

**MEDICAID
INSTITUTE**
AT UNITED HOSPITAL FUND

Providing Behavioral Health Services to Medicaid Managed Care Enrollees

About the Medicaid Institute at United Hospital Fund

Established in 2005, the Medicaid Institute at United Hospital Fund provides information and analysis explaining the Medicaid program of New York State. The Medicaid Institute also develops and tests innovative ideas for improving Medicaid's program administration and service delivery. While contributing to the national discussion, the Medicaid Institute aims primarily to help New York's legislators, policymakers, health care providers, researchers, and other stakeholders make informed decisions to redesign, restructure, and rebuild the program.

About United Hospital Fund

United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, clinics, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

Medicaid Institute at United Hospital Fund

James R. Tallon, Jr.
President

David A. Gould
Senior Vice President for Program

Michael Birnbaum
Director of Policy, Medicaid Institute

Copyright 2009 by the United Hospital Fund
ISBN 1-88127-7925

Free electronic copies of this report are available at the United Hospital Fund's website, www.uhfnyc.org.

**MEDICAID
INSTITUTE**
AT UNITED HOSPITAL FUND

Providing Behavioral Health Services to Medicaid Managed Care Enrollees: Options for Improving the Organization and Delivery of Services

PREPARED FOR THE MEDICAID INSTITUTE
AT UNITED HOSPITAL FUND BY

Melanie Bella, SENIOR VICE PRESIDENT
Stephen A. Somers, PRESIDENT
Karen Llanos, SENIOR PROGRAM OFFICER

CENTER FOR HEALTH CARE STRATEGIES, INC.

JUNE 2009

Executive Summary

There is no one-size-fits-all national model for managing physical and behavioral health for supplemental security income (SSI) beneficiaries with severe and persistent mental illness (SPMI). Clearly, the state and others in the field need to create more comprehensive models for capitating and managing the care of people with SPMI at the community level. The good news is that many states have had substantial experience with managed care approaches for SSI beneficiaries with SPMI, although more in behavioral health services than in physical health services. The bad news is that even though most experts favor the concept of fully integrated managed care, there are very few successful and scalable examples.

The Center for Health Care Strategies, Inc. was asked by the Medicaid Institute at United Hospital Fund to identify best practices in the organization, financing, and delivery of behavioral health services for Medicaid managed care beneficiaries with SPMI. Based on a literature review, interviews, and expert feedback, it seems clear that integrated management of physical and mental health services for SSI beneficiaries with SPMI must be introduced in order to achieve better outcomes at a more reasonable cost. With necessary beneficiary protections as well as strong purchasing requirements and oversight by the state, full-scale integration of both services into one capitated care management organization would be the optimal solution. The state has two basic purchasing options for building rigorous contracting relationships in its mandatory managed care regions:

1. Contract with existing managed care organizations (MCOs) to develop care management programs that support physical-behavioral homes for individuals with SPMI and that abide by strong purchasing standards, with particular attention to establishing appropriate behavioral health expertise. Ideally, the MCOs would have responsibility for the full set of physical and behavioral health benefits (i.e., no carve-outs).
2. Contract with a new behavioral health organization (BHO) with sufficient infrastructure to support a network of behavioral health care homes for SSI beneficiaries with SPMI. Ideally, there would be some financing or incentive mechanism to facilitate integration between this entity and existing physical health MCOs by holding them jointly accountable for improved utilization, outcomes, and costs they can both influence.

If New York wants to pursue an ambitious, scalable model, building on the pre-existing infrastructure of MCOs to provide the integrated care management infrastructure for primary-behavioral health care homes seems to be the most feasible approach. In either of these scenarios, a strong state procurement effort for joint physical-behavioral health care management activities would be needed. It would clarify the expected functions and deliverables and increase the likelihood that the option chosen by policymakers and program managers would dramatically improve care for SSI Medicaid beneficiaries with SPMI.

Introduction

The integration of care for Medicaid managed care beneficiaries with serious physical and behavioral health (i.e., mental health and substance abuse) comorbidities is an intractable challenge facing state health policymakers across the country. In spite of nearly two decades of efforts through various managed care approaches, few have been able to implement the conceptually compelling idea of a fully integrated medical and behavioral health care home. New York is not alone in seeking better ways to care for Medicaid beneficiaries with serious and persistent mental illness (SPMI).

The Institute of Medicine recommends that providers of medical services establish “effective linkages within their own organizations and between the providers of mental health and substance abuse.”¹ Yet, almost invariably, behavioral health services are still carved out into separate systems, whether managed care or unmanaged fee-for-service. Thus, the responsibility to pay for and manage Medicaid-funded behavioral health services is typically divided among separate state agencies and provider networks, resulting in fragmented systems of care for individuals with mental health and substance abuse problems. Many states are concerned that the behavioral health delivery system for people with SPMI still tends to rely too heavily on inpatient hospital services. The consequences are poor quality of life for the beneficiaries and excessive costs for the taxpayers.

Recently, some states have tried anew to design and implement more effective linkages between physical and behavioral health care. Not surprisingly, there is considerable state variation in how behavioral health services are financed. Arrangements include full risk, partial risk, no-risk with utilization management, and fee-for-service (FFS). There are also a number of options for organizing and delivering care, including managed behavioral health organizations, administrative or management services organizations, and community mental health centers.

