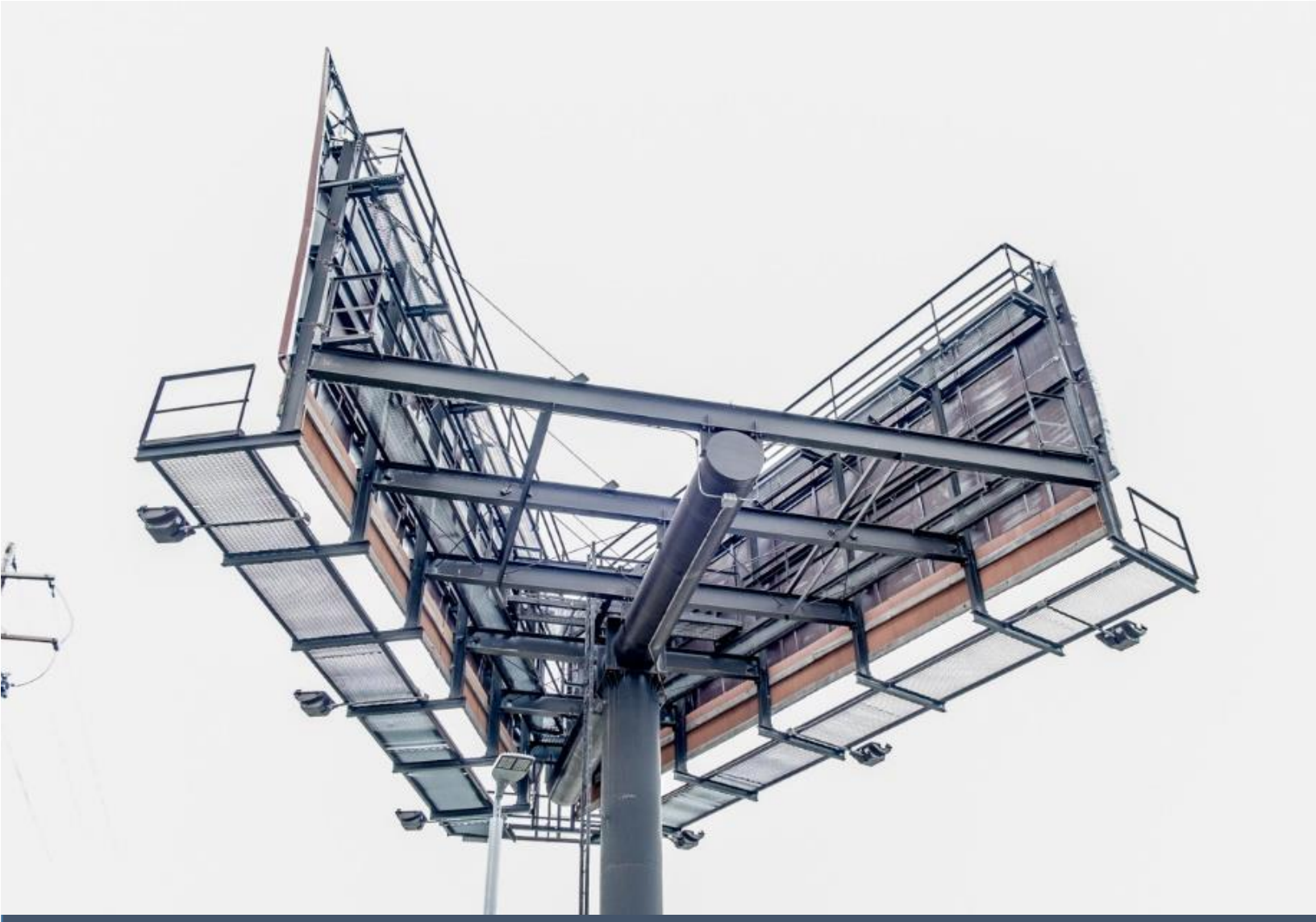

Beyond Appearances

Behavioral Health Financing Models and the Point of Care

tbdSolutions

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Executive Summary

This paper was commissioned in order to provide an overview of state experiences in managing behavioral health services and financing using various models. It is intended to inform decision-making regarding the redesign of behavioral health care in the state of Michigan.

Key Findings

A summary of our findings is as follows:

- A variety of approaches are employed across the nation to manage payment for behavioral health services; no single model emerges as dominant.
- There is no evidence that any single financing model is consistently associated with cost savings.
- Improving care integration to meet Triple Aim objectives is not dependent on the consolidation of financing.
- Model changes at the point of care may have a greater impact on Triple Aim objectives than consolidating financing.

Recommendations

A review of experiences from states across the nation leads to a series of recommendations for Michigan's behavioral health system:

- Engage a goal-driven, transparent effort for system redesign prior to making decisions about financing models.
- Measure and report outcomes and global costs.
- Broaden integration to include social services, education, justice and other systems that impact social determinants of health.
- Pilot shared incentive programs that include providers in accountability for value.

Background, Rationale, and Objective

Background

A Public and Social Health Concern

By now nearly everyone in the behavioral health industry knows the statistics. As life expectancy increases for most people around the world, people with serious mental illness continue to die substantially earlier than those without these conditions.[i] Moreover, the increased mortality of this population is not primarily due to mental illness itself, but to treatable chronic health conditions which affect others in the general population, especially cardiovascular and pulmonary diseases.[ii] Unfortunately, this disparity appears to be growing rather than decreasing.[iii]

The causes of this inequity are complex[iv] and woven into the history of our society.[v] Accepting any simple solution as if it were complete will increase the likelihood of unintended consequences due to policy decisions.

Something must be done.[vi] The question is "what?"

Steps toward a Solution: Integration of Care across Multiple Providers

There are hopes that this disparity may be reduced by addressing behaviors that lead to chronic and deadly conditions (*for example: tobacco and other substance use, lack of physical activity, and poor diet*). Doing this requires the coordination of specialized skills which span multiple providers: preventive interventions from primary care, behavioral interventions from behaviorists, and socio-economic interventions to ensure access to nutrition, safe housing and education.[vii]

Making this integration a consistent standard of care will require deconstructing and rebuilding the way in which people work, both at a systems-level and at the point of care. It entails changes in professional

training, the physical design of clinics, and communication between fields which do not currently have a shared language. Given the multi-systemic complexities of these challenges, there is not a "one-size-fits-all" model for enacting this change across communities. Evidence supports the effectiveness of integration using multiple models, whether by integrating behavioral healthcare into a primary care setting, primary care into a behavioral health setting, or coordinating specialty services across the continuum of care.[viii, ix]

Federal Initiatives

As awareness of these critical societal issues spreads, federal efforts are attempting to put policy and financing "in the right place" to support the multi-systemic coordination that is required to meet Triple Aim objectives. While there is a clear recognition of the importance of this issue, there is not a single, clear direction from federal agencies on how to reach the system's stated objectives.

Acknowledging the complexity of the issues at hand and the lack of clear evidence for a single care model, the Center for Medicare and Medicaid Services (CMS) has taken a pilot approach, testing multiple avenues for improvement via the Center for Medicare & Medicaid Innovation.[x] Other pilots are also underway; notably the integration of management for dually-enrolled Medicare and Medicaid recipients,[xi] and other federal resources support the development of integrated care models for patients with behavioral health conditions.[xii]

The Medicaid expansion authorized by the Affordable Care Act (ACA) has allowed millions of previously uninsured, low-income adults to gain coverage. States that have chosen to implement expansion have observed a higher than expected risk for behavioral health conditions[xiii] in this population, highlighting the need to integrate treatment with social services. Since Medicaid is administered at the state level, legislators and state agencies

make many of the decisions regarding how best to organize treatment and its required financing.

