

Washington Medicaid Integration
Partnership
Snohomish County Pilot
White Paper
Executive Summary

Prepared for North Sound Mental Health Administration by:

Barbara Mauer, MSW CMC and Dale Jarvis, CPA

MCPP Healthcare Consulting Inc.

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Introduction

Since the mid-1990's the Washington State public mental health system has been operating under a managed care waiver that uses fourteen Regional Support Networks (RSNs) to manage the mental health care and related finances of Medicaid enrollees and non-Medicaid individuals who are members of the state priority populations (chronically mentally ill adults, severely emotionally disturbed children, etc.).

In November 2003 the Washington Medicaid Integration Partnership (WMIP) released a Request for Proposals (RFP), inviting providers to register interest in a proposed Snohomish County pilot project to integrate medical, mental health and chemical dependency services for Medicaid-only clients under a new managed care design. The WMIP pilot was authorized by the Legislature to “develop an integrated health care program designed to slow the progression of illness and disability and better manage Medicaid expenditures for the aged and disabled population.”¹

Under the proposed WMIP pilot, Snohomish County, as one of the five counties in the North Sound Regional Support Network (NSRSN) would have two management structures for the Medicaid mental health care system - the North Sound Mental Health Administration (NSMHA), which serves as the Regional Support Network (RSN), and one or more WMIP-contracted health plans.

This White Paper was commissioned by the North Sound Mental Health Administration (NSMHA/NSRSN) for two purposes: 1) to bring together current information regarding how the integration of behavioral health (mental health and substance abuse) services with medical services can improve the care and health status of the Medicaid and priority populations; and 2) to assess the potential impact that a dually managed system (NSRSN and WMIP) would have on the Snohomish County residents receiving these services.

The preliminary analysis projects that if WMIP is implemented as currently designed substantial resources will be shifted away from the treatment of seriously mentally ill residents of Snohomish County to serve other Medicaid enrollees with low to moderate behavioral health risk and complexity, and key psychiatric inpatient diversion and alternative services will have their financial viability jeopardized.

Key Findings

There are fourteen key findings that summarize the *lessons learned* during the preparation of this White Paper.

- **Three Types of Integration:** There are three types of behavioral health/medical care integration: financial integration (benefit packages, carve-ins, shared risk pools or other incentives); structural integration (services delivered under the umbrella of the same organization, BH specialty services co-located with primary care services) and clinical integration (what is experienced by the consumer in relationship to the providers). Clinical integration is the “holy grail”. There are many systemic barriers to achievement of clinical

integration, even in integrated delivery systems. It is not achieved by financial and structural integration without well defined service models.

- **The Four Quadrant Clinical Integration Model:** There are roughly four subsets of the population that need both behavioral health and medical care. They can be briefly described as:
 - *Quadrant I:* The population with low to moderate risk/complexity for both behavioral and physical health issues.
 - *Quadrant II:* The population with high behavioral health risk/complexity and low to moderate physical health risk/complexity.
 - *Quadrant III:* The population with low to moderate behavioral health risk/complexity and high physical health risk/complexity.
 - *Quadrant IV:* The population with high risk and complexity in regard to both behavioral and physical health.

Different types of services and models of integration are needed, depending on which quadrant best fits a specific individual. System design based on addressing the unique needs of each quadrant will have a greater chance of meeting the needs of the entire population being served.