Despite the variation, a scan of selected states confirms movement away from FFS systems of behavioral health care, with unmanaged FFS systems, similar to New York’s current approach, remaining in only a handful of the reviewed states. Even more unusual are structures comparable to the arrangement in New York City and other parts of the state where physical health services are delivered through capitated managed care organizations and behavioral health services are provided on an FFS basis. Among the approximately 25,000 disabled — or Supplemental Security Income (SSI) — Medicaid beneficiaries with

¹ Institute of Medicine. 2005. *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington: National Academies Press.

² Per state policy, non-SSI beneficiaries with SPMI are exempt from managed care.

SPMI³ receiving their care under this system, 60 percent have at least one chronic medical condition (e.g., asthma, diabetes, cardiovascular disease) and 29 percent have two or more. Even so, the health care costs of these SSI adults with SPMI account for only 27 percent of their overall Medicaid expenditures; the remaining 73 percent is for behavioral services and pharmaceutical benefits.⁴ Given this level of comorbid physical and mental health issues, New York State policymakers know that the current fragmented system is untenable and they are eager to find new and scalable solutions.

The Center for Health Care Strategies, Inc. (CHCS) reviewed published materials and interviewed state and local stakeholders, including state Medicaid and mental health officials, managed care and behavioral health care representatives, and other national experts, listed in the acknowledgments of at the end of this report. It also sought written input from John Billings at New York University and two nationally respected experts in care for adults with SPMI, Colette Crose and Martin Cohen. Finally, to supplement its research, CHCS convened a small group of experts in September 2008 to brainstorm with leaders from the New York State Department of Health (DOH) and Office of Mental Health (OMH).

This report is divided into the following sections: (1) a vision for delivering and financing physical and behavioral health services in New York; (2) an overview of how the Medicaid benefit for SSI beneficiaries with SPMI is structured; (3) an examination of what is needed to better understand the target population; (4) an analysis of how to integrate and improve the delivery of physical and behavioral health services; and (5) a discussion of concrete options for New York's policymakers. There are no easy solutions for the challenges that New York faces. However, this report suggests ways for the state to create more integrated systems of care for SSI beneficiaries with SPMI to improve care and reduce unnecessary exacerbations of illness that can result in avoidable utilization of high-cost services.

I. A Vision for Delivering and Financing Physical and Behavioral Health Medicaid Services in New York

State Medicaid and mental health officials agree that the current systems for delivering publicly financed physical and behavioral health services are less than ideal for beneficiaries, communities, health care providers and managed care organizations, state and local governments, and taxpayers. The lack of coordination among primary care doctors, hospital emergency rooms, behavioral health practitioners, and other providers leaves patients — often with many other social challenges like homelessness — confused, frustrated, and, too

³ Birnbaum M and L Powell. Medicaid Managed Care for Persons with Severe Mental Illness: Challenges and Implications. Medicaid Institute at United Hospital Fund, 2007.

⁴ Ibid.

often, with inadequate care. Primary care physicians and mental health providers alike are often unaware of who is prescribing what to whom. Patients show up in emergency rooms with avoidable exacerbations, and their health plans typically do not find out until weeks later when discharge is imminent or reimbursement is due. These scenarios too often lead to poor outcomes for these beneficiaries. Nationally, people with SPMI have a high prevalence of serious physical illnesses and are likely to die much earlier than their peers without mental illness. Mortality from lower respiratory disease, diabetes, and liver disease is twice as high among people with SPMI as it is in the general population.⁵

New York is not alone in struggling with the care of high-need, high-cost beneficiaries with serious physical and behavioral health comorbidities. And its Medicaid and mental health leaders are also not alone in facing clinical, fiscal, political, and bureaucratic obstacles to creating a more rational system. However, as noted above, there is a consensus among state policymakers that the current situation is untenable and a new approach that will deliver more effective and efficient care for beneficiaries with SPMI is desired.

In most New York counties, MCOs now provide all physical health care services for SSI beneficiaries, which is an important step forward. MCOs could serve as the foundation for a fully integrated physical and behavioral health managed care model — i.e., a model with no carve-out.

This paper examines a broad range of managed care options that could help systematically integrate care, align financial incentives, and establish an infrastructure for creating and supporting accountable physical and behavioral health care homes for beneficiaries with SPMI. Two basic questions against which to measure these managed care options are: What are the critical features of an “accountable physical and behavioral health care home”? And how could such homes be established in New York?

Critical Features of Accountable Physical and Behavioral Health Care Homes

Beneficiaries with serious comorbidities should have access to one person or entity that knows about their physical and behavioral health conditions and the interrelationships between them, understands possible interactions between the prescribed treatments for their conditions, and can help them navigate the system, including community-based providers, to meet their particular health and social service needs.

An integrated team of medical and behavioral health providers located in a single physical place — a “physical and behavioral health care home” — would be ideal. But if that goal is

⁵ Harvey B, E Freeman, and JT Yoe. The Poor Health Status of Consumers of Mental Health Care: The Interaction of Behavioral Disorders and Chronic Disease. Presentation by Maine Department of Health and Human Services, Office of Quality Improvement.

too difficult to attain quickly, such a home could at least be built virtually through the use of electronic records, data sharing, coordinated case finding, and prevention-oriented interventions.