Rationale

Multiple Strategies Available to States

States are attempting to better organize publicly-funded behavioral and physical healthcare delivery using a variety of strategies. A recent paper by the *Commonwealth Fund* outlines several options that are being pursued by specific states:[xiv]

a) Consolidation of state-level agencies
b) Consolidated management of physical and behavioral health purchasing
c) Shared incentives for coordination
d) Informal collaboration

These strategies require varying degrees of administrative upheaval and reorganization, and, as of the writing of this report, no definitive strategy has emerged as the gold standard. The *Commonwealth Fund* concludes that "There is no single pathway through which all states will be able to achieve integrated behavioral and physical health care," and that "the best strategy or combination of strategies will depend on a state's political and health care environment."[xv]

According to the report, states who have been successful, regardless of the type of financing model they select, have purposefully engaged a range of stakeholders and used a deliberate process by which to accomplish change.[xvi]

This presents state Medicaid agencies with the challenge of complex choices and the opportunity to develop creative approaches that present the best solutions.

Managing Prospective Large-Scale Change

Two of the potential strategies listed above (options *a* & *b*) require substantial reorganization and compel the additional scrutiny of policy makers if they are to spur integration of care at the provider and patient level.

In particular, a number of states have chosen to consolidate physical and behavioral healthcare purchasing via a single, consolidated managed care entity rather than specialty managed care for behavioral health. These changes in financing arrangements have often been undertaken with the assumption that integrating financing would have the downstream impact of integrating and improving care while decreasing costs. Alternately, innovations at the point of service are often developing ahead of changes in financing[xvii]. Any proposed policy-level alterations must be careful to avoid undoing progress at the point-of-care.[xviii]

Objective

This paper will focus on an examination of state strategies and approaches and the effects of efforts to consolidate behavioral health financing and care related to the goal of improving population health, reducing costs, and improving care experiences. The report will:

> *"There is no single pathway through which all states will be able to achieve integrated behavioral and physical health care."*
>
> *~ The Commonwealth Fund*

- Provide an overview of how states contract for management of Medicaid funds for populations with behavioral health conditions, and
- Assess impacts of behavioral health financing models on key performance areas.

This analysis is intended to support decision-making regarding care redesign in the state of Michigan. The states selected for comparative analysis meet criteria that support similar decisions that Michigan is facing.

The Lay of the Land: Definitions and Scope

Characteristics of Systems Reviewed

Like any professional field, healthcare has its own lexicon of terms, which can be used in slightly different ways depending on context. In order to ensure clarity in our discussion moving forward, below are several definitions to ensure a common understanding.[xix]

Discussions about the management of behavioral health financing often attempt to classify all financing arrangement into two basic categories: "carve-in" or "carve-out." This paper uses the following terms: [xx]

Consolidated management: A Medicaid financing model where behavioral health benefits are managed on an at-risk basis by the same organization responsible for managing the physical health benefit. This model is referred to by some as a "carve-in", as the services and financing are bundled together.

Specialty management: A Medicaid financing model where some portion of behavioral health benefits (*e.g. mental health outpatient, psychiatric inpatient, addictions, or pharmacy*) is separately managed or financed on an at-risk basis by another organization. This specialization can be at one of two levels: (a) at the payer level or (b) at the health plan level. It is often referred to as a "carve-out" model.

Absent from either of these options are situations where behavioral health services are not "managed" at all, but provided under fee-for-service (FFS) arrangements. In order to provide a slightly more nuanced way of looking at

options for behavioral health financing, below are definitions of primary financing models commonly used across the United States.

Figure 1: Models of Behavioral Health Financing[xxi]

Model	Definition
Fee-for-Service (FFS)	The state funds behavioral health services primarily through fee-for-service (FFS) arrangements, directly paying providers for each covered service they provide. This includes instances where a state contracts with an administrative services organization (ASO) to pay provider organizations on a FFS basis. Not risk-based.
Primary Care Case Management (PCCM)	The state funds behavioral health services primarily via contracts with primary care providers, paying a case management fee in addition to regular FFS payments. Not risk-based.
Partial FFS	The state funds behavioral health services partially through Managed Care Organizations (MCOs), but continues to manage certain (usually more complex) populations using a FFS or PCCM model.
Managed Care Organizations (MCO)	The state funds behavioral health services primarily through MCOs for at-risk management of comprehensive Medicaid benefits to enrolled Medicaid beneficiaries for a pre-set per-member-per-month (PMPM) premium, or capitation payment.
Specialty MCO	The state funds behavioral health services primarily through MCOs, but requires that these MCOs demonstrate specialty knowledge of specific populations, either directly or by subcontracting.
Private Prepaid Health Plan (PHP)	The state funds behavioral health services primarily through a private, for-profit Pre-paid Health Plan (PHP) responsible for the management of defined services for behavioral health conditions and related issues. This is often done via contract with a specialty managed behavioral healthcare organization (MBHO).
Public PHP	The state funds behavioral health services primarily through a public, non-profit health plan that is responsible for the management of defined services for behavioral health conditions and related issues.

Coordinated Care Organizations (CCO)	The state funds behavioral and physical health services through local health entities called Coordinated Care Organizations (CCOs). CCOs have a single budget with fixed growth rate and are accountable for a defined set of population-level outcomes. *(This model is presently found only in Oregon.)*.

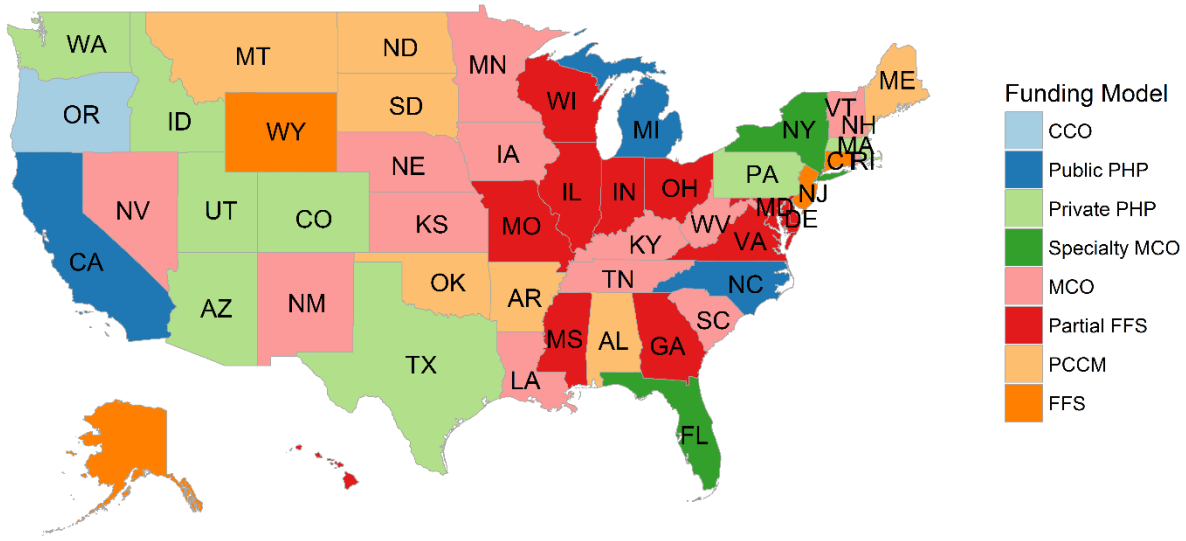
Of note in this examination of models are the following considerations:

- *Grouping of models into categories can disguise variances*: Grouping similar things has the side effect of hiding individual differences within the set. Each of the classifications here shows a particular approach to financing behavioral health services. However, there are substantial differences amongst states in implementation even within high-level groupings.
- *Varied populations included*: While this analysis groups states based on their predominant behavioral health financing model, the condition-specific populations included in the benefit may vary significantly from state to state. For example, in some states, persons with intellectual/developmental disabilities (I/DD) are served in a fee-for-service model, while other populations are managed by an MCO.

Financing Models for Medicaid Behavioral Health Services, by State

The map shown below (*Figure 1*) identifies the various financing models used by each state to provide behavioral health services under Medicaid. For definitions of the financing model types, see the discussion of "*Patterns of Behavioral Health Financing*" above.

