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Do States Still Have Medicaid Behavioral Health Carve-Outs?

By Athena Mandros

I often get asked two questions. The first is do states still have Medicaid behavioral health carve-outs? The second (and related question) is how are integrated plans working for consumers with behavioral health problems?

We have answered the first question with our new analysis of state Medicaid behavioral health financing arrangements in our new report: State Medicaid Behavioral Health Carve-Outs: The *OPEN MINDS* 2019 Annual Update. The short answer:

- Nine states have Medicaid behavioral health carve-outs to care management organizations (CMOs). Four of those are to private CMOs and five to public entities. This is a change from 15 primary carve-outs in 2011.
- 29% of the 74.7 million Medicaid beneficiaries are in Medicaid behavioral health carve-outs to CMOs. 7% of these individuals are in private CMOs organizations and 93% are in public entities.
- Four states have vertical carve-out plans, which integrate physical and behavioral health services for individuals with SMI. These plans represent less than 1% of the Medicaid population.

With this see change in policy, the question is whether the physical and behavioral health care delivery for the 64% of Medicaid consumers in integrated financing models is actually "integrated" from a clinical perspective. We don't know the answer to that question entirely.

- In 2017, 40% of Medicaid health plans used a secondary behavioral health carve-out (see The Medicaid Health Plan Secondary Carve-Out Market Landscape: The *OPEN MINDS* 2017 Annual Update).
- 3% of Medicaid health plans have payment models for colocation and 88.2% have specialty care coordination programs (see Trends in Behavioral Health: A Reference Guide On The U.S. Behavioral Health Financing & Delivery System).
- 22 states have Medicaid health homes and 32 states have patient-centered medical homes (see The 2018 Update On State Medicaid Care Coordination Initiatives: An *OPEN MINDS* Reference Guide and Approved Medicaid Health Home State Plan Amendments)

The move to integration leads to the second question: Do integrated financing models work? There is a lot of research on the benefits of physical and behavioral health integration at the clinical level, there isn't a lot of research on behavioral health and physical health financial integration. The Medicaid and CHIP Access Payment Commission (MACPAC) attributes this gap in research to a lack of quality measures and proven quality strategies (see Integration of Behavioral and Physical Health Services in Medicaid). Other research has focused on strategies that can help make integration successful and the challenges to integrating financing (see Integrating Behavioral Health Under an ACO Global Budget: Barriers and Progress in Oregon and Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators).

What does this mean for executives of provider organizations? For your Medicaid book of business, it's a matter of keeping an eye on the "big picture" changes. Will the nine states that have primary behavioral health carve-outs continue – and if so, with what lead organizations? If not, what does integration of behavioral health into Medicaid health plans mean for rates/revenue, referrals, and contracting? Will Medicaid health plans in your geographic area increase or decrease their use of behavioral health secondary carve-out plans, health homes and medical homes, other forms of value-based reimbursement for serving consumers with chronic conditions and complex needs? Its important to keep your market intelligence in these areas up-to-date.

Where are we seeing the most action? I'll be watching Michigan, which is currently piloting a variety of different behavioral health integration models in response to stakeholder advocacy (see Michigan Medicaid Delays Selection Of Cross-Region PIHP For Mental Health Integration Pilot Areas). Even though North Carolina has already committed to ending their carve-out, I'll be watching their implementation process and particularly the development of the vertical carve-out plans for serious mental illness and intellectual/developmental disabilities (see North Carolina Medicaid Selects Five Health Plans—One Regional & Four Statewide). Finally, I'll be keeping an eye on California as they gear up to renew their 1115 demonstration waiver in 2020. In the last waiver renewal, the Centers for Medicare and Medicaid Services put fairly stringent requirements on the county mental health plans as a condition of their continued operation (see California's Mental Health Carve-Out Preserved For Five Years, But With New Performance Transparency Requirements).

For more, see State Medicaid Behavioral Health Carve-Outs: The *OPEN MINDS* 2019 Annual Update. The report includes information on the trends in behavioral health financing models in state Medicaid plans, 2019 Medicaid behavioral health financing models by state, the number of Medicaid enrollees in each model, state Medicaid plans to transition behavioral health financing arrangements, and an overview of behavioral health financing arrangements and models.

For even more, join us at The 2019 *OPEN MINDS* Strategy & Innovation Institute in New Orleans on June 4 for the keynote address, "Harnessing The Power Of Analytics To Create Innovative Solutions For Complex Consumers" featuring Lynda Zeller, Senior Behavioral Health Fellow, Michigan Health Endowment Fund.

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