Effective integration will likely require a larger entity than a single provider — a care management organization rather than a primary care provider, federally qualified health center, or community health center. To the extent that integrating care could reduce avoidable emergency department visits and inpatient stays, the accountable entity should receive those savings. The savings, or at least a substantial portion of them, should be reinvested in health and social supports designed to sustain beneficiaries' gains in health and functional status. These flexible support services are especially important for beneficiaries facing difficult social circumstances (e.g., homelessness) that make it far more challenging for them to manage their own care, adhere to drug regimens, or prepare healthy meals for themselves.

In short, some measure of accountability — through capitation, sub-capitation, an at-risk care management payment, or a performance-based administrative fee — is also critical. Accountability can ensure that the care home takes responsibility for the beneficiary's physical and behavioral health outcomes and for ensuring that the medical model does not circumscribe the array of available psychosocial services. All entities that form the care homes, from the infrastructure support organizations to the providers themselves, should have a financial stake in the success of the integrated home.

Establishing Accountable Physical and Behavioral Health Care Homes in New York

There are dedicated primary care and behavioral health providers throughout the state, including dually licensed entities (e.g., hospitals); however, to date there has been little incentive and no framework for collaborating to create accountable care homes, even within dually licensed facilities. Managed care organizations now provide physical health services to all Medicaid beneficiaries and behavioral health services to Medicaid beneficiaries without SPMI. One or more of these health plans with a commitment to high-need populations could serve as a building block to organize and support care homes for individuals with SPMI. This could be done by expanding the MCO's responsibilities to include behavioral health services. A more modest step would be to identify comparable entities that could manage behavioral health services. In many states, that would take the form of a capitated behavioral health organization (BHO). In other states, it might be an administrative or management services organization (ASO or MSO), a care management organization (CMO), or a disease management organization (DMO). The entity would be accountable for analyzing data, identifying and reaching out to high-risk beneficiaries, and monitoring utilization. In other states, the best option might be a county-based or regional provider of

comprehensive behavioral health services responsible for all behavioral health services from outreach and care coordination to treatment and integration with the physical health care.

In most states, there is already an organizing mechanism for behavioral health that far exceeds the care coordination capacity of New York's bifurcated system of managed physical health services and fee-for-service behavioral health services. Whether through major changes to the carve-out of behavioral health benefits, incremental solutions such as the establishment of a BHO or CMO for all SSI beneficiaries with serious comorbidities, or models that create physical and behavioral care homes and co-manage high-risk beneficiaries, the responsible state policymakers themselves agree that they must consider taking significant steps toward greater integration of physical and behavioral health care services.

II. New York's Behavioral Health Services for Medicaid Beneficiaries with SPMI

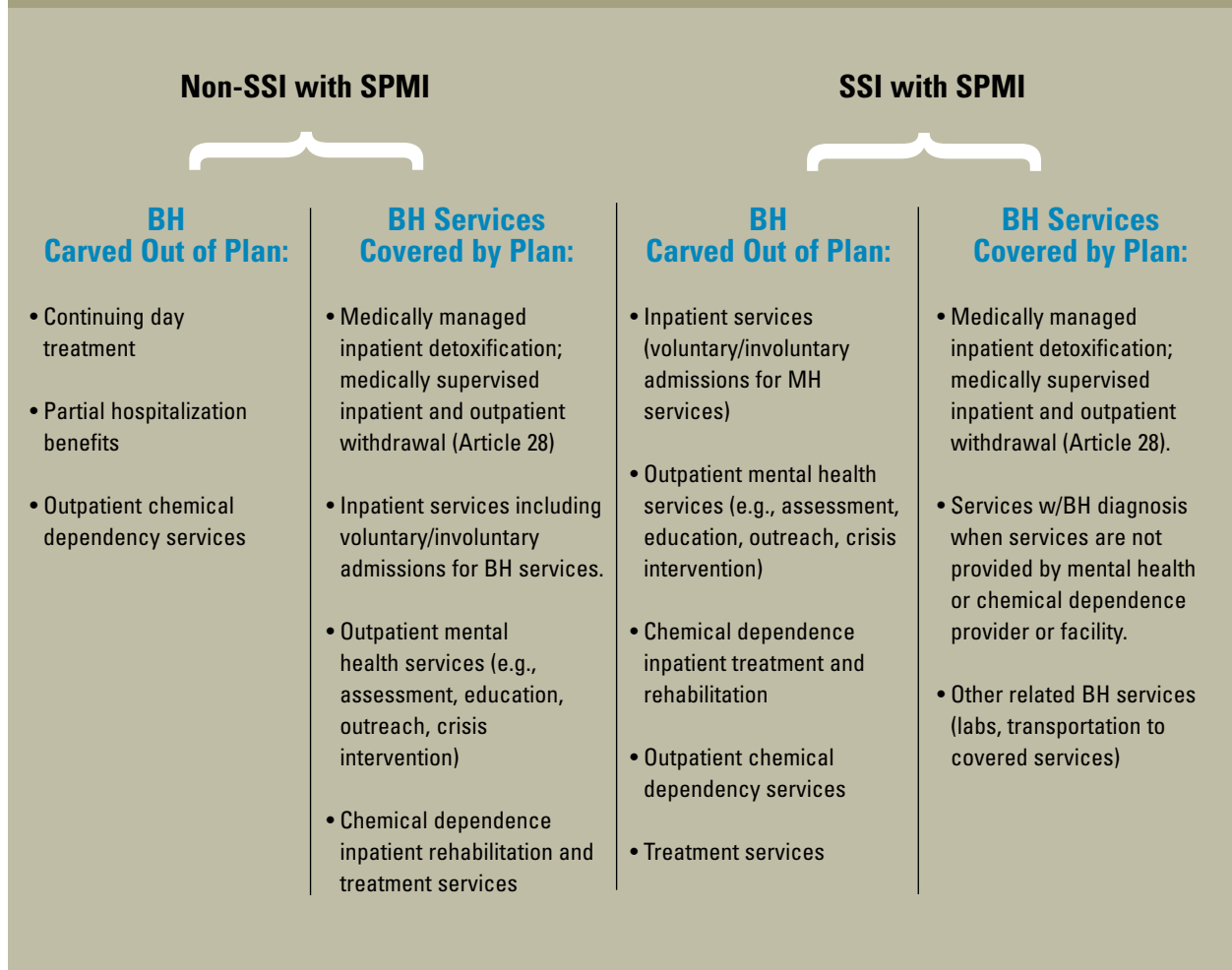
Medicaid beneficiaries with an SPMI diagnosis are roughly 25 percent more likely to have three or more chronic conditions than people without a mental illness diagnosis.⁶ These beneficiaries not only have complex physical and behavioral health needs but they are also likely to face inadequate housing and transportation, adding significantly to the challenges of daily living. The disconnect between the physical and behavioral health delivery systems makes things considerably more difficult for them.