Figure 2: Behavioral Health Financing Models, by State



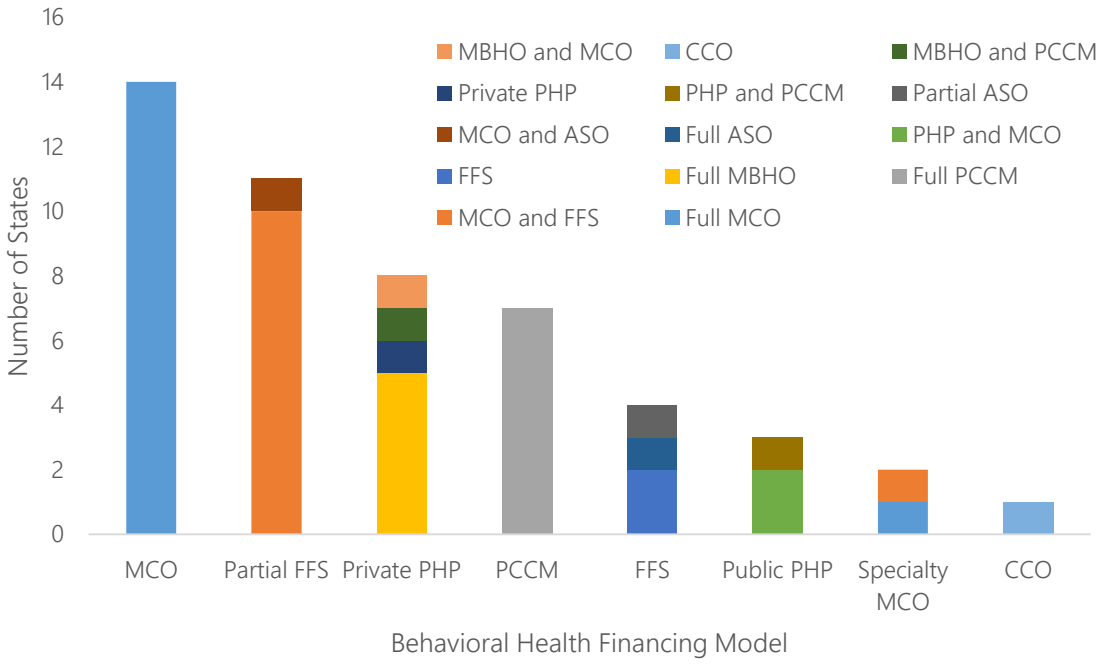
Looking at this high-level view across the nation, several observations are worth noting:

No single model. A glance at the map above is sufficient to underscore the adage that "healthcare is local," and that individual states are wrestling with how their Medicaid systems can navigate the complexities of integrated medical and social services within the context of other local systems (e.g. *education, housing, judicial, etc.*). Even after smoothing over certain

differences through grouping, there is not a single financing model emerging across the nation.

High clinical risk means high financial risk. In the 11 states where the financing pattern is "Partial FFS" coverage, a portion of the behavioral health services are delivered via fee-for-service arrangements, while another portion are delivered by an MCO. The FFS arrangements are frequently used to reimburse for services related to higher risk conditions. For instance, of the states with partial FFS coverage, 73% (8 of 11) use FFS to fund specialty mental health services while all states in this category use MCOs for less-intensive mental health outpatient services. Figure 3 (*below*) shows the number of states with each Financing Model, with additional subtypes specified within each.

Figure 3: Behavioral Health Financing Models, by Sub-Type



Financing models are not "evolutionary". While it may be tempting to view the current variation among states as various stages of an evolutionary process that will eventually lead to a map with only one color, this would be a dangerous oversimplification. For instance, to depict FFS as an inferior approach compared to MCOs, ignores the experiences of a state like Connecticut which purposefully transitioned from an MCO to a FFS model. In addition, it is worth noting that any of these models can serve as platforms for the development of value-based purchasing, and none are ideal in their present form.

Moving in multiple directions. In an attempt to impact the issues facing populations with behavioral health conditions, several states are implementing changes to their current financing models. What is worth noting is that these states are not all adopting the same approach. For instance, since 2013, one state has moved towards a specialty financing model (MD), three states have moved to a consolidated financing model (KS, LA, NM), one state has reduced the number of payers (AZ), three states have moved to a multi-payer model (IA, LA, NM), and one state has removed payers in favor of an ASO model (CT).

States Included in Review

Criteria for Inclusion

Fifty years of Medicaid financing and service provision across 50 states has led to some stark variations in policy, financing, and delivery of behavioral health services. This allows insight into the experiences of states who have chosen models

> ***"Most states pre-/post- change [measurement] in how they integrate care. It's hard enough at the practice level to assign..."***
>
> ~University researcher from Colorado

different than Michigan and to evaluate their experiences.

This analysis includes a group of states with diversity in managed care organizations and financing structures, with moderate-to-large sized populations and Medicaid populations, and variation in years of experience in their current financing model (3 months to 20+ years). The study includes states with behavioral health plans that are for-profit or non-profit, public or private, and PHP or MCO.

Figure 4: States included in analysis

Experience	State	Current Model
10+ years	Colorado	Private PHP
	Massachusetts	Private PHP
	Minnesota	MCO
	Pennsylvania	Private PHP
3-9 years	Georgia	Partial FFS
	Kansas	MCO
	Kentucky	MCO
	New Jersey	FFS (ASO)
	Tennessee	MCO
0-2 years	Arizona	Private PHP
	Iowa	MCO
	Louisiana	MCO
	Maryland	Partial FFS
	New Mexico	MCO
	New York	Specialty MCO
	Washington	Private PHP

States were included for comparison if they had been referenced in other reports about managed behavioral health care which had recently been released in Michigan[xxii, xxiii]. Additional states were included to ensure a balanced set of comparisons, creating a natural grouping of states who have:

- Made a change in the past two years (or are anticipating a change in the next year), or

- Made changes in the last 9 years, or
- Had 10 or more years with no significant changes to their plans.

States using a strictly FFS model were excluded from the sample group, and states with fewer than 2 million people (25th percentile, nationally) were also excluded.

Caveats

Many states are presently engaging this discussion to improve overall population health management, care delivery and cost efficiencies. For those states that have made recent changes to their financing models, there has not been sufficient time or data to effectively evaluate their impacts.[xxiv]

Nonetheless, some of these new-adopters are included in the survey, since these are cited by the reports referenced above. However, caution should be taken in drawing conclusions regarding long-term sustainability based on those states' excitement about their recent choices.

Additionally, there is no clear way of knowing the extent to which behavioral health services are managed differently within a single MCO entity and/or under sub-contractual relationships with that entity. This makes it unclear whether states in the "MCO" category have a complete integration of management functions for the behavioral health population, or whether they function similarly to a "Specialized MCO." MCOs which subcontract management of behavioral health services may appear to integrate financing but actually more closely resemble a specialty financing model.

State Summaries

The following states were included for comparison. Below is a brief synopsis of each state's current status with regard to behavioral health financing.

Arizona. Arizona employs a consolidated model for behavioral health services, except for persons with Serious Mental Illness (SMI), who are paid for

in a FFS model. Arizona recently eliminated its state Division of Behavioral Health, moving it into the state Medicaid agency.

Colorado. In Colorado, five Behavioral Health Organizations (BHOs) have historically managed the Medicaid behavioral health contracts for the state. Colorado has maintained a specialty financing model for 20 years, but plans to transition to a consolidated financing model in 2017.

Georgia. While currently maintaining a specialty financing MCO model, Georgia does not include the SMI population in the MCO. (Georgia refers to their MCOs as Care Management Organizations).

Iowa. In 2016, Iowa transitioned to a consolidated MCO model in which 3 health plans will manage the primary care and behavioral health care benefits. Iowa previously contracted with Magellan of Iowa for behavioral health services management.

Kansas. Kansas transitioned to a consolidated model operated by MCOs in 2013, called KanCare. Two of the three health plans subcontract with a behavioral health MCO in a secondary specialty financing model.

Kentucky. Kentucky began its transition to a consolidated financing model in 2011, with the entire state completing the transition in November 2014. Five MCOs manage consolidated funds, but two MCOs provide a secondary specialty financing to an MBHO, Beacon Health Options.

Louisiana. In December 2015, Louisiana moved to a consolidated financing model for behavioral health services. At that time Louisiana removed its behavioral health MCO (Magellan) and transitioned their five MCOs to include oversight of both primary care and behavioral health care.

