

Behavioral health

Mercer Government
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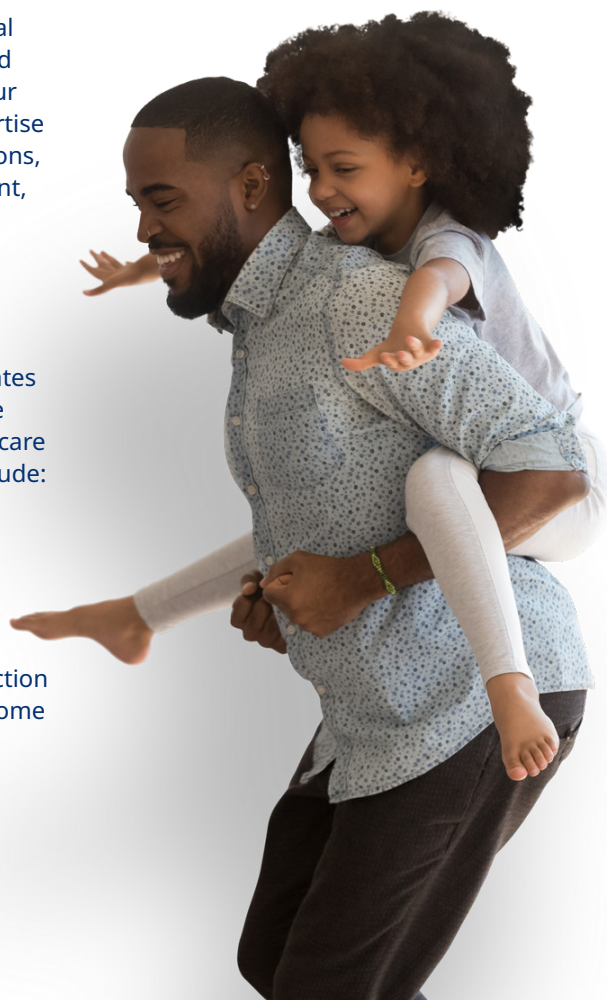
State governments are facing increasingly complex budgetary, clinical, and regulatory challenges in the provision of behavioral health services to vulnerable populations under new federal policy. For behavioral health, the stakes are especially high, as Medicaid is the single largest payer of behavioral health services in the United States. The national call to transform mental health systems increases the demands on state and local governments to improve access to evidence-based, cost-effective services. The ever-changing regulatory environment requires significant planning and creativity more than ever before on the part of government agencies tasked with monitoring and improving quality, access, and cost-effectiveness.

Many of Mercer Government's behavioral health specialists have public mental health system experience at the federal, state, and local levels and understand the barriers and opportunities faced by those involved in systemic change. Our public sector and behavioral health experience is complemented by our expertise in Centers for Medicare & Medicaid Services (CMS) policy and federal regulations, as well as our experience in information systems, encounter data management, actuarial rate setting, strategic planning, and managed care. By teaming our clinical and policy experts with our actuarial and information planning consultants, we have the depth and breadth of experience to help our clients increase their financial and operational efficiencies.

We combine high-level strategic consulting with practical solutions to help states transform and manage their behavioral health programs. Our consultants are actively working in a number of states to bring evidence-based practices and care initiative systems from concept to reality. Our capabilities and experience include:

- Strategic planning, including program design based on federal policies, national trends, and best practices, in addition to the development of waivers, clinical-practice guidelines, and pay-for-performance initiatives.
- Policy and regulatory guidance and technical assistance related to 1915(b), 1915(c), and 1115 waivers, as well as state plan amendments, including Section 1915(i) (home- and community-based services) and Section 1945 (Health Home State Plan Option).

Since 1985, we've worked alongside state and territorial partners to design practical, sustainable solutions that strengthen programs and improve outcomes.



- Procurement assistance, which may include development of program standards and requirements, as well as technical questionnaires and evaluation criteria. Additionally, this includes design of performance guarantees and incentives, training, technical assistance, oversight during the evaluation phase, and facilitation of site visits and finalist negotiations.
- Behavioral health program management, including performance-based contracting, readiness and clinical operational reviews of behavioral health managed care organizations; benchmarking studies; fidelity reviews; and related corrective-action plan development and monitoring.
- Actuarial analysis, including financial analysis for waiver and state plan development (including review of other state-funded programs for potential Medicaid coverage), capitated rate-setting for managed care programs, fee-for-service (FFS) rate setting for fee schedules, and cost driver analyses integrated with behavioral health program management consulting.



Situation

The state sought to transform the healthcare delivery system from a FFS chronic care model to a community-based Medicaid managed care model while improving health outcomes and reducing healthcare costs. Key objectives included promoting recovery-oriented services grounded in evidence-based practices and integrated across delivery systems and multiple state agencies.



Challenge

The state's Medicaid behavioral health delivery system was largely unmanaged and the FFS payment structure lacked accountability for outcomes and led to fragmented care. The broad array of treatment options was difficult to navigate, and there were few incentives for coordinated or person-centered care. As a result of historical funding and local priorities, behavioral health services varied by region, and many MCOs did not have experience managing complex behavioral health populations. A comprehensive, efficient approach to a statewide rollout was necessary for successful implementation.



Case study

Action

Mercer supported the state's cross-agency workgroup by providing policy, program design, and implementation assistance to support moving behavioral health services and populations from FFS to managed care. Phases of the project included:

1. Analyzing federal authorities, facilitating strategy sessions, and providing briefing documents to inform policy and program design decisions, including amending a 1115 demonstration waiver and integrating separate 1915c waivers into a single HCBS authority.
2. Providing clinical and policy expertise to develop needs-based eligibility criteria, service definitions, and staffing qualifications for HCBS.
3. Providing financial support for budget projections, budget neutrality calculations, fee schedule development for new or revised services, and capitation rate impact analyses.
4. Drafting behavioral health-specific contract standards to support the state's key objectives.
5. Developing a request for qualification and readiness review protocols with evaluation criteria to qualify existing MCOs to administer new behavioral health and HCBS benefits.
6. Training state staff on evaluation criteria, readiness review protocols, and HCBS requirements.
7. Co-leading a team of clinical, member services, network, quality management, information systems, claims, and financial subject-matter specialists to conduct desk and on-site readiness reviews at each MCO.



Results

The state is on a clear path toward system transformation that supports recovery-oriented, person-centered care that is integrated at the point of service delivery. Financing links payment to outcomes and supports evidence-based and promising practices as well as services, and supports to maintain individuals in their homes and communities. The service array and delivery system structure address the unique needs of individuals, including medically fragile children, transition-age youth and individuals with first-episode psychosis, serious emotional disturbance, serious mental illness and/or substance use disorders.



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