Planning Meeting on Managing Medicaid Behavioral Health - At the time of this meeting, the behavioral health benefit structure for many Medicaid beneficiaries in New York was unmanaged fee-for-service, which risks high spending on diverse, poorly coordinated services with little accountability. Providers have few fiscal incentives to coordinate care or promote recovery. To direct attention to these challenges, the New York State Office of Mental Health (NYS OMH), in collaboration with the Center for Practice Innovations at Columbia Psychiatry, brought together national, state and local experts on September 16, 2010 to: 1) Review the current structure of the State’s Medicaid behavioral health benefit; 2) Examine promising practices for behavioral health in Medicaid nationally; and 3) Identify strategies for managing behavioral and physical health care in an efficient, well-integrated manner in New York State. Thomas McGuire, Ph.D., from Harvard Medical School served as the facilitator. To see a summary of the meeting, please see below.
Planning Meeting on Managing Medicaid Behavioral Health
Multipurpose Room, 6th Floor, Room 6602
New York State Psychiatric Institute, NY, NY
September 16, 2010

Attendees:

NYS Office of Mental Health
Anita Appel
Norman Brier
Sheila Donahue
Bruce Feig
Stewart Gabel
Martha Shaefer Hayes
Michael F. Hogan
Gregory Miller
Robert W. Myers
Kristen Riley
Lloyd Sederer
Hao Wang

NYS Office for People with Developmental Disabilities
Jacklyn Spring

Columbia/NYSPI
Susan M. Essock
Carlos T. Jackson
Jennifer Manuel
Jon Morgenstern
Scott Stroup

NYS Office of Alcoholism and Substance Abuse Services
Kathleen Caggiano-Siino
Patricia Lincourt

NYC Department of Health and Mental Hygiene
Gregory Allen
Donna Frescatore
Vallencia Lloyd
Patrick Roohan, M.S.

NYS Health Foundation
Pamela Riley

NYC Department of Health and Mental Hygiene
Adam Karpati
Trish Marsik

FEGS Health and Human Services
Jonas Waizer

APS Healthcare
Richard Surles

Greater New York Hospital Association
Alison Burke

Arthur Webb Group, Ltd.
Arthur Webb

Harvard Medical School Department of Health Policy
Andrea Ault-Brutus
Thomas G. McGuire

Fidelis Care New York
LaQuetta Solomon

Manatt Health Solutions
Antony Fiori
Attendees (continued):

Nationwide Children’s Hospital
Kelly J. Kelleher

Coalition of Behavioral Health Agencies
Phillip Saperia

Community Care Behavioral Health Organization
Joan Erney
James Gavin

Healthcare Association of NYS
Cindy Levernois

HealthFirst, Inc.
Patricia Wang

Hinman Straub
Stephanie Piel

Institute for Health
Virna Little

Erie County Department of Mental Health
Philip R. Endress

National Council for Community Behavioral Healthcare
Linda Rosenberg

NYS Conference of Local Mental Hygiene Directors
Kelly Hansen

NYS Council for Community Behavioral Healthcare
John Kastan

OptumHealth Public Sector
Suzanne Feeney

United Hospital Fund
Michael Birnbaum

University of Rochester Medical Center
Steven Lamberti

ValueOptions
Richard Sheola

Meeting Summary:

Overview

The behavioral health benefit structure for most Medicaid beneficiaries in New York is unmanaged fee-for-service, which risks high spending on diverse, poorly coordinated services with little accountability. Providers have few fiscal incentives to coordinate care or promote recovery.

To direct attention to these challenges, the New York State Office of Mental Health (NYS OMH), in collaboration with the Center for Practice Innovations at Columbia Psychiatry, brought together national, state and local experts to:

- Review the current structure of the State’s Medicaid behavioral health benefit;
- Examine promising practices for behavioral health in Medicaid nationally; and
- Identify strategies for managing behavioral and physical health care in an efficient, well-integrated manner in New York State.
The Situation in New York State
An estimated 695,000 people receive treatment each year from the public mental health system, with the bulk of services delivered by community mental health providers. A relatively small number of disabled Medicaid recipients (including those with serious and persistent mental illness) account for a large share of costs. Medical comorbidities are extremely common among NYS OMH clients. The current system does not work well to facilitate coordinated care for those with chronic, co-occurring illnesses.