Maryland. Maryland operates a specialized financing model with ASO oversight by Beacon Health Options. One of the only states to move towards a specialized model in the past five years, Maryland's ASO reported 10 straight quarters of declining PMPM costs through March 2012.

Massachusetts. Massachusetts employs a secondary specialized financing model in which MCOs manage all Medicaid funds and contract with an MCO specializing in behavioral health management (in this case, Beacon Health Options).

Minnesota. Since 1995, Minnesota has maintained a consolidated MCO model, managed by five Prepaid Medical Assistance Plans (PMAPs). One PMAP, Medica, implements a secondary specialized financing model for behavioral health services.

New Jersey. New Jersey operates an ASO-influenced FFS model. Constituents indicate that a move towards consolidated care is on the horizon, but a specific timeline is unknown.

New Mexico. Similar to Louisiana, New Mexico increased their number of BHO/MCOs, from 1 to 4. New Mexico attributes some of the success of their model to the joining of their state behavioral health authority with the Human Service Department. This has allowed for more accessible communication and improved collaboration.

New York. While maintaining an MCO model, New York also separates individuals receiving Social Security Income benefits (SSI) into Health Assistance Recovery Plans (HARPs). Additionally, some health plans in New York operate in a secondary specialized financing model, contracting with an MCO to manage their plan's behavioral health funds.

Pennsylvania. Pennsylvania has maintained a specialized financing model for behavioral services since 1997. The state of Pennsylvania has been insinuating an end to specialized care financing but has not given a specific plan or timetable.

Tennessee. Tennessee has functioned with a consolidated model since 2007. All behavioral health services are currently under a specialized funding model, and they are also in the process of carving in services for people with developmental disabilities.

Washington. In 2016, Washington will change to a financing system driven by Behavioral Health Organizations (BHOs)—single, local entities that assume responsibility and financial risk for providing substance use disorder treatment, and the mental health services previously overseen by the counties and Regional Support Networks (RSNs). With this change, they anticipate increased access to appropriate and effective services, improved ability for behavioral health and primary care providers to meet the needs of the whole person, and better managed financial resources.

Key Findings

Methodology

What states seek to achieve through any large scale change is improvement: getting *better*. But how does one define whether a change is an improvement? These findings describe the perceived effects of behavioral health financing models using the structure of the Triple Aim: Better Health, Better Care and Lower Per-Capita Cost for the population.[xxv] Findings related to the Triple Aim objectives are informed by several types of sources.

- *Industry Reports.* Managed care financing models have been spotlighted by various industry reports in support of states looking to consolidate resources, simplify processes, or improve Triple Aim objectives. These are referenced here as applicable.
- *Key Stakeholders.* The views of stakeholders (including State Medicaid Directors, Advocates, Observers, Associations, and Provider Organizations) within each state were solicited. Executive directors and policy analysts from national organizations representing regional interests were also interviewed to understand the precipitating factors leading up to the implementation of their current model. Interviews were conducted with 31 individuals across 16 states. A copy of the

questionnaire used to guide these interviews is available in the appendix.

- *Available Research Literature.* While a systematic review of available research literature was not conducted, this analysis did not find conclusive evidence linking financing models to behavioral health outcomes. Relevant findings are referenced as footnotes throughout.

Better Health?

The initial question for national stakeholders was whether the change in their financing model was associated with changes in outcomes for people served (either positively or negatively). Outcomes here are defined as demonstrable changes in the lives of individuals receiving Medicaid services, as opposed to changes in process (*which are also important, and considered in the Better Care section, below*).

Absence of Published Outcomes

When asked about the driving reasons for systemic change, one of the most common answers from policy-makers is some variation of "better outcomes for people served." Given the importance of outcomes in weighing financing decisions, there was a surprising lack of outcomes available from the states we reviewed. The small number of available, standardized, population-level outcome measures for behavioral health services is well-known,[xxvi] and is being acutely felt by organizations attempting to develop accountable systems of care.[xxvii]

That said, there is no clear evidence base tying funding models to the long-term health outcomes of the population receiving behavioral health services.

State Experiences

Some states associate the financing model with improved outcomes, while other states believe the financing model is not responsible for better care. Some individuals in states with an established history using a specialized

financing model have attributed the achievement of Triple Aim objectives to that model, though this relationship is speculative:

> *"With the carve-out model, we were able to do an amazing job with reducing hospitalizations, saving the state money, and pumping the money back into services for consumers."* (Colorado interview).

Providers in some states do not view consolidated models of financing as intrinsically more effective, citing the increased emphasis on cost management as a disincentive to quality of care:

> *"The carve-in isn't a model that rewards best practices- it's basically the old FFS model. It puts you on this treadmill, where if you don't want to go broke, you have to have productivity expectations, have case managers see so many clients per day, rather than be able to go and focus more on wellness and outcomes. It rewards units of service."* (Minnesota interview).

Stakeholders were reluctant to draw a solid line between funding models and outcomes, opting instead to comment on the types of incentives that these models created:

> *"Managed care is not necessarily good or bad. Plans can save money just by watching trends- visits, readmission rates, disconnection from inpatient to outpatient. If you don't have protections and monitor trends, there's no guarantee that anything else besides saving money will take place."* (New York interview).

Those interviewed appear to understand the importance of outcomes, yet were unable to point to data to support their choices of models (regardless of the type of model selected). This is a non-finding, but important to highlight, due to the claims that are often made in support of one model or another.

Better Care?

States were also asked about whether their change in financing model was associated with improved care for the defined population. Changes in care include areas such as access to services, patient experience, and care coordination.

Key Issues at the Point of Care

The ability to provide better care relies on the availability of a competent workforce. Virtually all stakeholders interviewed reported inadequate workforce as a major challenge facing providers. While the country has experienced a shortage of psychiatrists[xxviii], other positions such as clinicians and direct care providers are becoming difficult to hire and maintain as well[xxix]. While wages in other industries have risen steadily, behavioral health care wages are often subject to freezes based on an organization's financial situation, and direct-service employees can sometimes go years without a pay increase, even for cost of living (New Jersey interview).

As primary care providers have begun to integrate care, behavioral health organizations are finding themselves competing with these providers for clinical staff, often losing in the bidding process because they cannot offer competitive wages or fringe benefits (Minnesota interview). Rural providers also struggle to attract and retain skilled employees who seek the competitive wages and opportunities for growth that urban settings offer.

Some providers have found success in partnering with nearby colleges to provide internship opportunities, grooming these students into prospective employees.

Satisfaction with services

Two states with consolidated financing report strong satisfaction scores in recent years. In Tennessee, the state's Medicaid plan, TennCare, has seen satisfaction scores steadily increase from 61% in 1994 to 95% in 2011. In

Minnesota, the ratio of grievance to plan enrollees declined steadily from 2009-2012, despite enrollment growth of nearly 20% during that time.[xxx]

Another state offers a potential reason for such improvements in satisfaction:

> "*Consumers appreciate the convenience, that the providers talk to each other, and that issues requiring a referral can be addressed quickly without too much back-and-forth.*" (Arizona interview on Maricopa County integrated model).

Access to services

Representatives from Tennessee report that while costs have been more contained under the MCO model, there have been few issues with access to care, despite the state's choice to not participate in Medicaid expansion.

Many states that have made recent changes to their financing models have insufficient data to assess their new models, but they are able to describe what they hope for their consumers to experience:

> *"We're early in it, it's a little hard to say what we're seeing. We expect to see significant changes that realize the Triple Aim. Early on, we're seeing better health care experience. There's fewer barriers, and there's no longer a discussion on who should be paying for services- the plan is solely responsible."* (Arizona interview)

In some cases, individuals report that consolidated financing has helped to resolve issues with billing and allow for a focus on services:

> *"When you change the way you pay for behavioral health in primary care, it doesn't force someone like me to get really creative on which code I use or who can I see because of their insurance; instead, I am a member of the team, and help to take care of anyone regardless of their condition."*[xxxi]

Coordination of care

There is more to coordinating care than simply consolidating financing. A review of existing research literature makes it clear that significant coordination problems exist within the services funded by a single management organization.[xxxii] The question remains as to whether or not consolidating financing plays a significant role in promoting coordination.

