Best Practices in State Medicaid and Mental Health Program Collaboration

INTRODUCTION

In the past several years, Medicaid has become a prominent and invaluable funding source for public mental health services. In 1997, Medicaid paid for half of state and local mental health services, whereas it paid for only one-third of these services in 1987.[1] The increasing reliance on Medicaid has led to a corresponding increase in the influence of Medicaid policies and rules on the operation of the public mental health system. States and localities have few policies and procedures to address the growing importance of Medicaid as a payer of these services.[2] Therefore, it can be of tremendous benefit if State Medicaid agencies and Mental Health agencies effectively work together to assure a sound and cohesive system within each state.

Collaboration between state Medicaid and Mental Health programs has varied greatly across states and administrations, ranging from written interagency agreements specifying the activities on which the two agencies will collaborate, to informal collaboration around a particular type of service or need, to no collaboration at all. The purpose of this paper is to identify and describe the basic elements of successful collaboration through 1) a review of the literature on collaboration, and 2) a description of collaboration in two states. The state examples highlight the mechanisms through which successful collaboration occurs and describe the types of activities in which collaborating agencies engage.

COLLABORATION LITERATURE

Fundamental elements of collaboration include the notions that 1) working together cooperatively toward a common goal is beneficial, and 2) useful synergy can be generated by interactive problem solving. The various definitions of collaboration emphasize these elements:

- Collaboration is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible[3]
- Collaboration is a mutually beneficial relationship between two or more parties who work toward common goals by sharing responsibility, authority, and accountability for achieving results[4]
- Collaboration is any joint activity by two or more agencies that is intended to increase public value by their working together rather than separately[5]

Collaboration can yield many benefits, such as improvements in the types of services covered, more appropriate targeting of services to clients, and cost savings for the agencies that deliver the services. Collaboration is based on the assumption that "the majority of negative outcomes in organizations result from faulty systems, rather than ineffective people."[6] Thus, collaborative activity focuses on the structure and functioning of organizations rather than on the individual personalities of members, although personality can play a role in the success or failure of collaborative efforts. Collaboration can be a more effective means of working for change than many other methods,[7] and builds on the notion that politics does not have to be a zero-sum competition among organizations that deliver services.[8] Rather than compete, organizations

providing overlapping services, or serving overlapping groups of clients, can work together to ensure the most efficient delivery of appropriate services where they are needed.

Conditions for which collaboration can produce benefits include the following:

- Problems are ill-defined, complex, or uncertain
- Stakeholders with vested interests are interdependent
- Stakeholder relationships are marked by disparities in power or resources
- Stakeholder relations are potentially adversarial
- Stakeholders bring complementary expertise and information to the table
- Existing relations and process are obviously insufficient (e.g., produce less than satisfactory solutions)[9]

Recognition of these conditions can promote a collaborative process progressing through stages:

- Stage 1: Groups or agencies exchange information (cooperate).
- Stage 2: Groups or agencies undertake joint projects and work together (coordinate). This stage often generates a set of "lessons learned."
- Stage 3: Groups or agencies change systemic rules that may act as barriers to collaboration.
- Stage 4: Collaborators change the system itself (e.g., change rules, personnel, and accountability in tune to a specific strategy).[10]

This progress may not be strictly linear, since an outside force can essentially induce some stages. Interagency collaboration, which is the focus of this paper, confronts the fragmentation of services across agencies and consists of four key elements[11]:

- Agreed upon and institutionalized mutuality and common goals
- Jointly developed structure and shared responsibility
- Mutual authority and accountability for success
- Shared resources and rewards

<u>What Leads to Successful Collaboration?</u>

For collaboration to work, it must be democratic and inclusive,[12] and emphasize organizational, programmatic, and fiscal factors.[13] Successful collaboration:

- Takes time, trust and commitment from leadership
- Requires adequate staff and financial support
- Requires all parties to operate as equals with high expectations of each other
- Is a process that builds on itself and that requires evaluation and the willingness to make mid-course corrections when necessary (i.e., it is iterative and flexible)[14]

Success in collaboration is best indicated by success in meeting stakeholder interests – patients getting better services, or agencies realizing cost-savings or a more efficient allocation of resources (such as when the administration of services becomes more streamlined), or program performance improves.[15]

One crucial condition – both in theory and in practice – is interdependence.[16] The concept of *induced interdependence* has been suggested as a way to overcome many barriers to collaboration by constructing a superordinate goal in which everyone has a stake and that can be achieved only by cooperative interaction. Interdependence can reduce prejudice and conflict and

facilitate the destruction of stereotypes and the reinterpretation of group roles.[17] It has also been suggested that such interdependence could be induced by structuring funding mechanisms (such as Request for Applications (RFAs) or Request for Proposals (RFPs) in a manner that would require collaborative efforts in order to secure funding.

