

The Benefits of a
**BEHAVIORAL
HEALTH
CARVE-OUT
PROGRAM**

INTRODUCTION

As federal and state health care expenditures continue to rise, state agency leaders look to the managed care industry for solutions to better manage health care costs while covering more members. The Congressional Budget Office Extended Baseline Scenario projects costs for Medicaid, Medicare, the Children's Health Insurance Program, and the health insurance exchange subsidies to grow by more than 60 percent of their 2010 levels by 2035. The recent economic downturn has placed particular strain upon state budgets, with fewer tax revenues to allocate for Medicaid and other publicly-funded health programs. At the same time, membership for these programs has increased in response to a weakened labor market, a lack of viable insurance alternatives, and other economically-induced factors.

Medicaid will play an even larger role in providing insurance coverage for aged, blind, and disabled (ABD) individuals with mental illnesses/substance abuse disorders post-health reform. Current estimates indicate that Medicaid will cover 24.3 percent of these individuals when reform is fully implemented in 2019. Medicaid members with behavioral health disorders are expected to account for approximately 31.9 percent of the expected increase in total Medicaid expenditures¹. These expenditures are expected to increase by 49.7 percent—not including the added costs of the many co-morbid medical conditions we know to exist among the Medicaid population suffering from mental illness. In total, the needs for appropriate care and improved health outcomes are imperative to states' control over their Medicaid budgets. We believe the only way to achieve these goals is through the implementation of a carve-out behavioral health program.

ADVANTAGES OF A BEHAVIORAL HEALTH CARVE-OUT PROGRAM

Behavioral health carve-outs are defined as programs that contract directly with managed behavioral health organizations, separately from the remaining health care benefit package. Carve-outs include mental health and substance abuse services specialists. Programs can range from simple administrative services only (ASO) contracts to shared savings models and full behavioral health capitation.

The advantages of carve-out programs have been studied since the inception of behavioral health managed care. Evidence suggests that carve-outs are successful in lowering costs and maintaining or improving access to care. They have been instrumental in addressing long-standing challenges in utilization, access, and cost of behavioral health care.

Across the country, behavioral health carve-outs have provided higher rates of access and greater levels of specialization for Medicaid managed care than integrated behavioral health programs. Through contract language and performance incentives, behavioral health carve-outs provide specialized recovery-oriented services that are critical for individuals with serious mental illness and children at risk. A SAMHSA-sponsored study of Medicaid managed behavioral health care found that public carve-out programs had penetration rates of 11 percent compared to the 5.6 percent penetration rates that HEDIS reported for Medicaid HMOs nationally in Quality Compass 2000 (1999 data). Penetration for outpatient care was considerably higher in carve-outs, with the SAMHSA study programs averaging 10.9 percent compared to NCQA's 5.5 percent average.

Some of the programmatic elements that have shown particular promise include:

- behavioral health carve-out programs to manage the special needs of the population, such as the individuals with serious and persistent mental illness (SPMI) or those with dual diagnoses
- targeted care management and care coordination for individuals with complex care needs
- development of contractual performance standards to ensure high quality of care for individuals
- provider access standards to ensure that members can receive timely care from health care providers and specialists
- transparency of program design and accountability of the contractors and providers involved within the program

¹Donohue, Garfield, & Lave, 2010

Additional advantages of carve-outs include:

- *Single point of accountability* with expertise at overseeing the behavioral health care for Medicaid individuals.
- *A reduction in expenditures, especially in inpatient services.* The greatest savings are experienced at the onset of behavioral health managed care programs.
- *Access to a specialized psychiatric and behavioral health provider network, including community-based providers,* offers members a wide variety of providers from which to choose.
- *Targeted behavioral health performance guarantees* enable clients to drive their program and attain desired results.
- *Experienced behavioral health professionals* provide utilization management in carve-out programs and are more effective in reducing costs while improving member outcomes. Traditional Medicaid managed care organizations have not shown the capacity or the interest in delivering specialized services for those with serious mental illness, unless there was significant money to be made by reducing benefits.
- *Focused attention on behavioral conditions,* especially those that are co-morbid with a medical condition, can reduce costs across the board.
- *Improved care coordination* ensures that treatment is both specialized and integrated into the medical PCP environment.
- *Use of recovery strategies, person-centered planning and evidence-based practices* serve populations with complex and serious needs who require a high level of expertise to develop treatment plans.
- *A demonstrated capacity to assist with reinvestment* into the behavioral health delivery system aids in expanding alternative services.
- *Behavioral health expertise is woven into all services* for clients: clinical, reporting and data management, and consultation allow each client to analyze the data necessary to make informed decisions.