A recent study by the Commonwealth Fund acknowledges the potential advantages of consolidated financing by aligning incentives, accessing comprehensive claims data, and having centralized accountability of quality and outcome measures. That said, the study disputes the notion that consolidation leads to integration. "In the absence of clear and enforceable contract provisions that require or incentivize integrated care approaches, a carve-in payment approach ultimately may be no more supportive of integrated care than a carve-out approach."[xxxiii]

Interviews with state behavioral health leaders support these findings:

> *"Integration doesn't have to happen at the payment level; that's irrelevant. What's important is what you're requiring at the local level"* (Pennsylvania interview).
>
> *"We have two completely different payment systems. To truly integrate, services, you need to align those payments"* (Colorado interview).
>
> *"Integrating financing at the MCO is not a magic bullet to get providers to integrate"* (Tennessee interview).
>
> *"Carving in behavioral health may or may not have any impact on our communities' attempts to integrate at a clinical level. Sometimes carving in and carving out do the same thing. If you want true and robust integration, the policies and payment arrangements for the mental health benefit must be seen and measured on the ground in the practice."* (Colorado interview)

Lower Cost?

In all states surveyed, decisions to pursue a given financing model were made based on the expectation that costs could be better controlled under the new model. Whether this actually occurred depended on a number of other factors.

Key Issues at the Point of Care

When we look at effects on providers of behavioral health care, we find many of the largest challenges faced are related in some way to the issue of financing. New Jersey, which uses a FFS model managed by an ASO, reports the lowest behavioral health reimbursement rates in the country. Stakeholders from Massachusetts, a Private PHP model, report that many community mental health providers are closing their outpatient practices because of inadequate reimbursement rates and insufficient business, cutting off one branch of services to save the provider as a whole. This survival strategy has resulted in a shortage of outpatient providers (New Jersey, Massachusetts interviews).

Furthermore, payment restrictions have not evolved at the pace of innovative service delivery. Antiquated models can interfere with newer care models that result in improved outcomes. For example, in many states, two types of services cannot be billed in the same day (Massachusetts interview).

Some states report difficulty in finding provider partners for care integration efforts. The challenge often arises when there are a separate set of incentives at the care level, regardless of financing model. For instance, primary care providers prioritizing their own quality and outcome measures may resist integration when they perceive that a specialty population has a detrimental effect on their incentives. In Arizona, some integration efforts have had a negative impact on patients, as primary care providers discharged some individuals from their practices after discovering they had a serious mental illness. These primary care provides expressed, concern that these patients would negatively impact their outcome-based incentives (Arizona interview).

States like Colorado are combating stigma by proactively seeking out physicians who buy into the integrated care model: one in which the doctor has less governance over the practice than in a typical office. These thoughtful hiring practices have resulted in more than 200 integrated care sites throughout the state (Colorado interview).

Some states have reported that during the procurement phase of MCO integration, savings and efficiencies are often promised. These promises are rarely actualized following implementation, at least not in a way that benefits all stakeholders, particularly the providers (Kentucky interview). Respondents from Kentucky reported that psychiatric hospitals had to fundamentally alter treatment practices due to changes in utilization management by the MCOs (Kentucky interview).

From the provider standpoint, the concern is that cost control may undermine the viability of their overall financial stability, even as they attempt to move a greater proportion of their services from inpatient to ambulatory settings. In a 2016 report, the Kansas Medicaid agency reported inpatient utilization days down 17%, behavioral health service utilization down 3%, and provider revenue down 7% (Kansas interview).

Prior to managed care, 98% of claims were paid to Kentucky community mental health centers (CMHCs) within 30 days. Since the implementation of managed care, the most successful CMHCs capture only 90% of claims, causing providers to decide how much of their staff resources to allocate to approving claims.

Global costs

While interest groups may make broad statements regarding the cost savings of one financing model or another, there is not broad support for any one model in the existing research literature. A comprehensive review analyzing the cost effectiveness of MCO and FFS models shows inconclusive results.[xxxiv]

Another thorough analysis of 24 studies on managed care indicates that managed care appears favorable in certain cases where the FFS model does a comparatively poor job at controlling costs. The study states that:

> "*Savings opportunities in Medicaid managed care are largely created by the inherent structural challenges of coordinating care… in the FFS setting… an unstructured system of care that creates incentives to provide as many services as possible…Managed care organizations (MCOs), on the other hand, combine… the financing and delivery of health care and thus have strong incentives –and means—to coordinate care and, in turn, reduce the costs… where Medicaid spending is concentrated*."[xxxv]

To the extent that a state's costs are currently uncontrolled, moving from a FFS model to a form of managed care (e.g. MCO, Specialty MCO, PHP, etc.) may reduce spending. For states that already use a managed care financing model, the resulting savings are likely to be less substantial.

Cost per person served

Decreasing per capita cost is an explicit part of the Triple Aim framework, and therefore an important measure of the impact of changes in financing.

Tennessee reports that per capita health care costs have decreased significantly since the introduction of managed care, and are well below the national average.[xxxvi]

An 18-month pilot study in Western Colorado has yielded promising results with integrating care through providing a global budget to provider practices. They saw a 5.5% reduction in Medicaid costs, 3% reduction in Medicare costs, and 5.4% reduction in the dual eligible population, totaling close to $2 million in savings in 3 practices.[xxxvii]

> *"When we changed the payment, we eradicated trapping providers into workflows. We allowed them to start consulting, collaborating instantly, because they weren't held to some artificial payment mechanism."*

Hidden costs of change

Any large scale change comes with unexpected costs. Stakeholders whose states had recently undergone a change in financing model discussed some of the costs that they had encountered during that process. Note that the cost incurred by changing funders is likely to occur regardless of the type of financing model to which one is transitioning.

While changes in financing models are generally intended to decrease per capita costs, states report that implementing best practices for health management can cause unanticipated expenses, especially in the first several months. In Arizona and Minnesota, as primary care treatment access was monitored and enhanced for specialty populations, individuals who had not received health care services regularly began seeing doctors and specialists. In Arizona, of the 80,000 people that receive both Medicare and Medicaid and do not have a serious mental illness, only 9,000 were accessing behavioral health services prior to integration efforts (Arizona interview).

In Georgia, providers report having been inundated with costs related to change in health plans (Georgia interview). New Mexico reported that a number of barriers arose as the state transitioned to a consolidated financing model.

> *"There were all kinds of disruptions to cash flow for providers in the first year. They had to get contracted and credentialed with MCOs in addition to the contracts for non-Medicaid services."* (NM interview)

In the absence of compelling evidence that a change in financing model actually achieves Triple Aim objectives, states should be cautioned that these unanticipated costs of transition in both resources and impact to persons served may outweigh any promised benefit.

Administrative costs

Another common promise of groups promoting one model or another is that their model will achieve greater efficiencies through administrative

simplification. A closer look indicates that such oversimplification of the structural impacts are not warranted by the available data.[xxxviii]

Not all administrative costs contribute equally to patient outcomes. Quality improvement, for instance, which is often deployed from an administrative department, has a direct value for the care people receive. This is implicitly acknowledged by the formula for calculating Medical Loss Ratio (MLR), which includes spending on quality improvement activities alongside provision of services.[xxxix]

Other types of administrative costs are less directly related to patient outcomes. The ACA requires public reporting and accountability of health plan spending on administrative costs such as sales and marketing under its MLR provisions,[xl] and for good reason. According to a report by McKinsey Global Institute, "sales and marketing alone account for one-third of total health administration expenses,"[xli] a cost incurred by necessity in a private, for-profit industry. This observation is related to their additional finding that "a privately administered insurance is intrinsically more expensive."[xlii]

These findings were corroborated by some of the states interviewed for this analysis:

> *"Lots of money was coming off the top at the MCO level (for-profits), then profit administration at the next level. By the time the money got to a provider, there was even less left over."* (Pennsylvania interview)

Michigan does not currently have a common formula for calculating administrative costs for management of Medicaid services across physical and behavioral health. This makes it challenging to do a direct comparison of the relative administrative efficiencies or inefficiencies of either system.

