HEALTH WEALTH CAREER

MERCER GOVERNMENT HUMAN SERVICES CONSULTING

CLINICAL & BEHAVIORAL HEALTH SERVICES

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MERCER GOVERNMENT HUMAN SERVICES CONSULTING

HELPING GOVERNMENTS SHAPE TOMORROW'S HEALTH PROGRAMS

BEHAVIORAL HEALTH

Mercer has consulted with more than 30 states on behavioral health and brings over 50 subject-matter specialists dedicated to behavioral health consulting.

State governments are facing increasingly complex budgetary, clinical and regulatory challenges in the provision of behavioral health services to vulnerable populations. The national call to transform behavioral 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 on the part of government agencies tasked with monitoring and improving quality, access and cost-effectiveness.

Mercer's behavioral health specialists understand the barriers and opportunities faced by those involved in systemic change and bring managed care and public sector experience at the national, state and local levels. Our public-sector clinical and managed care experience is complemented by our expertise in federal regulations and our experience with information systems, encounter data and financial management.

We combine high-level strategic consulting with practical solutions to help clients transform and manage their behavioral health programs. Our consultants are actively working in a number of states to bring program design, evidence-based practices and system-of-care initiatives from concept to reality. Our capabilities and experience include but are not limited to:

- **Strategic planning**. Based on national trends and best practices and grounded in federal requirements, Mercer works closely with states to identify key issues, facilitate planning and design solutions that meet state goals and objectives. Representative planning projects include managing opioid prescribing patterns, improving behavioral health/medical integration and improving recovery outcomes through service delivery system enhancements.
- **Policy and regulatory guidance** related to 1915(b), 1915(c) and 1115 waivers as well as state plan amendments, to include drafting Section 1915(i), Home and Community-based Services, and Section 1945, Health Home State Plan Options. Recent projects include adding 1915(i)-like benefits to an existing 1115 wavier, drafting 1115 waivers to address regulations regarding institutions for mental diseases and technical assistance in drafting new licensure regulations for intensive behavioral health services for children and youth.
- **Compliance with emerging regulations**. Mercer compliance support is sufficiently comprehensive to address each aspect of the regulation, and our approach can be scaled from targeted training and technical assistance

to more intensive compliance activities to help states navigate the intricacies of new regulations. Recent projects include supporting multiple states with the Mental Health Parity and Addiction Equity Act and network sufficiency studies related to the Medicaid Managed Care Rule.

- **Contract development and procurement assistance**, inclusive of drafting program standards/requirements, evaluation questions and evaluation criteria; providing training and technical assistance to the evaluation committee; and facilitating finalist negotiations. Mercer can provide end-to-end consulting during a new procurement or provide targeted technical assistance to update program standards and requirements for existing contractors to address ongoing program and regulatory changes.
- **Program management support**, including readiness reviews, ongoing monitoring reviews, program evaluation, focused studies and clinical investigations. Recent projects include a clinical and an operational review to assess readiness of a managed care organization (MCO) to manage behavioral health benefits that were previously administered under fee-for-service, an intensive clinical review of a large provider delivery system after a series of adverse events and an outcomes study to assess the effectiveness of high-fidelity wraparound.
- **Performance measurement**, including performance metric selection, specifications, and calculation and performance improvement study design and implementation. Examples of projects include cost-driver analyses to identify opportunities for improved program management with technical assistance to identify, design and implement performance improvement activities.
- **Payment reform**, including design and implementation assistance to support value-based purchasing (VBP). Mercer's experience includes briefing states, MCOs, prepaid inpatient health plans and providers on methods to effectively structure and implement VBP, developing quality and financial parameters for the program, designing bonus/incentive payment methodologies, drafting contract language and reviewing VBP proposals.
- **Actuarial analysis**, including financial analysis for waiver and state plan development (including review of other state-funded programs for potential Medicaid coverage), development of capitation rates for managed care programs and development of fee schedules for fee-for-service programs. Representative projects include estimating the cost impact of program changes, assessing provider financial experience and establishing provider reimbursement rates for new programs and services, including the incremental cost to support evidence-based practices.

Mercer's Government Human Services Consulting helps government agencies design, implement and monitor behavioral health programs that enhance the quality of care while controlling financial and operational burdens. Mercer's dedicated group of experienced accountants, actuaries, attorneys, nurses, pharmacists, psychiatrists, psychologists, social workers and former policy specialists from the Centers for Medicare and Medicaid Services provide varying levels of clinical, operational, policy and strategic consulting.