Focusing, for example, on New York City, which accounts for 73 percent of the state's Medicaid beneficiaries who are enrolled in managed care,⁷ SSI beneficiaries with SPMI are enrolled in MCOs for their physical health services and receive behavioral health services outside of the MCO on an FFS basis (Figure 1). Medicaid beneficiaries with mental illnesses who have not been deemed disabled and SSI-eligible receive both physical and behavioral health services from MCOs.

⁶ Ibid.

⁷ Medicaid Institute at United Hospital Fund analysis of New York State Department of Health Enrollment report, July 2008.

Figure 1
Structure of Behavioral Health (BH) Services for SPMI Beneficiaries in New York⁸



As is the case in other parts of the health care system, carve-outs create barriers to getting the right care to the right people at the right time. In New York, no plan or provider has the responsibility or financial incentive to divert beneficiaries from inpatient psychiatric care or to facilitate timely discharge back into community services. In fact, for the most part, the opposite is true when the state pays on a fee-for-service basis for the majority of high-cost behavioral health services. In states with fully capitated approaches, the capitated entity (e.g., MCO or BHO) generally accepts risk for these services and has strong incentives to reduce avoidable use of them. Even in states using ASOs or CMOs, the fees for these entities are often at risk based on their ability to control inappropriate utilization. Beyond its strong monitoring of claims by state officials, New York has few of these incentives operating in behavioral health. Data suggest that this represents a significant area of opportunity for program reform. Not only could reform control avoidable expenditures, it could also spur greater use of appropriate community-based services and improve the quality of life for New York’s SSI beneficiaries with SPMI.

⁸ New York State Medicaid Managed Care and Family Health Plus Model contract, April 1, 2008. Appendices K.1- K.3.

III. Better Understanding the Target Population: What Do We Need to Know?

The “SPMI population” is a heterogeneous group and often not well-defined. To develop better ways of caring for Medicaid beneficiaries with serious behavioral health needs, it is necessary to apply a common definition of SPMI, to understand the “faces” (e.g., diagnoses, utilization patterns, care settings, etc.) of beneficiaries with SPMI, and to identify care gaps and care improvement opportunities. Taken together, these steps provide the foundation for building new models of care around accountable physical and behavioral health care homes.

Defining SPMI

New York’s Office of Mental Health (OMH) provides a definition of SPMI based on diagnoses and utilization, with a caveat that it requires information that cannot be derived from claims data (difficulties in self-care, impairment in social functioning, etc.).⁹ New York’s Department of Health (DOH), by contrast, relies on claims data for a utilization-based definition of SPMI, which it uses when enrolling beneficiaries in managed care. Generally, states define SPMI with some combination of diagnoses derived from ICD-9 codes (e.g., schizophrenic disorders, episodic mood disorders, borderline personality disorder) and utilization criteria (e.g., designated number of encounters for mental health inpatient visits, specialty encounters, ER visits). Use of a common definition by all New York stakeholders would help provide a standard baseline and would allow DOH and OMH to target comparable beneficiaries. Once the state identified the population of mutual interest using a common definition, it would be better able to understand these beneficiaries and their needs, health status, disease prevalence, providers, utilization patterns, and care improvement opportunities. These insights could then provide a starting point for developing and testing new models well as broader policy and delivery system changes.