Additional Factors

While we have assumed that states are primarily motivated to select a given financing model in order to achieve objectives that align with the Triple Aim of Better Health, Better Care and Lower Per-Person Cost, this is not a complete picture of actual decision drivers. Interviewees from across the country also identified the following issues as driving state-level decisions regarding behavioral health financing:

Ease of Monitoring. Some states report a desire for a system that can be more easily monitored (i.e. moving from 4 MCOs to 1; using consolidated MCOs versus specialty MCOs).

> *"It is a real struggle to manage five health insurance companies; the workforce development around managing large insurance companies is enormous."* (Louisiana interview)

Political Climate. Several states referenced gubernatorial change as influencing Medicaid policy or preventing further movement related to financing models:

> *"The new governor has undertaken a significant redesign of the Accountable Care Model." (*Massachusetts interview)
>
> *"The governor has made it very clear that every population under Medicaid is going to move to managed care."* (Pennsylvania interview)
>
> *"[Carving in the Aged, Blind, and Disabled (ABD) population] has been talked about, but won't move under this governor."* (Georgia interview)

Legal Action. Class-action lawsuits have dictated the attention and direction of some states for 20 years or more, demanding increased care for people with disabilities (AZ, CO, GA interviews). These actions have resulted in increase in dollars to support greater service availability, though not all states have pursued this increase in service access using the same financing models.

Reluctance to Follow Fads. Behavioral health care has been inundated with fads and trends over the past 25 years, many of which have not stood the test of time. Some executive directors with a long tenure in the field have become reticent to make any changes that have significant cost implications without assurance of sustainability. The memories of past mistakes or lost investments are still fresh in their minds (Pennsylvania interview).

Shifting Paradigms. Some states reported that historical context was a factor in their decision. These states cited the circumstances in which behavioral health specialty financing gained momentum: a time in which health care pursued expertise amidst a split mind-body paradigm. While these states believe that the model has served them well, they acknowledge that philosophies and understanding have changed over time, contributing to the need to consider other models.

Growth in the Specialized Funding Population. While some states with specialty financing models initially developed those models for smaller populations, some states report that the growth in overall Medicaid eligibles and identified behavioral health needs has prompted them to reconsider this model. An interviewee from Colorado reported that the Medicaid population has grown tenfold since the development of specialty behavioral health financing 20 years earlier (120,000 vs. 1.3 million). Such growth has prompted consideration of models that can more sustainably handle risk as the volume of persons served increases.

Recommendations for Michigan's Specialty System

Michigan is currently engaged in a dialogue about how the integration of care for people with behavioral health conditions can best be achieved. Based on the experience of other states and a lack of evidence, a focus on the financing model is insufficient to drive the necessary change. The following recommendations are drawn from the analysis above:

Engage a Goal-Driven, Transparent Effort for System Redesign. Michigan should base its planning on other successful state approaches. This should include a purposeful inclusion of a range of stakeholders (especially those that receive behavioral health services), and use a deliberate process by which to engage such changes in a manner that is focused on Triple Aim objectives. The financing model ultimately selected should support the goals and outcomes defined by this process.

Measure and Report Outcomes and Costs. Any system that allies itself with the interests and needs of a specific population must also measure the impact of its effort on that population. Michigan's behavioral health system should (a) adopt existing measures where these are relevant[xliii] and (b) build new measures where indicators of effectiveness are lacking for this population.

Report Administrative Costs Consistently. Administrative costs are currently measured differently across MCOs and PIHPs in Michigan. This makes it difficult to compare the dollars going to services across MCOs, PIHPs and providers. State decision-makers would benefit from a transparent way of measuring what is included in administrative rates, from the plan-level to the provider-level.

Broaden the Scope of Integration. While the United States spends substantially more on healthcare than other nations, there is one notable area where their spending is less: social services. And it turns out that countries

with higher social spending compared to health spending report better outcomes.[xliv]

In order to be more than a buzzword or fodder for political agendas, integration must address multiple determinants of health: social, behavioral, biological, and more. This means integrating services and measuring costs across multiple systems in a way that has a tangible impact on the people who are served; from education to criminal justice to welfare and social services. The recent combination of Michigan's human services and community health departments provides a fulcrum for such efforts. Likewise, the population of individuals receiving behavioral health services are a sensible starting point for integration. Prototypes for this type of collaboration already exist and have lessons for the public behavioral health system in Michigan.[xlv, xlvi]

Integrate Financing Where it Counts. Integrating financing is not the same as integrating care. In order to ensure that improvements at the point of care flourish, savings need to be shared equitably at the service provider level. Implementing financing models that share savings and risk with service providers must thoughtfully tackle considerations related to the inclusion of high-cost patients in shared savings calculations.[xlvii] If the purpose of integrated financing is to unite physical health, behavioral health and social services to effectively serve a complex population, then assurances need to be made which will keep dollars directed to the point of care.

Increase Incentives for Performance. Payments need to align in a way that encourages providers to keep people healthy. The complexity of implementing value-based models with a population receiving behavioral health services[xlviii] requires a well-thought out approach. This does not imply that waiting for a state-level mandate is necessary.[xlix] Due to the importance of this issue, pilot programs should be developed at the plan level with results informing the state's chosen model(s).

Enhance Collaborative Open-Source Approach. One of the frequently cited strengths of the MCO model is its competitive nature. This can lead to incentives for performance, but also to a proprietary interest in information that might otherwise be used for the greater good of a population. Michigan's PIHPs and CMHSPs, on the other hand, serve discrete geographical regions and are not currently in direct competition with one another for funds. This lack of competition provides an opportunity for open sharing of knowledge. PIHPs and CMHSPs should further develop networks for sharing knowledge regarding best practices, evaluation findings and research to improve outcomes.

Complex Populations need Complex Analysis, Guided by Experts. A more complex population requires an even greater investment in obtaining high-quality data and analytics.[l, li] Greater complexity also lends itself to a greater amount of "noise" in the data, and many algorithms perform better when guided by experts who are intimately aware of the details of the population being analyzed. Sophisticated approaches to data use have shown themselves to be a critical component of designing, operating and evaluating programs for high-need, high-cost populations.[lii]

Engage Ground-Level Stakeholders, Namely Providers and Consumers. Sustainable, meaningful integration efforts must be championed by people with lived experiences of receiving treatment in a behavioral health setting. Their unique perspective, along with the practical expertise of clinicians, provides the context necessary to develop personal, effective systems of care. The Peer Support Movement has solidified the importance of empowering individuals in their care[liii], and some of the strongest behavioral health care systems in the country involve peer supports in their service delivery.[liv]

Use Available Public Data for Further Investigation. Additional analysis of available public data at both the federal and state level may help to provide context for these issues beyond the scope of this paper. This should include state level comparative analysis of administrative costs, penetration rates,

access measures, coordination of care measures, satisfaction, and adherence to best practices or outcomes. While time-consuming, such an analysis of available data is vital in driving decisions and guiding the development of pre- and post-state success measures.

This study was sponsored by the Michigan Association of Community Mental Health Boards (MACMHB). Created in 1967, MACMHB supports county mental health services programs (CMHSPs) in promoting, maintaining and improving a comprehensive range of community-based mental health services, which enhance the quality of life, promote the emotional well-being, and contribute to healthy and secure communities which benefit all of Michigan's citizens.

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Appendix: Interview Guide

Below is the set of questions which were asked of each participating interviewee:

Purpose of this study: The Michigan Association of Community Mental Health Boards is sponsoring this research, which we are conducting to gain a better understanding of the effect of carve-in versus carve-out models on each state's outcomes, efficiency, and cost, as well as implications on integrated care service delivery.

Statement of confidentiality: We can assure you that nothing that you say will be attributed specifically to you or your organization. We are trying to get an overall sense of what's going on with adult Medicaid beneficiaries in your community by talking to several different organizations, and then we will synthesize everyone's comments in our final report. However, we do expect that we will identify individual communities because the programs and delivery systems in each location are so different. We will be talking with representatives from 8-10 states.