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CASE STUDY

SITUATION

The state sought to transform the healthcare delivery system from a fee-for-service (FFS) chronic case 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.

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 an 1115 demonstration waiver and integrating separate 1915c waivers into a single Home and Community-Based Services (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

RESULT

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.

HEALTH WEALTH CAREER

MERCER GOVERNMENT HUMAN SERVICES CONSULTING

CHILD/YOUTH BEHAVIORAL HEALTH AND WELL-BEING

Since 1985, Mercer has consulted with more than 30 states and the federal government on a wide variety of healthcare and human services issues, including actuarial, data/systems analysis, clinical, policy, operations and procurement.

State governments are facing increasingly complex budgetary, clinical and regulatory challenges in the provision of behavioral healthcare to vulnerable populations. The national call and local demand to transform health systems increases the demands on state and local governments to improve access to evidenced-based, cost-effective and outcomes-driven services. In particular, for the approximately 45,231,315[1] children/youth enrolled in CHIP and Medicaid programs, there are added implications due to involvement from multiple state authorities (child welfare, special education, juvenile justice, etc.).

Despite improvement across child well-being domains, there are increasing rates of poverty, single-parent households, numbers of young children not attending school and children/youth entering and remaining in foster care.[2] Across all indicators, there is wide racial disparity, in which African-American, American Indian and Hispanic children, youth and families fare worse than the national average.[3]

[1] Based on state-reported data as of 5/2/2016 from the table "FFY 2015 Number of Children Ever-Enrolled in Medicaid and CHIP," available at https://www.medicaid.gov/chip/downloads/fy-2015-childrens-enrollment-report.pdf, accessed October 12, 2016.

[2] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. *The AFCARS Report*, Issue 22, July 2015, available at http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf, accessed October 12, 2016.

[3] Annie E. Casey Foundation. *2016 KIDS COUNT Data Book: State Trends in Child Well-Being*.

HOW MERCER'S GOVERNMENT HUMAN SERVICES CONSULTING TEAM CAN HELP

Mercer's dedicated consulting teams bring states a wide variety of expertise, including clinical, operational, policy and strategic consulting across the spectrum of behavioral health and operations as well as specialization in EPSDT and child/youth-serving systems.

The Mercer team has helped several states design, implement and advance their children's service system initiatives. The children/youth-focused consulting, TA and training services are outlined below:

- **System and program design** based on trends and evidence-based practices, clinical practice guidelines, cross-system collaborative models and specialty population considerations (for example, birth to five, transition-age youth, children impacted by trauma)
- **Operational design**, including quality management, utilization management, care coordination, care management, pharmacy management, health homes and associated streamlining of functions and assessments to reduce duplication and support navigation for families
- **Benefit design, policy and regulatory** guidance and technical assistance related to eligibility, service array, waiver development (1915[b], [c], [i], 1115), state plan amendments (SPA), parity, CHIP and EPSDT
- **Financing strategies and stewardship**, such as maximizing federal match, leveraging cross-system financing (for example, Title IV-E), braiding funds, cost sharing and pay-for-performance initiatives
- **Collaborative systems design**, including development of agreements, committee and communication structures, and family/caregiver/stakeholder inclusion and involvement

MOVING TO MANAGED CARE TO TRANSFORM A STATEWIDE SYSTEM — CASE STUDY

Situation

The state was tasked with restructuring the Medicaid program to achieve improvement in outcomes, sustain cost and build a more efficient administrative structure. Key features included moving behavioral health (BH) services from FFS into managed care and incorporating the ability to manage specialty BH services. Managed care organizations would now be responsible for managing integrated physical health, behavioral health and home- and community-based services (HCBS). For children/youth, the state's vision is a future in which managed care plans, service providers, family peers, youth peers and government partner to improve the health and wellness of children/youth with physical disabilities, intellectual/developmental disabilities (I/DD) and mental illness and substance use disorders, regardless of entry point.

Challenge

The state decided to merge five existing waivers across multiple agencies into their 1115 waiver. This needed to be done without interrupting existing access, care and services for children currently enrolled in the waivers; resolve different eligibility and enrollment processes while managing cost; and address the varying needs of foster care, I/DD and medically fragile populations.

Action

Mercer's team included federal policy and managed care experts as well as child/youth clinical specialists and actuaries. Mercer facilitated strategy discussions (including briefing documents) with state leadership to inform key design decisions, provided financial impact analyses and supported drafting the 1115 waiver and state plan amendment. Mercer provided extensive support with the development of HCBS functional criteria, contract standards specific to children/youth/families, a readiness review tool and rates.