<u>What are the Obstacles to Collaboration?</u>
Some obstacles include differences in perspectives, needs, and agendas among different groups; and different missions, priorities, and timelines.[18] Agencies also differ in their missions, mandates, funding streams, service areas, accountability processes, organizational cultures, and the legislative mandates under which they operate.[19] In addition, staff in different agencies often come from different disciplines and backgrounds with attendant differences in training, credentials, socialization, reference groups, and professional associations.

Other specific barriers include differences in organizational interests (which leads to competitiveness), organizational features (lack of structures to enable collaboration), experiential and training factors (lack of experience in how to coordinate and implement service delivery), communications, focus (on systems design rather than on functional role in system), time (lack of time, including lack of staff buy-in), definitions (regarding the target population, client eligibility, and role definitions), and data (e.g., the lack of centralized information base).[20]

Finally, there are situations in which collaboration is simply not an appropriate method for improving services.[21] For example:

- Collaboration is time-consuming, and thus is not suitable for problems that require quick and decisive action.
- Power inequalities among agencies will ultimately hurt efforts to collaborate.
- The "common good" often has to win over the interests of the few. In situations where this is not feasible, collaboration will likely not work.
- Collaboration works best in small groups, and not so well in large groups.
- Collaboration is meaningless without the power to implement final decisions.

Several useful lessons can be drawn from this review of collaboration.

1. Many organizations, agencies, or groups may have previously unrecognized mutual goals, even if their unique origins and histories appear to suggest otherwise. The identification and joint pursuit of common goals can be of tremendous value.
2. Collaboration is an approach that takes advantage of the different perspectives of various stakeholders to promote creative and novel solutions to shared problems.
3. Joint activity among stakeholders can result in many benefits to both the organizations that deliver services and individuals who receive those services.

SUCCESSFUL MEDICAID AND MENTAL HEALTH AGENCY COLLABORATION: STATE EXAMPLES

Two state-level case studies illustrate many of the principles reviewed above, including:

- Legislative, organizational, and fiscal changes that effectively induced interdependence between mental health and Medicaid agencies, and thus helped promote collaboration.
- The contributions of shared history, professional relationships, leadership, and the development of mutual trust in promoting and maintaining collaborative activity.
- The progression of collaborations through the four stages outlined above.
- The benefits that have resulted from collaboration.

Maryland

Maryland currently operates its Medicaid and Mental Health programs within the Department of Health and Mental Hygiene, and thus a single Secretary oversees both agencies. This structure, instituted in the mid-1990s, induced the two agencies to collaborate by initially coordinating their efforts and resources. According to a former Secretary, this reporting structure facilitated the flow of work and allowed the Department to act as a key player in pushing for needed mental health reform and shifting the locus of services from institutions to the community.[22]

Subsequent discussions on whether mental health services should take a comprehensive or managed care approach within the state system further increased cooperation between the Mental Health and Medicaid state programs. A Memorandum of Agreement was issued and legislation on a managed care carve-out passed in November and December of 1996. As a result, the Maryland Medicaid agency and the Mental Health agency worked collaboratively on all aspects of the managed care carve-out program, including administrative, programmatic, and financial issues. The Mental Health agency had the day-to-day responsibilities for the administrative and programmatic issues, while the Medicaid agency retained overall oversight of the services.[23] The program, implemented through an 1115 demonstration, included all inpatient and outpatient mental health services, case management as well as residential treatment center services provided by both public and private providers. Under the agreed upon waiver design, all mental health pharmaceuticals and specialty mental health services were continued as fee-for-service, and prescribed or authorized by the mental health system. Both a former Secretary and a former Director of the Mental Health program stressed that the transfer of administrative and programmatic aspects of the waiver into Mental Health was the key to improving the coordination within the State between Medicaid and Mental Health, as was the transfer of one staff member from the Medicaid agency to the Mental Health agency.[24]