Voluntary Participation: I want to acknowledge that your decision to talk with us is voluntary, and we really appreciate your time. If you need to stop at any time, that's fine. And of course, if there are any questions that you don't know the answer to, or don't want to answer, that's okay too.

1) Tell me about the work you do at your organization.
2) What services are carved-in or carved-out of your Medicaid delivery system?
3) How would you assess your state's Medicaid service delivery model? Does it appear to be working for all stakeholders involved?
4) If the model was introduced recently, what were the reasons for the change? What challenges have been faced in implementing this model? Does it appear to be improving care?
5) Was the change associated with changes in outcomes for people served (+/-)?
6) Was the change associated with changes in care for the defined population (+/-)?
7) Was the change associated with changes in satisfaction with services?
8) Was the change associated with changes in access to services?
9) Was the change associated with changes in availability of evidence-based practices?
10) Was the change associated with changes in cost (+/-)?
11) Was the change associated with changes in global costs at state level?
12) Was the change associated with changes in cost to person served?
13) What are the biggest challenges facing your organization?

References

End-notes for the references cited throughout this paper can be found below:

[i] One commonly-cited study estimates that individuals with serious mental illness die 25 years earlier, on average. See: Svendsen, D., Singer, P., Foti, M. E., & Mauer, B. (2006). Morbidity and mortality in people with serious mental illness.

[ii] To say that mortality in the population of individuals with mental illness is not primarily due to the mental illness itself is not to downplay the impact of suicide on mortality in this population. A recent systematic review by Walker et al. found that 17.5% of deaths among individuals with serious mental illnesses were related to "unnatural causes" such as suicide.

[iii] Walker, E. R., McGee, R. E., & Druss, B. G. (2015). Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. JAMA psychiatry, 72(4), 334-341.

[iv] The issue of health disparities for people with behavioral health conditions fits the definition of what is called, in systems design, a "wicked problem." These problems have the following characteristics: 1) there is not a single way to define them, 2) difficult to measure success because interrelated issues bleed into one another, 3) no perfect end state, so the focus is on continuous improvement rather than a final solution, 4) there is no "one-size-fits-all" template, 5) every "wicked problem" is a symptom of another problem, 6) Those attempting to address a wicked problem must be fully responsible for their actions. Excerpted and modified from Kolko, Jon. (2012). Wicked Problems: Problems worth solving: a handbook and call to action. Austin, Texas : Ac4d, Austin Center for Design.

[v] The books to read are: Porter, Roy. (2002). Madness: A Brief History. Oxford: Oxford University Press, and Shorter, Edward. (1997). A History of Psychiatry: From the Era of the Asylum to the Age of Prozac. Wiley.

[vi] One recent paper describes a species of "super-wicked problem" that has the following additional characteristics: 1) Time is running out, 2) there is no central authority, 3) individuals seeking to solve the problem are also causing it, and 4) policies discount the downstream effects of the incentives that they enact. See: Levin, Kelly; Cashore, Benjamin; Bernstein, Steven; Auld, Graeme (23 May 2012). Overcoming the tragedy of super wicked problems: constraining our future selves to ameliorate global climate change. Policy Sciences 45 (2): 123–152. doi:10.1007/s11077-012-9151-0

[vii] Research literature related to the social determinants of health is substantial, and continues to grow. The Center for Disease Control (CDC) devotes an entire website to data and policy options related to social determinants here: http://www.cdc.gov/socialdeterminants/. Additional key documents are listed below: Farmer PE, Nizeye B, Stulac S, Keshavjee S (2006) Structural Violence and Clinical Medicine. PLoS Med 3(10): e449. doi:10.1371/journal.pmed.0030449

[viii] Butler, M., Kane, R. L., McAlpine, D., Kathol, R. G., Fu, S. S., Hagedorn, H., & Wilt, T. J. (2008). Integration of mental health/substance abuse and primary care.

[ix] Alakeson, V., Frank, R. G., & Katz, R. E. (2010). Specialty care medical homes for people with severe, persistent mental disorders. Health Affairs, 29(5), 867-873.

[x] The Innovation Center has been tasked with developing new payment and service delivery models in accordance with section 1115A of the Social Security Act, as well as additional specific demonstrations as directed by Congress. Current pilot programs can be viewed on the Innovation Center's website, here: https://innovation.cms.gov/initiatives/map/index.html

[xi] Additional information is available at the website for the Medicare-Medicaid Coordination Office: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html

[xii] For more information, see SAMHSA-HRSA Center for Integrated Health Solutions website: http://www.integration.samhsa.gov/

[xiii] Specific at-risk populations from the newly-eligible Medicaid expansion population include homeless individuals; the jail-involved population; and veterans. See: Fact Sheet: Reaching Vulnerable Populations through Health Reform. Center for Health Care Strategies (April 2014)

[xiv] Bachrach, D., Anthony, S., Detty, A., Manatt, P., & Phillips, L. L. P. (2014). State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment. New York: Commonwealth Fund.

[xv] *Ibid*. p. 8.

[xvi] New York's Governor Cuomo, for instance, established a Medicaid Redesign Team (MRT) in January 2011 as a means of finding new ways to lower Medicaid spending in New York State during the 2011-12 fiscal year. Changes in financing model took place after a deliberative process including a diverse and representative set of stakeholders, and comprehensive system reform continues to be developed by ten multi-disciplinary teams.

[xvii] Miller, B. F. (2015). When frontline practice innovations are ahead of the health policy community: The example of behavioral health and primary care integration. The Journal of the American Board of Family Medicine, 28 (Supplement 1), S98-S101.

[xviii] Ader, J., Stille, C. J., Keller, D., Miller, B. F., Barr, M. S., & Perrin, J. M. (2015). The medical home and integrated behavioral health: advancing the policy agenda. Pediatrics, 135(5), 909-917.

[xix] For a helpful review of more general key concepts and terms related to Medicaid financing, please see the following issue brief: Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts. Kaiser Family Foundation, 2015. This paper has sought to keep its use of the terms consistent with the definitions used in Kaiser's glossary, where possible.

[xx] The term "consolidated management" is used in lieu of the more commonly-used term "carve-in", and the term "specialty management" in lieu of "carve-out." The intention here is two-fold: 1) to ensure a clear distinction between the integration of care and the integration of financing streams, and 2) to avoid common associations between "out" and "in" groups. This naming convention attempts to name each approach for its perceived strengths: "consolidation" referring to the potential for administrative simplification, and "specialty" referring to the application of population-specific knowledge in the management of behavioral health services.

[xxi] Information regarding state financing models is based on up-to-date market intelligence from Open Minds, (see: Which State Medicaid Plans Carve-Out Behavioral Health Benefits? *Open Minds Market Intelligence Report*, January 2016). The classifications used in this paper were derived from specific combinations of financing related to three of the five key subsets of benefits noted in this report: *Outpatient Mental Health Services, Specialty Mental Health, Psychiatric Inpatient,* and *Outpatient Addiction Treatment*. The additional two areas (*Mental Health Pharmacy* and *General Pharmacy*) were not considered in the groupings. For consistency of terminology, certain groupings were relabeled to fit the definitions developed by Kaiser (see above, endnote). For instance, MBHOs referenced in the Open Minds report are referred to as prepaid health plans, as they are non-comprehensive benefits using a capitated, risk-based arrangement.

[xxii] Michigan League for Public Policy (January 2015). *Behavioral Health Change and Transformation: Looking Ahead, Learning from the Past.* Prepared for the Michigan Association of Community Mental Health Boards

[xxiii] Beacon Health Options (2015, Nov 6). *Program Audit of Lakeshore Regional Entity PIHP*.

[xxiv] States that have recently changed models include Iowa (1/1/16), Louisiana (12/1/16), Arizona (4/1/14), New Mexico (1/1/14)

[xxv] While not all states have explicitly adopted the Triple Aim as a model for evaluation, the model is widely known across the healthcare industry and is useful as a common framework to discuss the desired goals of

systemic changes to systems. For a discussion of the Triple Aim related to discrete measurements for evaluation, see: Stiefel M, Nolan K. A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org)

[xxvi] The National Quality Forum's Measure Applications Partnership (MAP) has noted behavioral health measures as a high priority gap in both the Adult and Child Medicaid measure sets as part of its 2015 review. Measures of functional outcomes are also a critical area where gaps in existing measures have been noted.