Results

The design resulted in multiple agencies working together on a common vision to break down silos between mental health, physical health and child welfare. Ultimately, the transformation will allow for streamlined cross-system coordination to deliver one integrated system, giving children/youth/families access to the level and array of services needed to meet their unique needs.

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CLINICAL QUALITY CONSULTING

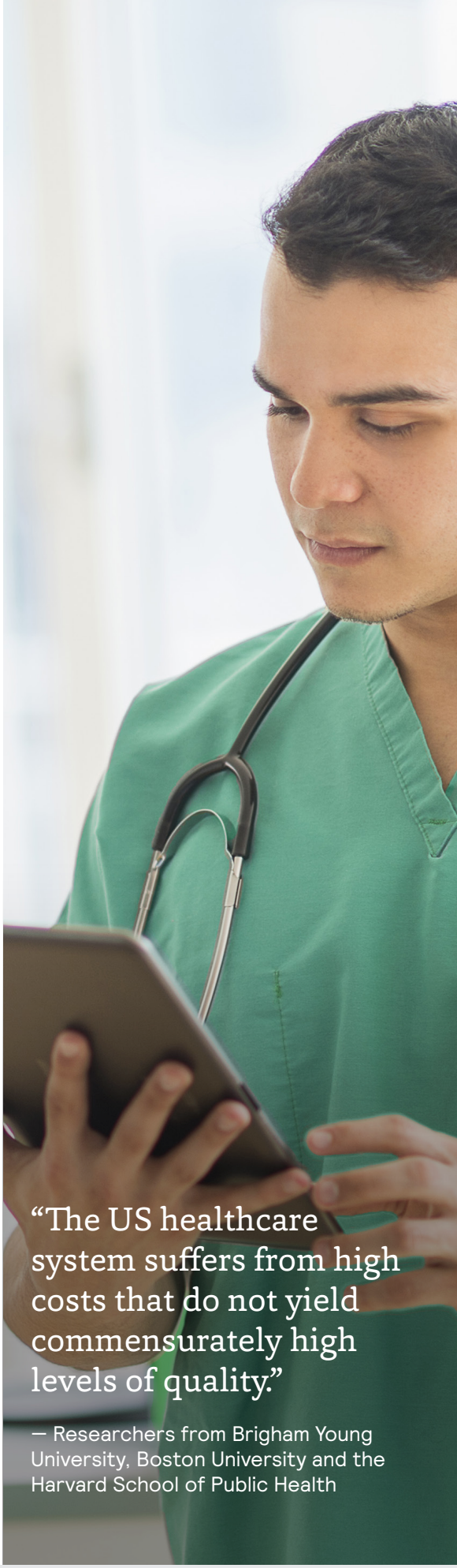
The delivery of high-quality, cost-effective healthcare is crucial to ensure our healthcare delivery system remains viable not just for today but for the future.

Providing government-sponsored healthcare to some of the sickest and most vulnerable populations — in a cost-efficient manner — can be especially challenging for states, and Medicaid agencies are often tasked with defining value and measuring clinical quality. Yet poor clinical quality can have lasting adverse effects on a Medicaid program. Delivery system fragmentation, poor care coordination, a lack of integrated care that supports both medical and physical health, and inconsistency in coordinating supports for those with functional, intellectual and developmental disabilities have resulted in many states turning to Managed Care Organizations (MCOs) to develop cost-efficient and coordinated high-quality healthcare models. States functioning under a managed care model now have an urgent need to understand if their managed care program and their MCO contractors are truly producing the best value.

High-quality healthcare should be cost-effective and utilize evidenced-based medicine to produce healthy outcomes. When you partner with Mercer, we ask the right questions to help you define the quality and value you desire in your program. We develop evidenced-based strategies to improve clinical quality and provide customized technical assistance to help you bridge learning gaps and teach your team to perform program evaluations that determine program effectiveness. Below are some of the questions we pose to help states improve and realize their goal of delivering clinical quality:

MANAGED CARE OPERATIONS

- Though your MCOs are passing their compliance reviews, do you still have questions about the efficiency and effectiveness of their operations?
- Have the interventions implemented by the MCOs driven measurable and meaningful improvement in outcomes?
- Are your MCOs building, engaging and leveraging community-based organizations and partnerships to address social factors that influence poor health outcomes (social determinants of health for your members)?
- Are perceived gains in quality clearly real and sustainable?