- **National Experience Integrating Care for Medicaid Disabled Populations:** There are very few projects around the country that have attempted to achieve behavioral health/medical care integration with aged, blind and disabled Medicaid enrollees. Most projects have focused on medical care/long term care integration; or behavioral health/medical care integration for Medicaid enrollees with low to moderate behavioral health risk and complexity. Most managed care systems with carved-in behavioral health benefits have subsequently carved the behavioral health benefit out to a Managed Behavioral Healthcare Organization, thus reducing the opportunities for integration.
- **Medical Cost Offsets:** When clients use less medical care if they get mental health services, the net savings are defined as medical cost offsets. The pursuit of medical cost offsets has been one of the drivers of financial integration. A recent DSHS study found that providing mental health care to a general Medicaid population can reduce subsequent medical service use, but “...for individuals with serious mental illness mental health treatment may not create medical cost offsets...”ⁱⁱ This and other studies suggest that Medicaid enrollees with low to moderate behavioral health risk and complexity that are not currently receiving mental health care should be the target for expanded mental health services in the WMIP project.
- **The WMIP Integration Design:** The WMIP design contains components from the three types of integration – financial, structural, and clinical – at a high level. The WMIP RFP and related documents provide much specificity regarding financial integration (benefit packages, per member per month rates, etc.), but only a general framework regarding structural and clinical integration. Instead, the RFP takes the approach of asking the RFP proposers to describe how they would achieve structural and clinical integration within this general framework. This approach, which may yield positive results, runs the risk that the WMIP project could be implemented without well-defined service models because of

limited experience in clinical integration and lack of clarity about which segment of the population is going to be targeted for services.

- **WMIP Financial Planning and Analysis:** Through the process of designing and preparing for the WMIP pilot, DSHS did not examine specific Snohomish County mental health utilization and cost data, nor was an analysis completed to evaluate the potential impact the pilot might have on the seriously mentally ill adults in the County.
- **Use of NSRSN-Funded Mental Health Services in Snohomish County:** There are approximately 9,600 Medicaid enrollees in Snohomish County that are aged, blind or disabled, and 21 years of age and older – the WMIP target population. Of this group 3,800 are receiving care through the NSRSN – a 39% “penetration rate”. A recent DSHS study found that almost half (47%) of the Washington State Medicaid aged, blind and disabled population over 18 years of age had a mental health diagnosis and slightly over half of those with a mental health diagnosis (25% of the total population) were served by the RSN system. Snohomish County is currently serving a higher proportion of the aged, blind or disabled than the statewide average.

If Snohomish County was at the statewide average 4,500 of the target population would have a mental health diagnosis and 2,350 would be receiving care from the NSRSN. Because the number of clients in care in the county (3,800) is substantially larger than the statewide average (2,350) and the RSN has fairly strict admission criteria, there is a strong likelihood that the vast majority of seriously mentally ill adults are in service, along with a number of persons with moderate mental health risk and complexity.

- **The WMIP Mental Health Financial Design:** The WMIP project is designed to enroll 6,000 of the 9,600 aged, blind or disabled Medicaid enrollees in Snohomish County. All or part of their mental health care would be funded through shifting all or part of their per member per month Medicaid premium dollars from the North Sound RSN to the WMIP contractor(s). The WMIP contractor(s) would then be responsible for integrating their behavioral health and medical care, as well as increasing the number of individuals receiving mental health care in order to achieve additional medical cost offsets.
- **NSRSN Service Delivery Expenditures:** In fiscal year 2003 the NSRSN funded over \$10.4 million of direct mental health service to the 3,800 aged, blind and disabled Medicaid clients in Snohomish County. These services included inpatient, outpatient, crisis, and residential care.
- **WMIP Revenue and Expense Transfer Implications:** A preliminary study completed for this White Paper of WMIP enrollment scenarios for the 6,000 enrollees projects that between \$4.5 million and \$7.1 million of the Medicaid mental health premiums would be transferred to the WMIP contractor(s). If inpatient care is excluded from this transfer the figures decrease by approximately \$1.5 million. The same study suggests that a much smaller amount of service costs would follow the 6,000 enrollees – between \$63,000 and \$3.6 million, depending on how many of the clients currently in care remained within the NSRSN system and how many were enrolled in the WMIP pilot. The study determined that a net transfer to the WMIP contractor(s) of between \$1.8 and \$4.5 million – money that is currently used to provide services to NSRSN aged, blind and disabled clients in Snohomish County – would take place to serve Snohomish County Medicaid enrollees with low to

moderate behavioral health risk and complexity.