VALUEOPTIONS, INC.

As a nationally recognized managed behavioral health care provider, ValueOptions has wide-ranging experience in working with state agencies to develop customized carve-out programs that meet the specific needs of Medicaid beneficiaries. Our experience includes increasing access to services, expanding engagement and satisfaction of Medicaid beneficiaries and advocates, and achieving savings that have been reinvested in the behavioral health care systems we serve.

ValueOptions leads the industry with 52 publicly-funded programs under management in 14 states. We tailor program strategies and administrative approaches to each client's target populations and management vision. In each program, we have successfully developed a delivery system that provides mental health and/or substance abuse services for adults, adolescents, children, seniors and families from diverse economic, cultural and ethnic backgrounds.

We believe our formula for success has been a simple one:

- partner with local providers—aligning incentives to re-engineer the system of care
- focus our efforts on the most vulnerable Medicaid members—serving those that no one else wants to serve
- maximize the power of integrated technology for data sharing, clinical improvement, and client reporting
- reduce inpatient admissions and significantly improve access to community-based care
- improve outcomes, reduce costs, and increase the value of each dollar spent

VALUEOPTIONS' CARVE-OUT SOLUTIONS AND PROGRAM SUCCESSES

ValueOptions' Carve-Out Solutions

Public behavioral health programs for individuals with disabilities and high-risk populations require specialized solutions and dedicated staffing to coordinate care. We tailor our program strategies and administrative approaches to address the needs of targeted populations and the management visions of each of our clients. Our experience, technological innovations, and flexible program design enables us to partner with public sector entities to develop and implement cost-effective behavioral health programs and solutions that are responsive to all stakeholders—consumers, families, and our clients.

Some of the solutions we bring as a specialty behavioral health carve-out include:

- **Braided FundingSM**—As states have increasingly braided Medicaid dollars with other funding streams, such as mental health, child welfare, substance abuse and juvenile justice, ValueOptions Braided Funding has applied new and innovative technology to bring increased efficiency and effective monitoring. With this technology, clients are able to track dollars across agencies and programs, and to realize savings from five to 10 percent of total expenditures by maximizing the value of the different funding sources.
- **Peer Support Services**—Recovery and resiliency are fundamental to our approach. We offer unmatched experience serving Medicaid populations across the country with innovative program designs emphasizing peer support and member-driven care. We integrate peer and family support services into best practice delivery of behavioral health care to drive consumers toward recovery. Service planning processes encourage consumers and their families to not only participate but lead goal setting, selecting service options and engaging treatment professionals. Network and program development, which are driven by consumer and family member voices, offer the widest possible array of service and support options—whether through a nationally-recognized housing program, extensive peer support networks, or innovative vocational programs.
- **Care Coordination**—ValueOptions has invested heavily in developing program designs and infrastructures that provide coordinated physical health and behavioral health care for high risk/high cost populations. We know these populations require more support than any other and we acknowledge our role as system navigators, advocates, and social support networks that connect consumers with the resources they need to access appropriate, timely care. Our proactive interventions foster increased functioning, prevent exacerbation of symptoms and crises, and help members to live in the least restrictive, most supportive environment. We ensure that an active care team, anchored by the consumer or family and including both behavioral and physical health providers, understands and informs the member-centric care plan.

ValueOptions' Carve-Out Program Successes

We provide contract-specific examples of our success, by state of service, below:

MARYLAND

Since September of 2009 ValueOptions Maryland, as the ASO for the Maryland Mental Hygiene Administration, has provided utilization management and claims adjudication services for behavioral health care delivered by the State's Public Mental Health System network of providers. This program covers approximately 1.0 million Medicaid and Uninsured adults and children across the State.

Through the use of targeted UM strategies focused on managing those providers whose utilization patterns differ the most from best practice trends, ValueOptions Maryland has consistently delivered reduced cost of care both on a PMPM basis and cost per consumer served basis while facing ever increasing membership growth year over year. As of 03/31/12, *VO Maryland has delivered 10 straight quarters of declining PMPM costs arriving at a PMPM global cost of care that is \$4.89 lower than that at contract inception. This equates to a savings of approximately \$46 million* over 3 years. During this same time, membership has grown at an average rate of approximately 9.0% per year as penetration has increased.