The behavioral health benefit in New York Medicaid is primarily unmanaged fee-for-service. Specialty mental health services are often “carved out” of Medicaid managed care and are unmanaged. SSI recipients and those receiving both Medicaid and Medicare (dual eligibles) receive services on a fee-for-service basis. Even managed care companies that cover mental health services generally carve out these services and do little to promote coordinated clinical care.

Current Approaches to Managing Behavioral Health
Innovative programs across the country and in New York that promote and facilitate integrated care show promise. These programs include:

- New York Care Coordination Program, presented by Phil Endress. This is a multi-county, multi-stakeholder learning collaborative that seeks to improve outcomes for those with serious behavioral health issues. Comprised of county directors, peers, family members, providers and OMH partners, the collaborative is working on care integration across multiple areas, such as mental health, substance abuse and physical health.

- Pennsylvania HealthChoices Program, presented by Joan Erney. The HealthChoices Program is a Medicaid managed care program designed to improve access, improve quality of services and stabilize Medicaid costs, using an integrated and coordinated health care delivery system for medical, psychiatric and substance abuse services.

- Medicaid Behavioral Health in Pediatrics, presented by Kelly Kelleheer. The Nationwide Children’s Hospital in Columbus, Ohio has developed innovative electronic applications to facilitate more efficient ways of coordinating care across healthcare systems. For example, electronic medication records facilitate the tracking of chronic illnesses across the state, and digital applications, such as Health eTouch, expedite mental health screenings in primary care. A key to the success of this program may have been getting all key stakeholders at the table, sharing financial risks and benefits, so that everyone has a fiscal stake in providing effective services.

- Institute for Family Health, presented by Virna Little. The Institute for Family Health, a community health center in New York, has established new ways of redesigning space so that behavioral and physical health providers are working together. For example, digital records provide a way to share information across disciplines.
• **Strong Ties, presented by Steven Lamberti.** To address mental health and comorbidities, Strong Ties, a community support program in Rochester, New York, focuses on increasing access to care (on-site services), efficiency of care (one stop shopping) and quality of care (sensitivity to client’s special needs).

• **Missouri’s High-need/High-risk Approach, presented by Richard Surles.** Missouri uses data systems to identify high-risk/high need consumers and provides individualized care management to improve and coordinate care while controlling costs.

**Challenges and Opportunities for Financing Integrated Care (Tom McGuire)**

In considering integrated general health and behavioral health benefits, it is important to recognize that managed care organizations know that people with mental illness typically have greater health expenditures than those without mental illnesses. In an integrated model, managed care organizations might organize their benefit structure to discourage enrollment of behavioral health consumers. Managed care organizations would have less interest in investing in mental health than physical health because mental health use is predictive of high service use and costs.

Elements of a model Medicaid health system may include the following: access to behavioral and pharmacy data; electronic records; patient access to personal records (“right to know”); utilization management linked to a care management provider; true integration of physical and behavioral health care services with alignment of incentives (not necessarily through a single/integrated payment); and sharing of clinical information across providers.

**Strategies Possibly Applicable to New York State**

1. **Managed carve-out of behavioral health services.** Carved out specialty managed care, such as the Health Choices Program, can work well to promote access, integrated care and cost control. In the Pennsylvania model, access to behavioral health care has increased and costs have been constrained. The success of Pennsylvania’s effort depended on several factors: broad patient eligibility, comprehensiveness of services, linkage to services, and structures for collaboration and data sharing.

2. **Promoting attention to mental health disorders in general health settings.** An insurance risk model (that is, capitation) alone is not enough to ensure that providers in general health settings pay attention to mental health disorders. Providing such incentives as paying physicians an increased rate to manage cases is more likely to succeed. Standards of care, screenings, and data reporting and sharing across healthcare are also necessary supplements to facilitate integration.

3. **Improving care for high-need/high-risk populations through care management.** A personalized, multi-disciplinary approach to care management is improving care and reducing costs of high-need/high-risk populations in Missouri. Missouri’s approach to care coordination is to use data systems to identify high-risk individuals and assign an interdisciplinary team to work with each one.