VALUE-BASED MODELS OF CARE

- Do you use the carrots and sticks available to you to manage your MCO contractors to the best extent possible (that is, pay for performance and sanctions)?
- Are MCOs driving real innovation and developing strong provider partnerships?
- Do your providers feel a true partnership with your MCOs?
- Do your MCOs design value models that are sensitive to provider burden?
- Is your value-based purchasing model targeting the true drivers of healthcare quality?

QUALITY STRATEGY

- What story would you like to tell through your program's healthcare outcomes?
- Are your members really receiving person-centered care that empowers them to make the right healthcare choices and be engaged in their care?
- Are your quality activities and your MCO quality activities aligned to achieve the goals and objectives of the state's quality strategy?
- Is your monitoring and oversight program streamlined such that you can do more with less and can quickly allocate limited resources to the most problematic areas to ensure the greatest success?

PERFORMANCE MEASUREMENT

- Are you measuring what matters or making what you measure matter?
- Are the reports your team reviews giving you actionable information on the successes and opportunity areas of your program?
- Do your selected performance indicators measure compliance or performance improvement?
- Are all your performance measures meeting established benchmarks and targets?
- Are your performance measures aligned across your quality strategy and your value-based purchasing model?

If you have answered "no" or "I'm not sure" to any of these questions, Mercer can help.

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OUR EXPERTISE

Mercer's value is in our strong, multidisciplinary team, which includes licensed clinicians (registered nurses, clinical social workers and psychologists, etc.) physicians, healthcare analysts and certified coders. We can assist in developing and implementing clinical quality-monitoring strategies, evaluating program achievements and assessing the value each managed care contractor contributes to program goal attainment. To support our analyses, our clinical team taps into the vast knowledge of our Mercer colleagues, including pharmacists, government policy experts, statisticians, informatics specialists, certified public accountants and actuarial experts.

Mercer can assist in the end-to-end process of overseeing and evaluating your program. We believe in using rapid-cycle quality improvement methodology to allow for real-time evaluation and interventions. We have more than 20 years of experience developing tools to create efficiencies, and we can help you move the needle on your clinical quality outcome goals.

Mercer can help you focus on quality in the following areas:

- Preventive care
- Disease/chronic-care-specific programs
- Accessibility and availability of services
- MCO oversight
- Delivery system performance
- Member satisfaction
- Utilization strategy
- Integrated services
- Compliance with federal and state rules
- Performance vs. compliance measures
- Provider satisfaction
- Evidenced-based practices

We can provide the following support:

- Technical assistance to revise your quality strategy and your program evaluation criteria
- Performance measure selection, calculation and validation
- Development and implementation of value-based purchasing strategies
- Managed care plan reviews
- Survey administration
- Running of focused studies
- Development of monitoring and oversight tools and reports
- Provision of technical assistance to state staff and MCO contractors
- Evaluation of and recommendations for managed care contract revisions to support clinical quality activities

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SUBSTANCE USE DISORDERS

Since 1985, Mercer has consulted with more than 30 states and the federal government on a wide variety of healthcare and human services issues, including actuarial, data/systems analysis, clinical (for example, program design, clinical and managed care operations), pharmacy, policy, operations and procurement.

States are experiencing an unprecedented demand for substance use disorder (SUD) services and, as a result, are actively seeking new opportunities and innovative approaches to optimize resources. For example, the national opioid epidemic has resulted in aggressive efforts at both the federal and state levels to prevent addiction to prescription opiate pain medications, limit access to heroin and synthetic fentanyl, prevent death from unintentional overdoses and reduce the prevalence of neonatal abstinence syndrome. States want to increase access to treatment for addiction, and legislation is being enacted in many states that limits prescriptions for opioid pain relievers, requires use of prescription drug monitoring programs (PDMPs) by physicians and pharmacists, and makes naloxone readily available to first responders and members of the broader community. Although there was a 10.6% reduction in opioid prescribing nationally in 2015,[1] drug overdose remains the leading cause of accidental death in the US, with 52,404 lethal drug overdoses, including 33,091 (63.1%) that involved an opioid.[2]

Although the opioid epidemic is drawing national attention, Mercer and state systems realize states must continue to respond to the ongoing needs for treatment for other dangerous and disabling substances as well, including alcohol, marijuana, methamphetamine, cocaine, synthetic drugs and tobacco. An estimated 88,000 people die from alcohol-related causes each year, making it the fourth leading preventable cause of death in the United States.[3] Data from 2013 indicate that approximately 46% of the 72,559 deaths due to liver disease among individuals age 12 and older involved alcohol.[4] Collaboration with a broad array of stakeholders, including public health, public safety, criminal justice and others, is vital to impacting cost and quality outcomes associated with SUDs, regardless of the substance involved. For example, through collaboration, numerous states now enroll Medicaid-eligible individuals immediately upon release from custody to facilitate rapid engagement in SUD services.