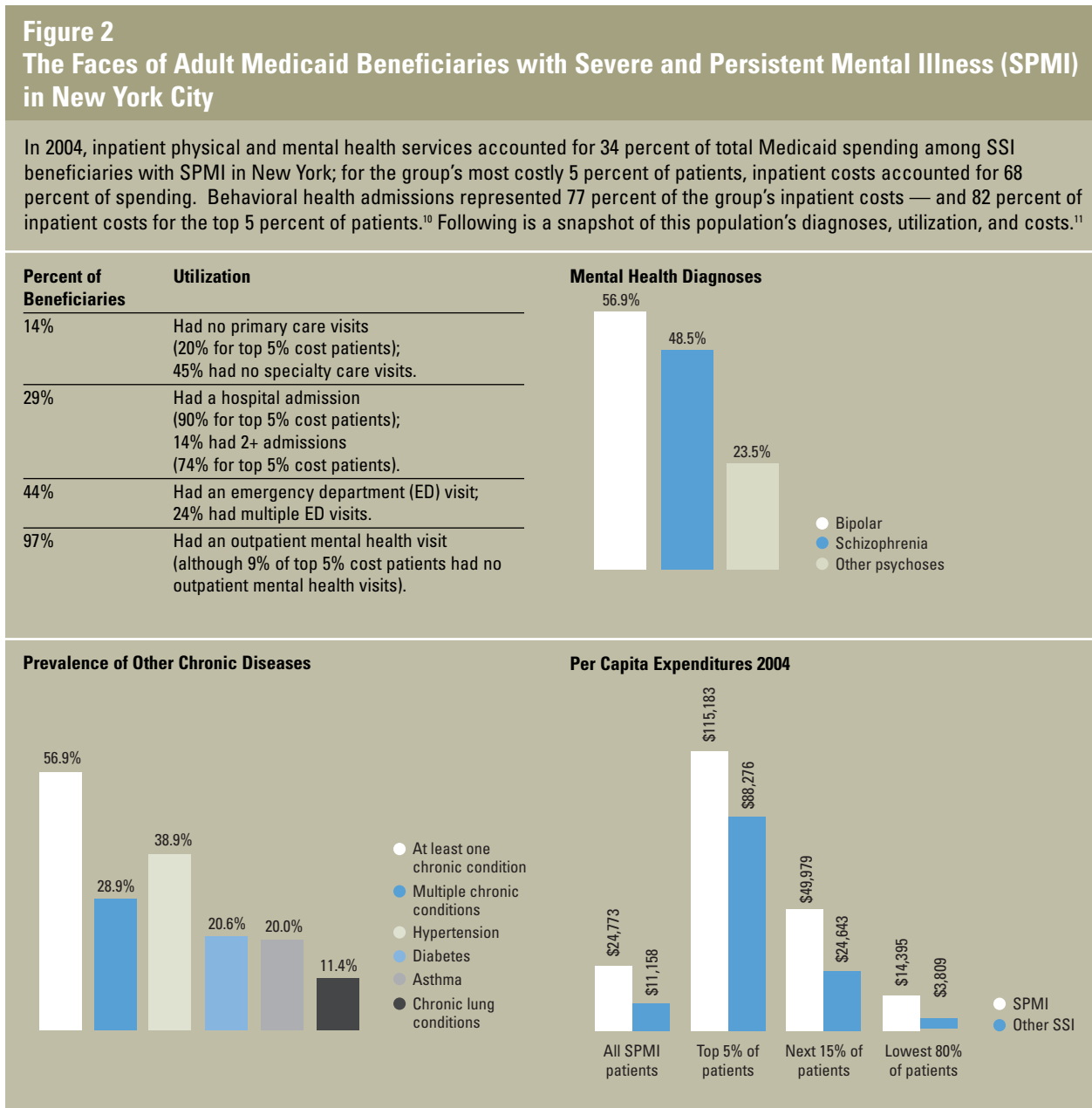
Faces of Beneficiaries with SPMI

It is widely known that there is a high burden of SPMI and substance abuse among the Medicaid population and that many patients with SPMI also have physical comorbidities such as diabetes and cardiovascular disease. In these complex populations, the presence of chronic disease and other physical health conditions compounds the negative effects of mental illness, in part because adherence to therapy for other conditions is often adversely affected. For example, a recent unpublished analysis by a Medicaid health plan showed that among the chronically ill population, the addition of one behavioral health condition doubles medical expenditures for physical health and also doubles both the emergency room visit rate and hospital admission rate.

⁹ For the Office of Mental Health’s definition of SPMI, visit: http://www.omh.state.ny.us/omhweb/guidance/Serious_Persistent_Mental_Illness.html.

Accordingly, it is important to understand the “faces” of beneficiaries with SPMI in terms of mental health diagnoses, chronic disease conditions, frequency of utilization, etc. because one-size-fits-all approaches do not address their complex needs. Analyzing and stratifying the population by risk, severity, comorbidity, level of need, and other characteristics will help the state assess and tailor potential care models and delivery system options to meet the needs of well-defined subsets within the SPMI population.

Earlier analysis of adult SSI beneficiaries with SPMI in New York City (in 2004, before mandatory managed care enrollment) is documented in Figure 2.



¹⁰ Birnbaum M and L Powell. Medicaid Managed Care for Persons with Severe Mental Illness: Challenges and Implications. Medicaid Institute at United Hospital Fund, 2007.

¹¹ Analysis done by the Center for Health and Public Service Research, New York University. 2007.

A. Care Improvement Opportunities

Figure 2 presents a set of important characteristics of beneficiaries with SPMI in New York City that may be indicative of the challenges faced by beneficiaries elsewhere in the state. Those charged with designing new program interventions and related policy changes for this population would benefit from timely and substantial analysis of recent data for the entire state. New data mining could uncover the prevalent, high-cost, and “impactable” clusters of physical and mental health comorbidities. In Maine, for example, robust, real-time data analysis of adult SSI beneficiaries with SPMI (e.g., health status, chronic disease prevalence and interaction, medication therapy management, and access and quality of care indicators) helps state policymakers develop priorities for program development.