- NSRSN/WMIP Benefit Mismatch:** A preliminary study of the WMIP and NSRSN Benefit Packages finds that between 24% and 36% of services being currently provided to 3,800 NSRSN Medicaid aged, blind and disabled clients appear to not be included in the WMIP Benefit Package. This could result in potential service reductions of between \$400,000 and \$1.2 million per year for Medicaid enrollees who transfer from the NSRSN to the WMIP pilot.

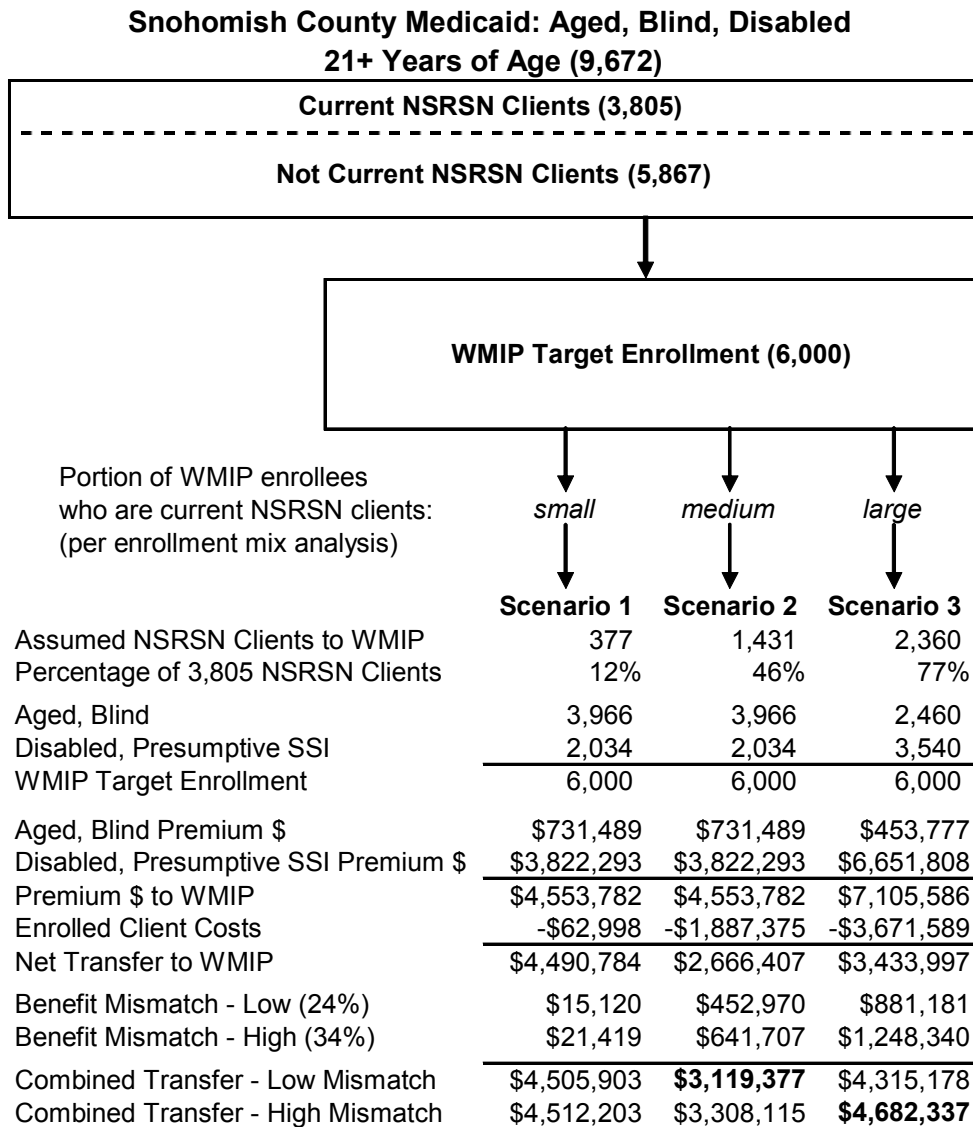


Figure A – Transfer of Clients and Premium Revenue – NSRSN - WMIP

- **Combined Premium Transfer and Benefit Mismatch:** The combined impact of net premium dollar transfers and benefit mismatch in the current WMIP design means that between \$3.1 and \$4.6 million of resources would be shifted away from the treatment of seriously mentally ill residents of Snohomish County to serve other Snohomish County Medicaid enrollees with low to moderate behavioral health risk and complexity.
- **Adjustments for Inpatient Dollars and Risk Staying with the NSRSN:** A new, proposed WMIP design shift that would move WMIP inpatient premium dollars and risk back to the NSRSN provides only a minor return of premium dollars and substantially increases the financial risk to the NSRSN, including the potential loss of a number of inpatient diversion and alternative resources currently in place.
- **Potential Change in Available NSRSN Service Capacity:** Implementation of the WMIP Project, as currently designed, could jeopardize the fiscal viability of the Mukilteo Evaluation and Treatment Center, the Bailey Center Crisis Residential Facility, and potentially the six NSRSN-funded residential facilities in Snohomish County, all of which provide services that appear to not be in the WMIP benefit package.

Recommendations

Three recommendations are being proposed to leverage the research and analysis that have been pulled together for this White Paper.

- DSHS should ***defer the implementation of the WMIP project until the financing of the project can be redesigned*** to prevent a substantial degradation of services and service capacity for seriously mentally ill adults in Snohomish County. DSHS should seriously consider stepping back from the plan to transfer capitation revenues from the RSN to the WMIP pilot. Financing the WMIP integration of MH services from current RSN resources improves system resources for populations with low to moderate behavioral health risk/complexity at the expense of the seriously mentally ill.