In addition to successfully managing costs through targeted UM services, VO Maryland in partnership with the State's MHA and the University of Maryland has also successfully implemented one of the most robust and comprehensive behavioral health Outcomes Measurement Systems (OMS) in the country. As stated in a recent issue of *Mental Health Weekly*, the system "is designed to track how individuals receiving outpatient mental health treatment services in Maryland's Public Mental Health System (PMHS) are doing over time." The system was developed with the input of consumers, caregivers, providers and other PMHS stakeholders with the intent that the data will be used for effective systems management and program development. Most recently the OMS data has been incorporated in to the development of a financial modeling tool to be used in conjunction with VO's pay for performance program being piloted in the State of Maryland. VO is partnering with McKesson in this first of its kind program designed to provide financial incentives for improved quality based outcomes in the Public Sector.

COLORADO

Our Colorado Health Partnership program is a partnership between eight CMHCs in Southern and Western Colorado with more than 16 years of proven success. This program covers 170,000 Medicaid eligible members in 43 of the 64 counties in Colorado. Since 1995, we have re-balanced Medicaid health spending—*instead of 65 percent of funding going to institutional care, more than 90 percent now goes to community-based services*. Individuals with serious and persistent mental illness have been moved from restrictive treatment settings and successfully engaged in alternative treatment and support, including: supported employment and housing, respite homes, in-home crisis intervention, and homeless outreach. These interventions improve access to the most at-risk members and represent a historical program *savings of approximately \$20 million*.

Members have experienced improved outcomes as a result of the partnership's investment in community-based services and de-emphasizing restrictive levels of care, such as inpatient and residential levels. In one recent study using the Basis-32 instrument, members showed *significant improvement on six of the 32 individual items, as well as on three of the five domains* measured. In another measure, members' global assessment of functioning (GAF) scores increased three points.

Not only did GAF scores rise, but housing adequacy improved. We also found positive evidence of more social contacts, higher personal income and better family relationships among people with severe, persistent mental illness. One CMHC found that *38 percent of their clients with severe and persistent mental illness reported working, volunteering, or going to school* after making the shift to community-based treatment.

TEXAS

ValueOptions' Texas NorthSTAR program provides an integrated system of care with mental health and substance abuse services from multiple programs and funding sources. This program covers approximately 1.1 million Medicaid and indigent adults and children.

According to a 2006 analysis conducted by The Perryman Group², "NorthSTAR is an effective steward of public resources consistently delivering enormous value for lower cost than other areas." *Membership has consistently increased—approximately 97 percent from 2000 to 2009—while cost per enrollee decreased from \$2,563 to \$1,830*. Further evidence of cost savings for both SSI and TANF Medicaid adults were presented in a preliminary analysis conducted by the Legislative Budget Board staff in 2009. Results indicated Medicaid spending in FY 2006 was *\$5,689 less per member among SSI and SSI-related Medicaid adults* receiving substance abuse treatment services through NorthSTAR and *\$4,439 less per member among TANF and TANF-related Medicaid adults*.³

²Effective, Efficient, and Essential: The Economic Impact of the NorthSTAR Model for Providing Mental Health and Substance Abuse Services and the Potential Benefits of Program Expansion and Increased Funding. The Perryman Group. (2006, September).

³Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations. Texas Legislative Board Report. (2009, January)

Additionally, in the Greater Dallas County Region, we developed an integrated behavioral health and physical health intensive care management (ICM) program in 2009 that is part of co-located services available through the Dallas “Bridge” homelessness initiative. This ICM program was developed to more effectively integrate services provided at the Bridge for those high-risk/high cost individuals with a history of inappropriate use of emergency room resources. Through our ICM program, we have achieved a **46 percent improvement in appropriate access, a \$72,000 reduction in per member, per year costs for severe outlier populations**, and serve approximately 1,400 homeless members per day by coordinating all their bio-psycho-social needs.