Another good opportunity to improve care would be identifying where adults with SPMI currently receive their physical and behavioral health services, and assessing the appropriateness of care and care gaps. This would lay the groundwork for improving quality, access, and costs of both physical and behavioral health care. For example, primary care and community-based mental health providers who deliver high-quality care to many patients with SPMI could, through linking mechanisms such as co-location, data sharing, and gain sharing, establish accountable physical and behavioral health care homes. These practitioners would represent “high-opportunity providers” for the state and a managed care contractor specializing in either physical health or behavioral health, or both. More in-depth analysis could take the following potentially valuable directions:

- **Provider analysis.** For physical health, are patients loyal to specific providers (for primary or specialty care), or do they “shop” extensively? Such an analysis would also identify infrequent and non-primary care users, who often represent a substantial portion of patients, as well as patients who depend on emergency departments for much of their primary care. Similar analysis would be conducted for outpatient and inpatient mental health care utilization, to gauge the extent of loyalty and shopping, and to identify opportunities for improving continuity of care.
- **Utilization patterns.** The population should be profiled to identify costs and utilization across all major categories of service to identify areas of opportunity for quality improvement, cost savings, and potential over- and under-utilization.
- **Comorbid condition clusters.** It would be useful to identify combinations of diagnoses that demonstrate strong correlation, and subsets of patients with similar “clusters” of diagnoses (e.g., schizophrenia and cardiometabolic disorders; or depression, diabetes, and substance abuse). Further analysis could identify these clusters for patients with SPMI and assess implications for intervention strategies. For example, there are certain

combinations of physical health conditions and psychiatric illnesses for which accepted treatment protocols for one disease may exacerbate the other, such as psychotropic medications and diabetes. Such complex associations need to be recognized by policymakers and clinicians alike.

- **Linkage between physical and behavioral health providers.** In addition to identifying high-volume providers of physical health or behavioral health services to beneficiaries with SPMI, this analysis would involve identification of naturally occurring “networks” of physical and mental health providers. Do patients of some physical care providers tend to use the same mental health providers (and vice-versa)? In examining the service use of beneficiaries and the high-volume providers, the analysis could also tease out subsets of people who need different kinds of care (e.g., people with diabetes and schizophrenia, or with a combination of cardiovascular problems, serious depression, and chemical dependency). This analysis could also identify which health plans the high-volume providers of physical health care services participate in so that dominant payers can be engaged in designing and supporting possible interventions to integrate care.
- **Provider performance analysis.** This analysis would measure the performance of physical and mental health providers (controlling for differences in patient severity) against several intermediate outcomes. Indicators would be obtained from claims and encounter records, and would include the following:
 - Linkage to primary or specialty care for physical health (and vice-versa);
 - Emergency room use rates;
 - Hospitalization rates for preventable or avoidable visits and mental health conditions;
 - Ambulatory care follow-up following discharge from emergency department or hospital;
 - Appropriateness of drug regimen; and
 - Adherence to drug regimen.

An analysis incorporating the approaches above would greatly help efforts to reform and improve New York’s current split system for caring for people with SPMI.

IV. Integrating and Improving the Delivery of Physical and Behavioral Health Services for SSI Adults with SPMI in New York

Integrated care was recently defined as: “the process and product of medical and mental health professionals working collaboratively and coherently toward optimizing patient health...”¹² This is a broad goal; achieving it will require many specific steps. The list below outlines the elements that would be present in an ideal integrated system.

The Ideal Elements of Integrated Care

1. Comprehensive physical and behavioral health screening.
2. Electronic data system capable of sharing screening data (and other relevant “real-time” data) with physical and behavioral health providers.
3. Clear designation of physical and behavioral health care home that capitalizes on opportunities for co-location and deeper collaboration.
4. Engagement of consumers, both broadly (through program design) and at a patient level (through self-management and involvement in care plan development) — and recognition of the importance of maintaining existing provider relationships.
5. Shared development of care plans addressing physical and behavioral health (available to both providers electronically).
6. Care coordination support for SSI beneficiaries with SPMI and for providers (care homes). Care coordination and navigation support is especially needed to help beneficiaries access specialty, diagnostic, and acute care services outside of the integrated primary care setting.
7. Sensitive and competent physical primary health providers with training and support to appropriately deliver medical care and change health behaviors.
8. Standardized protocols and evidence-based guidelines that can be tailored to meet the needs of individual patients and set clear expectations for providers.
9. Joint and standardized clinical and performance measures, treatment follow-up, and feedback mechanisms that are shared among providers.
10. Mechanisms (e.g., pay-for-performance) for assessing and rewarding high quality care, particularly on indicators of collaboration.
11. Mechanisms for sharing savings from reductions in avoidable emergency and inpatient utilization across physical and behavioral care delivery systems.

¹² Butler M, RL Kane, D McAlpine, RG Kathol, SS Fu, H Hagedorn, TJ Wilt. Integration of Mental Health/Substance Abuse and Primary Care No. 173 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09-E003. Rockville, MD. Agency for Healthcare Research and Quality, October 2008.