Following the shifting of administrative responsibilities, staff from the Medicaid and Mental Health programs worked together on the state's Medicaid program. The two agencies held weekly meetings and ongoing strategy meetings together throughout the first year to evaluate the progress of implementation and to provide trouble-shooting. Subsequent legislation created a Medicaid Advisory Group chaired by a mental health advocate. The Medicaid Advisory Group also induced both programs to increase coordination by monitoring their collaborative interactions closely. Both a former Secretary of the Department of Health and Mental Hygiene and a former Director of Mental Health felt that an environment in which key people were familiar with and trusted each other contributed to successful collaboration.[25]

Crucial to the success of Maryland's program are the long-standing professional relationships between the staff members of the Mental Health and Medicaid agencies. The foundations of trust that had already been laid prior to this formal collaboration of programs contributed to the success of the collaboration. According to a former Secretary of the Department of Health and Mental Hygiene, Maryland was able to increase access to community-based mental health services while decreasing utilization for facility-based/inpatient services.[26]

New Jersey

In New Jersey, the Department of Human Services (DHS) has responsibility for the state divisions of Mental Health (Adult Mental Health and Child Behavioral Health), Medicaid, Child Welfare, Developmental Disabilities, TANF, Substance Abuse, and the Blind and Hearing Impaired. In addition, the Medicaid division administers the State Children's Health Insurance Program (SCHIP). In the mid-1990s, discussions about health care reform provided New Jersey with the opportunity to revamp the mental health services offered through Medicaid with a special emphasis on children in foster care and juvenile justice. Previously, these divisions were working independently of one another. The Commissioner realized the potential for the divisions to collaborate and fully utilize their resources and was able to make children's mental health reform a priority for New Jersey. In 2001, the Governor supported the Commissioner's efforts and allocated $10 million to expand behavioral health services for children.[27]

The Commissioner created a new reporting structure for all of the divisions related to child and adolescent behavioral health services. The new structure was in the form of a task force whose members reported to the Deputy Commissioner, who in turn reported to the Commissioner. The members of each of the divisions in DHS had responsibility for child and adolescent behavioral health services, including Medicaid and Mental Health. Further, the Commissioner, as part of the cabinet, was able to secure the Governor's support.[28] This structure induced all of the divisions to develop relationships with one another and increase their coordination. DHS also offers continuous cross-training and coaching to inform each division of the current work of the other divisions and to ensure that all of the divisions are working together effectively.

A high level planning team that included directors of the divisions of Mental Health, Medicaid, and child welfare reviewed successful, unsuccessful, and sustained efforts of other states, as well as the use of the rehabilitation option under Medicaid, EPSDT, and Medicaid waivers.[29] They decided to utilize the rehabilitation option in conjunction with expanding EPSDT services through a State Plan amendment. They defined the services to be provided, set reimbursement rates, developed codes for the expanded services, and developed a strategy for provider enrollment.[30] New Jersey also formed a management team that included task force members in supervisory positions. Once the initial planning and implementation phase was completed, the management team assumed responsibility for the day-to-day operation of services. Currently, the management team, which includes the policy director for Medicaid and her counterpart in Mental Health, meets every two weeks to discuss issues, engage in strategic planning, and resolve problems. One of the key members of the management team is the administrator for the Office of Policy for Medicaid. Her office is physically located in the Mental Health division although she remains an employee of the Medicaid division. As part of the management team, she reports directly to the Deputy Commissioner. This staffing action helped a good working relationship to develop between the agencies, allowed for streamlining policy and procedures on a day-to-day basis, and improved accountability for the program.[31]

Having the Medicaid division involved with the Mental Health division from the start of this project served as a catalyst to building a close partnership between the two divisions. The Medicaid division is familiar with the needs of the Mental Health division, provides resources for enhancing statewide access to mental health services, and works with the Mental Health

division to efficiently build a budget consistent with the concepts and plans of the mental health program. As the two divisions are operated under DHS, the Department head is able to continuously steer the two divisions in the same direction and ensure that they are working towards the larger departmental goal.[32]

SUMMARY

The increasing reliance on Medicaid to support the public mental health system makes collaboration between Medicaid and Mental Health agencies essential. Studies of interagency collaboration show that it requires time and commitment, and must pass through successive stages to be fully successful. The state examples illustrated several factors necessary for successful collaboration. These include: 1) a recognition of the need for collaboration brought about by changes in organization, communication, and funding, 2) strong leaders who believe in and have a long term commitment to collaboration, 3) an emphasis on the importance of professional relationships, including staff exchanges, and 4) the recognition or establishment of mutual goals to promote cooperation.

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