

LOUISIANA STATE PROFILE

A. Program Description

Overview

The Louisiana Behavioral Health Partnership (LBHP), effective March 2012, transformed the state's mental health and substance abuse services for all Medicaid-eligible and non-Medicaid-eligible adults into a managed care system that operates as a prepaid inpatient health plan. A single managed behavioral health organization (MBHO; currently Magellan Health Services of Louisiana) manages all behavioral health services in Louisiana. Physical health services are managed separately through managed care organizations (MCOs), collectively referred to as Bayou Health plans; they are not part of the LBHP (Andrews et al. 2014). In November 2014 (after the data collection period for the current study concluded), Louisiana announced plans to integrate specialized behavioral health services into the Bayou Health managed care plans starting in December 2015, thus terminating use of a single MBHO to manage all specialty behavioral health services. This decision was driven in part by the desire to further coordinate behavioral and medical care (DHH 2014).

Financing

The MBHO operates on an at-risk basis for Medicaid adult behavioral health services and manages (on a non-risk basis) behavioral health services for eligible non-Medicaid adults served by the Office of Behavioral Health (OBH) within the Department of Health and Hospitals (DHH). Non-Medicaid services, including for those individuals with co-occurring mental health and substance use disorders (SUDs), are funded through state general funds and block grants (Andrews et al. 2014). Before LBHP, quasi-public, locally governed human services districts or authorities provided most of the behavioral health services in the state, using general funds, transfers from DHH and, to a lesser degree, fee-for-service Medicaid payments (Louisiana Legislative Auditor 2013).

Goals

The goals of the LBHP include improving access to and quality and efficiency of behavioral health services for adults, and coordinating behavioral health and physical health care services (Andrews et al. 2014). According to OBH officials, the first two years of the LBHP were focused on building the managed care infrastructure, including the provider network. In 2014, OBH focused on facilitating coordination between behavioral health and primary care services, and integrating the permanent supportive housing (PSH) program into the LBHP.

State Context

OBH was created from the merger of the Offices of Mental Health and Addictive Disorders before the inception of the LBHP. The merger consolidated state-funded substance abuse and mental health clinics. Although our study focuses on the service system for adults, it is worth noting that the LBHP encompasses a comprehensive system of care (CSoC) for children and youth with behavioral health challenges. Since the beginning of the LBHP, four child-serving state agencies have pooled funds into the MBHO contract to support the CSoC (Andrews et al. 2014). According to OBH, this funding arrangement only impacts the delivery of mental health services for children enrolled in the CSoC. Additionally, OBH is working to increase integration outside of the LBHP umbrella through Substance Abuse and Mental Health Services Administration (SAMHSA) policy academies and technical assistance. Louisiana will not be expanding Medicaid eligibility under the Affordable Care Act.

Partnership Structure

OBH manages and oversees the LBHP. Since its implementation, OBH has contracted with Magellan for the latter to serve as the single MBHO. In 2014, the DHH Bureau of Health Services Financing (the state's Medicaid office) executed a memorandum of understand with Magellan and the Bayou Health plans to begin defining what coordination between the state management organization and MCOs will entail. Behavioral health providers have direct contact and formal relationships with OBH and Magellan. The LBHP requires providers to be credentialed with both OBH and Magellan, and each provider establishes a service contract with Magellan.

B. Coordination or Integration with Physical Health

Coordination Mechanism and Financing

LBHP is attempting to use the MBHO contract as a mechanism for coordinating behavioral and physical health care. Managed care offers the promise of helping individuals better connect to services by providing a central point of entry and access to a wealth of patient and provider data. Although the original MBHO contract had a general coordination requirement, OBH officials reported they were just beginning to define care coordination at the plan and provider levels at the time of this report. Specific coordination strategies will likely change in the future when the state carves behavioral health services into the Bayou Health MCOs.

Although recent efforts to facilitate coordination through the health plans have yet to affect consumers directly, some coordination has been available to them since the beginning of the LBHP. Magellan's care navigators offer consumers or their families telephonic support to identify resources. Additionally, Medicaid adults with a serious mental illness (SMI) who qualify for services under the 1915(i) option can receive some degree of care coordination through Medicaid case management benefits, which are

covered by the MBHO. Such benefits include community psychiatric support and treatment (CPST), assertive community treatment (ACT), and intensive case management (ICM) (Andrews et al. 2014). Case managers and multidisciplinary ACT team members coordinate with providers of different service systems and help ensure that clients can access any needed service.