For such an ideal system to be realized, care management organizations must have the infrastructure and capacity necessary to implement and sustain the elements above — and they must also have strong relationships with the state.

Promising examples from other states indicate that all the key players must have the potential to share in any realized savings. This sharing is especially critical if the benefit is carved out and financial risk is limited. Some new and innovative financing plans aim to share incentives among state and providers, in both physical and behavioral health. For example, Pennsylvania will be piloting a shared savings pool, money from which will be allocated based on performance measures. The performance measures can be influenced by both physical health MCOs and county behavioral health MCOs, and both will be jointly accountable for the measures. In the first year, the measures will reflect evidence of collaboration and integrated care (e.g., member assessment, stratification, and jointly developed plan of care). Later in the pilot, the measures will evolve to capture intermediate outcomes, such as reduced use of emergency departments and reduced inpatient admissions.

Prevention Quality Indicators (PQIs), developed by the federal Agency for Healthcare Research and Quality, may be a good starting point for selecting measures of joint accountability. Examples could include diabetes short-term complication admission rate, chronic obstructive pulmonary disease admission rate, and congestive heart failure admission rate. The Healthcare Effectiveness Data and Information Set (HEDIS) is another potential source of measures. One example would be the percentage of members who receive follow-up care within seven days of discharge from hospitalization for mental health disorders. Note that this is considerably harder for plans to collect if behavioral health is carved out into a separate entity.

Although there is a strong desire for physical and behavioral systems to be fully integrated, CHCS was unable to identify an integrated system with all or even most of the elements listed above. At the edge of the frontier may be the TennCare program, which recently announced the re-integration of behavioral health services into its mandatory managed care program for all Medicaid beneficiaries, including SSI adults with SPMI. This approach will bear watching. Minnesota is also striving to achieve full integration through the Governor's Mental Health Initiative, in which the state provides integrated mental and physical health care as well as a comprehensive mental health benefit across publicly funded health care programs.

Another “frontier” effort is the care management program for the chronically unemployed non-SSI adult population run by the Massachusetts Behavioral Health Partnership (see page 17 for more detail). Although promising, this program involves no direct partnership with physical and behavioral health practitioners.¹³

¹³ Laszlo A, et al. Evaluation of Mass Health Essential Care Programs. Center for Healthcare Policy Research, CHPR# 2005-202, January 2006.

Also worth watching is a pilot in Washington in which Molina Healthcare, an MCO, has taken full risk for physical, mental health, chemical dependency treatment, and long-term care services. The Washington Medicaid Integration Partnership (WMIP) incorporates many of the ideal elements described above, including a comprehensive integrated assessment, consumer engagement in program design, and a single care coordinator through which beneficiaries access the broad range of covered services. Molina's care coordination teams include staff with behavioral health expertise, and all care management staff receive training in mental illness. Evaluation findings from the first two years of the program indicate that, relative to a comparison group, WMIP enrollees have experienced lower rates of psychiatric inpatient hospitalizations, similar growth in outpatient mental health utilization, improved fill rates of mental health prescriptions, and decreased state hospital days.¹⁴

States are not the only sources of innovation; Medicaid managed care companies with deep experience in serving the SSI population are also experimenting with integration. One such example is Schaller Anderson, Inc. (now part of Aetna), which is exploring new models for integrating physical and behavioral health services for individuals with SPMI. In the past, when given responsibility for behavioral health care, some MCOs have simply taken a percentage of the capitation off the top and passed behavioral care responsibilities to a subcontractor without any attempt to integrate or even communicate with the MCO's physical health network. This practice prompted the observation from Schaller and from many others interviewed for this report that integration must start with very strong state purchasing requirements to ensure that the capitated plans do not underestimate the complexity of caring for this population and that they staff themselves with the necessary behavioral health expertise.

While Schaller sees fully integrated managed care as the "gold standard," it recognizes that, in most jurisdictions, many logistical, fiscal, and political obstacles stand in the way of rapid reform on such a sweeping scale. In its role as a CMO for Indiana's Care Select program, Schaller is working toward full integration by negotiating a contract with a non-risk umbrella organization that will broker management and service arrangements with participating community mental health centers — in this case serving as care management extenders for individuals with mental illness. This entity would function as an MSO, and its principal responsibility would be in care management across physical and behavioral health care. A model like this could eventually allow all participants — the MCO or CMO, the MSO, and the high-volume physical health and behavioral health providers — to share any cost savings from reductions in inappropriate utilization.

Many states contract with an intermediary organization to help manage FFS or primary care case management programs, in both physical and behavioral health. No single organization

¹⁴ WMIP Monitoring: A Data Briefing. Washington State Department of Social and Health Services, November 14, 2007. Available at <http://fortress.wa.gov/dshs/maa/mip/files/Progress%20Reports/WMIP%20Utilization-11-14-2007-both-Cohorts.ppt>.

provides such services for both sides under an integrated contract. Generally speaking, states contract for a specific scope of work and agree on a price for carrying out these activities based on either specific monthly management fees or an overall approved budget. Many contracts require these organizations to guarantee savings, thus putting management fees at risk. Some also include performance guarantees around expected process and care outcomes. These entities do not take insurance risk but, otherwise, they tend to perform many of the same functions as risk-bearing MCOs and BHOs. Typical functions include utilization management, provider profiling, dissemination of best practices, and care management. However, these entities rarely hold provider contracts; this responsibility stays with the public purchaser, thus removing the leverage they might otherwise have with the providers.