- The exciting opportunity to ***create a new clinical service model shared by the behavioral health system and the healthcare system should move forward***. DSHS should clarify the intended target population and develop a service model appropriate to the specific needs of that group. The WMIP project should focus on creating this service model and learning from that model regarding the impact on medical service costs and the implications for RSN services and populations.
- DSHS should ***use the medical cost savings*** that can be projected based on the DSHS studies to ***finance increased services to Medicaid enrollees*** with low to moderate behavioral health risk and complexity, as opposed to using dollars targeted for the seriously mentally ill. The DSHS studies of substance abuse and mental health services show that medical services savings can be achieved if these services are provided to individuals who are not now served by those systems.

Dale Jarvis is a Managing Consultant at MCPP Healthcare Consulting, a Seattle-based consulting firm, and a member of the National Council for Community Behavioral Healthcare's Consulting Services. Mr. Jarvis has extensive experience helping managers and providers of health care redesign their administrative, fiscal and information systems. He has contributed articles to books and publications and is a co-author of The Primary Care Performance Management System and How to Thrive in Managed Behavioral Healthcare. Mr. Jarvis has been a certified public accountant in the State of Washington and a member of the American Institute of Certified Public Accountants since 1982.

Barbara Mauer is also a Managing Consultant at MCPP Healthcare Consulting and a member of the National Council for Community Behavioral Healthcare's Consulting Services. She has extensive experience in working with providers and communities in redesign of their service delivery systems and supporting quality and utilization management processes. Ms. Mauer has contributed articles to books and publications and is a co-author of The Primary Care Performance Management System and How to Thrive in Managed Behavioral Healthcare. She was trained as a social worker, has managed large county human service systems and was a senior administrator at Group Health Cooperative, is a Certified Management Consultant and has been consulting for over 15 years.

End Notes

ⁱ ESSB 5404, Part II, Section 201

ⁱⁱ Anderson N, Estee, S. Medical Cost Offsets Associated with Mental Health Care: A Brief Review. DSHS. December 2002.