Coordinated Services and Stakeholder Interactions

Interviews with Magellan and OBH leadership identified some recent efforts to coordinate between behavioral health and physical health plans, including the following:

- Magellan began receiving Medicaid pharmaceutical data, physical health claims, and encounter data, and began sharing their encounter data with the physical health plans.
- Magellan has been working with the state Medicaid office to obtain information on clients' primary care physicians (PCPs).
- Magellan and the Bayou Health plans have developed a common referral form to refer patients between care systems.
- Magellan officials indicated that they have been communicating more regularly with the Bayou Health plans and discussing how ultimately to co-locate physical and behavioral health providers. (To date, co-location has not yet occurred through the LHBP, although a SAMHSA grant and a provider's own initiatives have funded a few local co-location efforts.)
- State officials are considering strategies to help PCPs respond to some behavioral health needs, such as by requiring the health plans to have a behavioral health specialist on staff for consultation. OBH is also exploring ways to support behavioral and physical health integration and co-location as part of a SAMHSA grant.

Coordination efforts are beginning to trickle down to the provider level. According to behavioral health providers and Magellan administrators, examples of recent efforts include the following:

- Magellan has encouraged hospitals and providers to help patients identify a PCP and obtain a release of information so providers can exchange information.
- Magellan is beginning to encourage behavioral health providers within its network to assess patients' medical histories and address certain medical issues in the treatment plans (such as discussing anxiety about PCP appointments or medications).

C. Coordination or Integration with Housing or Other Social Services

Aside from the PSH program and the individual efforts of case managers and other providers, there do not appear to be formal policies or programs to coordinate behavioral health with other types of social services. OBH indicated that it is, however, attempting to improve coordination with the criminal justice system, recognizing that a large percentage of behavioral health clients are in the correctional system. Individual providers may also have their own means of service coordination. For example, one quasi-public behavioral health provider operates the Supported Employment model.

Permanent Supportive Housing Background

The PSH program, which originated after Hurricanes Katrina and Rita, subsidizes approximately 3,300 rental units and offers tenants behavioral health and long-term care services. Rent is subsidized mainly through the federal Section 8 Project-Based Voucher and Shelter Plus Care programs. Congress appropriated \$73 million for 2,000 Section 8 units and 1,000 Shelter Plus Care units in summer 2008, and the state was awarded Section 811 Project Rental Assistance vouchers in March 2013. Units are scattered across various sites, and tenants contribute up to 30 percent of their adjusted income toward rent. The program currently operates in the hurricane-prone region of the state, with plans to expand statewide. It is based on the Housing First model, which prioritizes maintenance of housing over treatment. PSH is centralized at the state level, with formal agreements between the state housing agency and DHH, which includes OBH, the Office of Adult and Aging Services, and Office for Citizens with Developmental Disabilities.

Coordination Mechanism and Supportive Services Financing

A supportive housing program, by definition, integrates housing and support services. In October 2013, funding for the supportive services provided to PSH participants shifted to Medicaid from time-limited community development block grant (CDBG) funding. Management of the services shifted from local providers to the MBHO (and, by extension, the LBHP). The need for a sustainable funding source drove this decision. The MBHO also became responsible for screening PSH applications for Medicaid eligibility, coordinating applications and housing placements with the state housing agency, and managing tenant-landlord relationships--in part due to the state's desire to have a single entity centralize these processes.

According to interview respondents, financing the services through Medicaid restricted program eligibility to those who qualify for the authorizing waivers. Participants now must be eligible for Medicaid and the 1915(i) State Plan Amendment that authorizes intensive behavioral health services. According to two local providers, individuals who do not qualify for 1915(i), including those with SUDs without a co-

occurring illness, are no longer eligible.^{1,2} PSH participants must also be in need of both housing and behavioral health services, and qualify for the federally funded housing programs.

Coordinated Services and Stakeholder Interactions

Although participation in services is voluntary, participants must have a certified PSH service provider. The services for PSH participants are available to anyone in the state who meets the appropriate Medicaid eligibility. PSH participants are likely to receive intensive supports, such as ACT, ICM, or CPST. Providers noted that one change to service delivery under Medicaid is that providers can now bill only for face-to-face interactions with clients who have been approved for services. Time spent searching for a client in the community, assisting a client telephonically, or contacting another provider or landlord without the client present is no longer reimbursable. Additionally, providers are no longer reimbursed for the services that transitioned to the MBHO (such as application assistance and tenant-landlord mediation).

State, MBHO, and provider respondents agree that delivering supportive services to PSH participants requires frequent communication across partners. At the ground level, local stakeholders--including behavioral health providers, Shelter Plus Care subsidy administrators, and landlords/building managers--work closely with one another, the state agencies, and the MBHO. They communicate regularly about program and service eligibility, applications, wait list status, unit availability, tenant-landlord challenges, and any issues that could lead to eviction.