[xxvii] A recent evaluation of a Massachusetts-based ACO, the Alternative Quality Contract (AQC), noted the lack of available behavioral health measures as a key barrier in the evaluation of integrated funding and services. See: Barry, C. L., Stuart, E. A., Donohue, J. M., Greenfield, S. F., Kouri, E., Duckworth, K., & Huskamp, H. A. (2015). The Early Impact Of The 'Alternative Quality Contract' On Mental Health Service Use And Spending In Massachusetts. Health Affairs, 34(12), 2077-2085.

[xxviii] Crary, David. (2015, September 8). "There's a Serious Shortage of Psychiatrists in the U.S." [News article]. Retrieved from http://www.huffingtonpost.com/entry/theres-a-serious-shortage-of-psychiatrists-in-the-us_us_55eef13ce4b093be51bc128f

[xxix] Turham, H., and Stein, R. (2015 September). "Employers Can't Attract Direct-Support Workers with Current Reimbursement Rates." Retrieved from http://progressivelifestylesinc.org/wordpress/wp-content/uploads/2015/10/Partnership-for-Fair-Caregiver-Wages-Brief-9-2015.pdf

[xxx] Public Consulting Group. *Report on the Value of Minnesota Health Care Programs (MHCP) Managed Care, As Compared to Fee-For-Service*. (September 2013). https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6787-ENG

[xxxi] The Carter Center. (2015, November 30). *2015 Rosalynn Carter Symposium on Mental Health Policy Pt 3/5 (Carter Center)* [Video file]. Retrieved from https://www.youtube.com/watch?v=uisdCgrRt4I

[xxxii] For a wealth of examples, see the details of systematic reviews conducted within this study by the National Institutes of Health: McDonald, K. M., Sundaram, V., Bravata, D. M., Lewis, R., Lin, N., Kraft, S. A. & Owens, D. K. (2007). Closing the quality gap: a critical analysis of quality improvement strategies (Vol. 7: Care Coordination). Rockville (MD): Agency for Healthcare Research and Quality.

[xxxiii] Bachrach, 12.

[xxxiv] Public Consulting Group. *Report on the Value of Minnesota Health Care Programs (MHCP) Managed Care, As Compared to Fee-For-Service.* (February 2013), p.29-31 http://archive.leg.state.mn.us/docs/2013/mandated/130629.pdf

[xxxv] The Lewin Group, (March 2015) "Medicaid Managed Care Cost Savings- A Synthesis of 24 Studies". p.5 http://leg.mt.gov/content/Committees/Interim/2011-2012/Children-Family/Topics/Medicaid%20Monitoring/lewin-synthesis-of-managed-care-studies.pdf

[xxxvi] Gordin, Darren (November 2012). Tennessee's Experience in Controlling Medicaid Costs (presentation). Retrieved from http://www.nga.org/files/live/sites/NGA/files/pdf/1112REDESIGNGORDON.PDF

[xxxvii] The Carter Center. (2015, November 30). *2015 Rosalynn Carter Symposium on Mental Health Policy Pt 3/5 (Carter Center)* [Video file]. Retrieved from https://www.youtube.com/watch?v=uisdCgrRt4I

[xxxviii] While some data related to state spending is publicly available, it is not consistently aggregated to include spending at the state, plan and provider level. The MACPAC site, for instance, reports administrative costs at the state level but excludes plan-level administrative spending. See: https://www.macpac.gov/publication/total-medicaid-administrative-spending-by-state-and-category/

[xxxix] For details on the methodology of calculating MLR, see: CMS-9965-P: Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans

[xl] Information on health plan spending on administration is available on the CMS website, here: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html

[xli] Farrell, D., Jensen E., Kocher B., Lovegrove N., Melhem F., Mendonca L., et al., Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More, McKinsey Global Institute, December 2008. p. 75. Exhibit 50.

[xlii] Farrell et al., p. 76. Exhibit 51.

[xliii] This should include a thorough review of available measures endorsed by either the National Quality Forum or used in programs by the Center for Medicare and Medicaid Services (CMS). Initial efforts to build on available measures for populations with behavioral health conditions have been underway for some time (see NQF's project to endorse Behavioral Health measures) and these should be reviewed and considered for inclusion in a balanced measurement portfolio before new measure development is begun.

[xliv] Bradley, E. H., Elkins, B. R., Herrin, J., & Elbel, B. (2011). Health and social services expenditures: associations with health outcomes. BMJ Quality & Safety.

[xlv] Multiple examples of such initiatives are cited in this review of Accountable Communities for Health, an ACO model which approaches care and social determinants across service sectors. Tipirneni, R., Vickery, K. D., & Ehlinger, E. P. (2015). Accountable communities for health: moving from providing accountable care to creating health. The Annals of Family Medicine, 13(4), 367-369.

[xlvi] S.F. Sandberg, C. Erikson, R. Owen, K.D. Vickery, S.T. Shimotsu, M. Linzer, et al. "Hennepin Health: A Safety-Net Accountable Care Organization For The Expanded Medicaid Population." Health Affairs, 33, no. 11 (2014): 1975-84. Available at: http://content.healthaffairs.org/content/33/11/1975.abstract.

[xlvii] A discussion of several options available for use with high-cost outliers is available in the briefing cited below. Since the population of individuals receiving behavioral health services is likely to have a disproportionate number of individuals qualifying as "high-cost" compared to the general population, the methodology adopted must be purposeful in addressing this difference. See: Bailit M. and Hughes C. (2011) Issue Brief: Key Design Elements of Shared-Savings Payment Arrangements. Commonwealth Fund, p. 4.

[xlviii] A recent article cites treatment adherence, stigma and social determinants of health as significant challenges in implementing value-based payment designs Ferguson, A., Yates, C., & Tilford, J. M. (2015). Value-based insurance designs in the treatment of mental health disorders. *The American Journal of Managed Care*, *22*(1), e38-44.

[xlix] The road to enacting pay-for-performance (P4P) arrangements which have a net benefit on complex populations will be a long one. Research in behavioral economics, for instance, indicates that the assumptions upon which P4P is based may not hold true in instances where complex decision making is required. A study by Ariely, *et al.* found that "as long as the task involved only mechanical skill, bonuses worked as would be expected: the higher the pay, the better the performance. But when we included a task that required even rudimentary cognitive skill…the offer of a higher bonus led to poorer performance." See: Ariely, D., Gneezy, U., Loewenstein, G., & Mazar, N. (2009). Large stakes and big mistakes. *The Review of Economic Studies*, 76(2), 451-469.

[l] D.W. Bates, S. Saria, L. Ohno-Machado, A. Shah, and G. Escobar. "Big Data in Health Care: Using Analytics to Identify and Manage High-Risk and High-Cost Patients." Health Affairs, 33, no. 7 (2014): 1123-31. Available at: http://content.healthaffairs.org/content/33/7/1123.abstract.

[li] C.S. Hong, A.S. Hwang, and T.G. Ferris. "Finding a Match: How Successful Complex Care Programs Identify Patients." California Health Care Foundation. March 2015. Available at: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/F/PDF%20FindingMatchComplexCare.pdf.

[lii] One prominent example is the work that Jeffrey Brenner and colleagues have done with super-utilizers in Camden, N.J. Their use of data is highlighted here: Green S.R., Singh V., and O'Byrne W. "Hope for New Jersey's City Hospitals: The Camden Initiative." Perspectives in Health Information Management, Spring

2010. Available at: http://search.proquest.com.ezproxy.princeton.edu/docview/213202979?pq-origsite=summon.

[liii] National Coalition for Mental Health Recovery, (2014 April 16). "Peer Support: Why It Works." Available at http://www.ncmhr.org/downloads/References-on-why-peer-support-works-4.16.2014.pdf

[liv] Interviewees from established providers in several states, including Arizona, Georgia, Minnesota, and New Jersey, attested to the critical importance of peer supports in their service delivery models.