[1] American Medical Association. *Physicians' Progress to Reverse Nation's Opioid Epidemic*, 2016.

[2] Centers for Disease Control and Prevention. "Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015," *Morbidity and Mortality Weekly Report (MMWR)*, Volume 65 Issue 50–51 (December 30, 2016), pp. 1445–1452.

[3] National Institute on Alcohol Abuse and Alcoholism. *Alcohol Facts and Statistics*, February 2017.

[4] Ibid.

States need a cost-effective, comprehensive and responsive healthcare system capable of identifying and treating individuals with SUDs and services that demonstrate positive outcomes. In the absence of such a system, individuals with SUDs can be caught in a negative pattern of repeated admissions for detoxification/withdrawal management, frequent emergency department utilization and unstable employment, housing and family relationships. Individuals experiencing SUDs often develop severe and costly physical health problems, such as cirrhosis, hepatitis and HIV/AIDs, and are at higher risk for preventable accidents when impaired. Mercer can assist states with adoption and implementation of best and promising practices, including but not limited to:

- Screening, brief intervention and referral to treatment (SBIRT) models
- American Society of Addiction Medicine (ASAM) criteria
- Medication-assisted treatment (MAT)
- Motivational interviewing, motivational enhancement therapy (MET), community reinforcement approach (CRA)/adolescent community reinforcement approach (A-CRA) and cognitive behavioral therapy (CBT)
- Peer recovery support specialists and healthcare navigators
- Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain
- Active monitoring and surveillance of potentially excessive or problematic prescribed opioid use outside of Food and Drug Administration (FDA) guidelines
- Value-based payment models incorporating opioid-related outcome measures

Mercer understands states must consider cost containment and program sustainability, network development and capacity needs and how to incentivize high-quality performance through effective procurement and contracting. States must consider how they will finance these services and understand the regulatory requirements of funding streams. Requirements related to the Mental Health Parity and Addiction Equity Act (MHPAEA) final rule, the Home and Community-Based Services (HCBS) final rule and the Medicaid Managed Care final rule all impact the design and implementation of a state's SUD service system.

Mercer assists states in SUD program design, development of federal state plan amendments and CMS waivers, procurement activities, actuarial rate setting and analysis, managed care contracting, value-based purchasing, staff training and development, and conversion from fee-for-service to a managed care delivery system.

SITUATION
Prior to 2011, the state's Medicaid program did not include SUD treatment services as a covered benefit. State general funds and/or federal block grant dollars were the primary source of funding to pay for SUD services to Medicaid-eligible members. In an effort to contain costs while also expanding access to SUD services for Medicaid-eligible members, the state decided to add SUD benefits to its Medicaid state plan and incorporate these benefits into its managed care structure.

CHALLENGE
The state wanted to expand coverage and capacity for an array of ASAM levels of care and support adoption of medication-assisted treatment. The state wanted to support providers and managed care organizations in this transition by helping them fully understand service definitions, provider qualifications and billing expectations. The state also recognized the need to gather current SUD program and staffing information from providers in order to assist in provider reimbursement and capitation rate development.

ACTION
Mercer worked in collaboration with the state's behavioral health and Medicaid agencies to draft an SUD state plan amendment (SPA) that included ASAM levels of care. The SPA included methods and standards for coverage and reimbursement of these services within the Rehabilitative Services option and supported recovery-oriented treatment. Mercer provided clinical, pharmacy, policy and actuarial support to design an SUD continuum of care consistent with national standards and best practices. We worked with state SUD experts to establish service descriptions, provider qualifications and FFS rates as well as assist with identifying MMIS programming edits. Mercer supported CMS negotiations, assisted with the drafting of a comprehensive state manual to explain the benefits, drafted contract language for the capitated vendor to manage the benefit and assisted with readiness reviews of the statewide vendor.

RESULT
Today, the state is able to offer Medicaid-reimbursable SUD services, including medication-assisted treatment and ASAM levels of care consistent with any federal limitations applicable to larger residential settings. In 2016, the state carved in all behavioral health services, including SUD, into the managed care plan contracts. Mercer assisted with drafting the integrated contract, including performance measures, and setting the capitation rates. We are currently assisting the state in pursuing an 1115 waiver authorizing reimbursement for use of institutions for mental disease for residential stays exceeding 15 days.

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