D. Key Perceptions and Lessons Learned for Implementing the Care Coordination Strategy

Changes in billing processes impact providers; clear communication and careful, upfront planning is essential. Several of the providers we interviewed expressed frustration with initial challenges in processing claims in the new electronic billing system (Clinical Advisor), which resulted in significant reimbursement barriers. These providers also reported that revenue declines (which they attributed to the implementation of the managed care arrangement and new billing practices) led some providers to close, lay off staff, or refuse to see Medicaid beneficiaries. Some providers and consumer representatives felt that these challenges--especially related to changes in rates, provider and beneficiary eligibility, authorizations, and certification processes--could have been mitigated through better planning and communication. These respondents stressed the importance of seeking input from providers and consumer advocates, and ensuring new billing system adequacy and training before a launch.

¹ Applicants who are no longer eligible have been removed from the wait list. Participants who were previously housed but would no longer qualify are still being served through CDBG funding.

² This report focuses exclusively on the mechanisms for serving adults with behavioral health conditions; PSH serves children and adults with long-term physical or developmental disabilities through different mechanisms.

In-person case management is an important service for those with SMI. Adult Medicaid beneficiaries with SMI who are eligible for 1915(i) services can receive case management. Providers and a consumer advocacy organization emphasized the importance of case management in coordinating care for individuals with SMI. As one provider explained, “This population needs someone to follow up with them to make sure they attend appointments and receive whatever assistance they need.” Respondents emphasized that delivering care management in person is critical. One respondent recommended having a single case manager positioned overall service systems touched by a client.

Managed care entities are well positioned to share useful data with providers in support of care coordination. Providers indicated that they would benefit from systematically learning about patient events (behavioral or physical) or a client’s physical health needs through the MBHO or other providers, rather than relying on self-reported updates from clients. The MBHO is beginning to make progress in exchanging some information with providers. It recently began receiving pharmaceutical data and physical health claims and encounter data, and is working to obtain information on clients’ PCPs. Efforts to co-locate physical and behavioral health providers will further improve the potential for data exchange.

Improvements in billing practices could streamline behavioral and physical health coordination. In a behavioral health carve-out model, financial responsibility must be clearly delineated between physical health and behavioral health plans. Managed care representatives and providers identified some confusion in determining which plan is financially responsible for behavioral health care delivered in primary care settings, which creates reimbursement challenges.

A flexible contract between a state and a managed care entity can help address evolving service and coordination needs. Louisiana included care coordination as a requirement when initializing the MBHO contract in 2012 but did not begin to detail specific elements until 2014. The contract terms allowed for this type of flexibility, which also enabled the state and MBHO to add to the service definition manual based on needs that became apparent over time. For example, the contract had initially neglected to add billing codes for nursing services, an oversight corrected through an “in lieu of” agreement. The state reported creating 11 “in lieu of” agreements with the MBHO as of March 2014.

Medicaid may be a sustainable funding source for PSH supportive services; centralizing management of services comes with trade-offs. Funding PSH supportive services through Medicaid has enabled the PSH program to continue past the availability of time-limited grant funding. There were two notable trade-offs, however: (1) eligibility is restricted to those who qualify for Medicaid 1915(i) services; and (2) providers are reimbursed only for face-to-face time with participants. Providers generally felt that integrating behavioral health services into the MBHO contract streamlined communication with state agencies, although the transition was perhaps

easier for those already enrolled in the MBHO's network and familiar with Medicaid eligibility rules. Providers are no longer reimbursed for the services related to supportive housing that transitioned to the MBHO (such as application assistance and tenant-landlord mediation), requiring consumers to seek support from the MBHO rather than their local behavioral health provider.

UNDERSTANDING INNOVATIVE STATE SYSTEMS THAT SUPPORT COORDINATED SERVICES FOR INDIVIDUALS WITH MENTAL AND SUBSTANCE USE DISORDERS

Reports Available

Improving the Coordination of Services for Adults with Mental Health and Substance Use Disorders: Profiles for Four State Medicaid Initiatives

HTML <http://aspe.hhs.gov/report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-profiles-four-state-medicaid-initiatives>

PDF <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-profiles-four-state-medicaid-initiatives>

Illinois Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Louisiana Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Massachusetts Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Tennessee Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

State Strategies for Coordinating Medicaid Services and Housing for Adults with Behavioral Health Conditions

HTML <http://aspe.hhs.gov/basic-report/state-strategies-coordinating-medicaid-services-and-housing-adults-behavioral-health-conditions>

PDF <http://aspe.hhs.gov/pdf-report/state-strategies-coordinating-medicaid-services-and-housing-adults-behavioral-health-conditions>

State Strategies for Improving Provider Collaboration and Care Coordination for Medicaid Beneficiaries with Behavioral Health Conditions

HTML <http://aspe.hhs.gov/basic-report/state-strategies-improving-provider-collaboration-and-care-coordination-medicaid-beneficiaries-behavioral-health-conditions>

PDF <http://aspe.hhs.gov/pdf-report/state-strategies-improving-provider-collaboration-and-care-coordination-medicaid-beneficiaries-behavioral-health-conditions>