FLORIDA

ValueOptions first began operations in Florida in 1996 with the implementation of the first Prepaid Mental Health Plan contract, Florida Health Partners, Inc. (FHP). FHP is owned by ValueOptions and Florida Behavioral Health, a group of local, not-for-profit mental health and substance abuse providers. FHP has since expanded to three additional areas of the State, covering 13 more counties. In 2006, we formed North Florida Behavioral Health Partnership, another provider partnership, to provide behavioral health services for 16 counties in North-Central Florida.

Working closely with our Florida community partners, **we reduced the administrative rate from 22 percent in 1996 to less than 13 percent in 2010**. We achieved this through operational efficiencies, economies of scale, program innovations like telehealth, and a new provider contracting/funding model. We devoted those savings to providing more services to more members across the state.

We employ a medical management strategy to identify medically and/or psychiatrically complex members who are likely to have poor outcomes with only “routine care.” This outlier management philosophy is **proactive about providing care to these members at critical junctures and to track outcomes** to determine the effectiveness of treatment strategies.

Our most recent generation of medical management strategy is to target individuals with co-morbid medical and mental health issues. This integrated care model provides increased quality of life and better outcomes for Medicaid members. Since the start of the integrated care program, **meaningful contact with primary care physicians in Florida increased from between 60 and 70 percent, to 97 percent** over a two-year period.

CONNECTICUT

ValueOptions’ Connecticut Behavioral Health Partnership (CBHP) manages a combination of Medicaid and non-Medicaid funding for the Connecticut Department of Social Services, the Department of Children and Families (DCF), and the Department of Mental Health and Addiction Services. This program includes the full continuum of behavioral health services for 585,000 children, families and adults, and encompasses evidence-based programs and community-based alternatives to restrictive institutional levels of care. Through collaboration with the members served, their family members, providers and social support systems, ValueOptions promotes a strengths-based treatment approach focused on member success and recovery.

Since the inception of the contract, we have **decreased child/adolescent inpatient discharge delays by 39 percent, received 100 percent satisfaction for our peer and family specialist program involvement, and have been rated 91 percent in overall member satisfaction**. We have also **decreased the number of children being placed in out-of-state care by 42 percent and out-of-home care placements by 16 percent**, resulting in an increase in community-based care.

Earlier this year, our positive performance resulted in a program expansion to include an additional 200,000 SSI and dual-eligible adults through a subcontracting arrangement with Community Health Network of Connecticut, the state's medical ASO. This includes supporting joint care planning for members at the highest level of risk who suffer from co-morbid physical health and behavioral health conditions, thus improving quality and providing cost-effective care.

MASSACHUSETTS

In Massachusetts, ValueOptions currently provides behavioral health services to more than 380,000 Medicaid adults and children. We have managed this contract for 15 years, *saving the Commonwealth approximately \$1 billion in inappropriate and unnecessary care, resulting in a return on investment (ROI) of 2.70:1.*

Our care management program focuses on the top two percent of high utilizers and has produced a 50 percent reduction in emergency room (ER) visits, a *68 percent reduction in inpatient hospitalizations, a 60 percent reduction in medication refill gaps, and a 19 percent reduction in overall medical costs.*

In addition, through our utilization management program, we have accomplished the following:

- We implemented the Children's Behavioral Health Initiative to ensure *more community-based behavioral health services for children.* We built a comprehensive network to provide these services and as a result, decreased the use of intensive 24-hour care among children and youth, increased the proportion of mobile crisis intervention encounters in community locations, and decreased likelihood of inpatient readmission for recipients of intensive care coordination and in-home therapy
- The cost of 24-hour levels of care *decreased approximately \$2.4 million for members under the age of 21.* This included both inpatient and diversionary services. The cost of 24-hour levels of care per member aged 0-20 decreased from an average of \$13,297 in 2009 to an average of \$10,431 in 2010.

CONCLUSION

The impact of Medicaid managed care varies widely depending on the members served. Medicaid policy makers should be mindful of these differences when designing managed care programs, paying particular attention to the impact of traditional Medicaid managed care plans for members with special needs and chronic conditions. The goal is to maximize quality and value and achieve efficiencies in behavioral health care—carve-out managed care programs are proven to do just that.

ValueOptions has led the industry in developing premiere carve-out programs. We offer highly specialized, high-quality care management programs with proven success in increasing efficiency, effectiveness, and accountability, all while reducing costs, achieving greater access to care, and improving treatment outcomes.

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