Monitoring Access to Mental Health Services – On July 29, 2009, the Center for Practice Innovations convened a meeting to help OMH and DOH identify ways to monitor access to mental health services within Managed Care Medicaid. Thomas McGuire, Ph.D., from Harvard Medical School, was invited to consult. Recommendations included using contracting and performance monitoring as tools to influence service utilization. To see a summary of the meeting, please see below.
DOH provided Tom McGuire with background information on managed care contracting for Medicaid enrollees in NY and the various encounter and other data available. Currently, the most common/expensive mental health diagnoses are ADHD and depression, however this may change as more individuals who are disabled because of a mental illness come under managed care for their mental health services.

Tom pointed out that NY has unusually rich data sources and described several ways they might be used to measure/monitor access to services. As background, he noted that previous research has found that managed care typically decreases racial disparities and increases access to care. He also noted that plans have incentives to craft their benefits so that individuals who can be identified as high risk for high expenditures will be dissuaded from enrolling in a plan, therefore payers must find ways to discourage such skimming and dumping by targeted monitoring and establishing counter-incentives via the way they contract for services. He reviewed findings from three studies showing that:

- Mental health care is particularly subject to underprovision in capitated managed care environments,
- Weighting CAHPS global reports by expected utilization (e.g. CRG risk score) can improve incentives to managed care plans to allocate resources to services used by costly enrollees,
- Medicaid managed care reduces racial/ethnic disparities in access.
With respect to NY, Tom recommended considering the following:

1. **Drug spending can be part of a performance contract with a managed care vendor even if pharmacy is not part of the capitation payment.** By rewarding/punishing a vendor for pharmacy spending below/above a particular target, the vendor has an incentive to encouraging prescribers to consider generic/less expensive alternatives when selecting among medications for the same indication. By setting only a moderate amount at risk, DOH could encourage cost control without being very heavy handed. Given the large fraction of expenditures related to pharmacy, encouraging the script writers to write prudently makes fiscal sense. This is particularly important with respect to mental health services because the increase in mental health expenditures is directly related to increase in pharmacy expenditures; the remainder of mental health spending (inpatient, outpatient) is flat or decreasing. In this way NYS can retain rebates and encourage the plans to behave as if drugs are part of their management. The target can be risk adjusted, and risk sharing above and below the target can be moderated. For example, there could be 50/50 risk sharing above and below the target.

2. **Large variations in healthcare spending can exist without rationale; identifying such variation is a first step to targeted interventions.** Tom suggested identifying regional and other variations (e.g., by plan, by ethnicity) within particular high-risk cohorts (e.g., individuals with bipolar disorder, individuals with schizophrenia). Researchers collaborating with the state of Florida have used claims data to define various mental health populations. This allows payers to identify variations from expected utilization.

3. **The overlap between managed care and direct payment bears considering.** How do plans perform when there is overage with respect to the 30/20 limit? Tom suggested examining how much the State pays in fee for service beyond the limit and how this varies by plan. Given the strength of state data, use and payment for individuals in managed care plans and from direct state payments.

When asked what he would recommend pursuing, Tom said that he expected that the highest payoff would be gained from including controlling the pharmacy spend as a target with fees at risk in the contracts of managed care vendors even though pharmacy claims are managed by other vendors. He also suggested determining the overlap of the State and direct pay programs. Contracting and oversight of the contract are powerful tools; Tom noted that sometimes identifying patterns is itself a form of oversight. The results of such performance monitoring become targets for successive contracts.
Citations


