.

Moving Rapidly to Integrated Health Home Care. Although whole-health and person-centered care can be achieved through integrated health homes, their development must be planned and staged. One simply cannot take a field, such as Intellectual and Developmental Disability Services (I/DDS), which has been separately organized and operated since the middle of the twentieth century, and integrate it successfully with primary care in a three to six month period. Such a move would cause severe dislocations for clients who are served as well as massive disorganization of the current specialty service system. Carefully planned, staged changes are needed. As an example, behavioral healthcare already has been planning for such changes for several years through discussion, technical assistance, etc. Even in behavioral healthcare, much remains to be done to complete successful integration strategies. For example, it will be very important to apply the newly-announced Medicaid options and state plan amendments going forward.

Failure to Incorporate the 2014 Medicaid Expansion into Current Planning. In some instances, states are proposing adjustments to current Medicaid programs without also considering how the anticipated 2014 Medicaid Expansion will affect the proposed realignment. For example, if a state elects to narrow the population coverage of its Medicaid Program now, it cannot incorporate these same persons into the 2014 Medicaid Expansion at the higher rate of federal financial participation. These persons must be reincorporated into the Medicaid program for which they qualified previously at the lower rate of federal financial participation.

Simplifying Medicaid to a Single Omnibus Waiver. Efforts to simplify a state Medicaid program to a single waiver frequently are justified on the basis of the need for administrative simplification to
produce cost savings. However, we must be very careful so that it also does not imply that one size fits all populations. Clearly, persons enrolled in Medicaid through the Supplemental Security Income Program (SSI) as a result of disability have different service needs than mothers and children enrolled through the Temporary Assistance to Needy Families Program (TANF). Further, we can expect that the 2014 Medicaid Expansion will add a third strata governed by an Essential Health Benefit with a different service configuration. Little can be gained and much can be lost by inappropriately forcing these populations together.

**Some Principles Going Forward.** Here, I would like to introduce some general principles that can guide the state Medicaid reform efforts, as well as a few dos and don’ts to consider along the way.

First, the principles:

- Managed care will become ubiquitous in Medicaid programs in order to improve quality and to contain costs. However, unlike the managed care of the past, which relied on utilization review, modern managed care will be very likely to be self-directed through the use of performance adjusted case (per care user) and capitation (per population) rates.
- Integration of care will become ubiquitous in Medicaid programs, and social services will likely be included. However, it does not follow, and it should not follow, that care integration requires integrated or carve-in financing. Integration of services should be paid for through care out funding in order to protect behavioral health services.
- Disease prevention and health promotion programs will become ubiquitous in Medicaid programs to save downstream costs, and these services will be provided to enrolled persons who do not have a current disease condition, as well as to those who do.

A few moments reflection will suggest that effective application of these principles will require careful implementation activities, and that any promise to have a Medicaid system transformation up and running in 6 months, or even a year, is unrealistically optimistic and potentially even dangerous.

Now, a few additional dos and don’ts:

- Do understand the characteristics of the current Medicaid service populations, and do understand the number and characteristics of the new population that will enroll in 2014. At a national level, we have estimated that approximately 40 percent of the new expansion population will have a prior behavioral health condition.
- Do understand that those who qualify for a current state Medicaid program, but are not enrolled in the program, are not eligible to participate in the 2014 Medicaid expansion.
- Do early adoption of the 2014 Medicaid expansion if possible because it will produce financial rewards on the other side of 2014.
- Do pay attention to option and state plan announcements from the Centers for Medicare and Medicaid Services (CMS). Examples include the Health Home state plan amendment in 2011 and the recent Community First Choice state plan amendment from a few weeks ago. Why? Because they will produce additional revenue to accomplish important Medicaid goals.
- Don’t assume that the freedom and flexibility promised by a, so called, “omnibus waiver” will ever be realized in practice or that they will improve care for persons with behavioral health conditions. Why? In an omnibus waiver, behavioral health populations are likely to lose services and may be forgotten.
Clearly, the behavioral health field cannot control the Medicaid transformations that are underway in almost all states. However, we can and must guide these efforts so that persons with behavioral health conditions do receive appropriate services in a timely manner. In this sense, it is very important that we achieve a “soft landing” for each of these Medicaid transformation efforts.

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