As illustrated by the examples described above, care management entities come in many, often overlapping, shapes and sizes. The range of delivery system designs starts with fully capitated health plans responsible for both physical and behavioral health services. Options that New York may wish to consider first are listed below.

V. Options to Consider for New York's SSI Population with SPMI

1. Fully Capitated Health Plans: As Tennessee is currently doing, a state can contract with a single, risk-bearing MCO for both physical and behavioral health services for SSI beneficiaries with SPMI. In New York, this would require “carving in” the behavioral health services and, in regions with mandatory managed care, contracting with MCOs for the full array of physical, behavioral, and support services. As noted above, this would need to be accompanied by strong purchasing requirements and contract oversight, including standards for the following:

- Access;
- Network adequacy (physical and behavioral);
- Credentialing in both physical and behavioral health care specialties; and
- Utilization and financial tracking and reporting to ensure that the medical model is not “shortchanging” behavioral or social services needed by the SSI population with SPMI.

Considerations: It bears repeating that the “integrated model” has often taken the form of the MCO carving out its behavioral health responsibilities and the bulk of the related funds, then giving them to a BHO or, in some instances, to a behavioral health MSO without full risk. Thus, most past attempts have sought to achieve integration through one state contract for the care of SSI adults with SPMI, even though there are two different organizations engaged in, at best, parallel management of care, or, at worst, almost completely

disconnected systems of care. While one might hope to derive lessons from the way MCOs manage behavioral health services for non-SSI beneficiaries with SPMI or from models that integrate primary care and depression treatment, people with SPMI and complex medical conditions constitute a genuinely different challenge.

In a related model in Pennsylvania, the state has a full-risk contract with a physical health MCO that is part of a corporation (the University of Pittsburgh Medical Center, or UPMC) that also has a BHO under a capitated contract with the counties for behavioral health services for SSI beneficiaries with SPMI. However, despite both sets of services ultimately being housed in one corporate entity, integration remains more difficult than one would expect. This difficulty springs from the fact that there are two purchasers (one for Medicaid and one for mental health) with two contracts; however, UPMC is conducting pilot programs to demonstrate which entity could better integrate physical and behavioral care.

For integration via a single fully capitated MCO to become less myth and more reality at the operational level, state purchasers must collaborate to integrate and standardize performance expectations. Because MCOs, in general, have demonstrated limited ability to develop the necessary behavioral health expertise, the states must address not only organizational structure and financial arrangements, but also the actual engineering of clinical strategies designed to change the practices of both physical and behavioral health providers.

2. Fully Capitated Behavioral Health Organizations: Beginning in the mid-1990s, fully capitated behavioral health plans experienced rapid growth in the public sector. The states or counties that have entered into risk-based contracts with BHOs have generally done so with either national or local plans. If the behavioral health carve-out remains, the state could contract with a BHO. The majority of components in BHO contracts are fairly uniform, addressing utilization management, quality improvement, network development, provider relations, and claims processing.

Considerations: BHOs were conceived as a fiscal and clinical solution to the growth in Medicaid spending for behavioral health services, fragmented delivery systems, and inconsistent clinical care. While they have for the most part demonstrated that they can manage utilization and costs, they have not demonstrated consistent improvement in quality of care at the provider level. In some jurisdictions, utilization management systems have been able to reduce overall behavioral health spending or spending on high-cost services, especially acute inpatient treatment. This has most often occurred when the public system used high volumes of inpatient treatment before the implementation of managed care. Some states have used funds saved from inpatient hospitalization to expand community-based treatment.

Most relevant to this report is whether the BHO model has developed sophisticated approaches to physical-behavioral health collaboration. Most are still attempting to coordinate behavioral health services with primary care through written notification and other means of communication, little of which is done jointly, proactively, or in real time. There are typically no requirements for collaborative treatment. Standard BHO contracts usually do not require collaboration beyond simple communication and coordination with primary care providers. If the state opted to follow the BHO model, it should consider strong purchasing specifications and contract language designed to move beyond reactive, one-way communication toward deeper collaboration and shared care.

The Massachusetts Essential Care program, alluded to earlier, bears watching as a promising practice for integrated care management. In this model, one BHO manages both the physical and behavioral health benefit for a small group of state-only, chronically unemployed beneficiaries with comorbid physical and behavioral health conditions. The program, managed by the Massachusetts Behavioral Health Partnership, provides medical care management for these MassHealth (Medicaid) beneficiaries, employing nurse and social worker care managers in a field-based model. The case managers schedule appointments and accompany beneficiaries to them; facilitate communication among beneficiaries, PCPs, and other providers; provide health education material; and support the PCPs' care plans. Preliminary results from a 2005 study conducted by the University of Massachusetts Medical School Center for Health Policy Research found that patients in the program generally followed treatment plans, showed improvement on both mental and physical functioning scales, received more targeted, integrated medical and behavioral health care, and had greater access to primary care, thus resulting in fewer acute and emergency care services.¹⁵ A caveat is that this model still relies on activities external to the clinical process rather than building a direct partnership with the medical and behavioral health practitioners themselves.

In sum, BHOs have had extensive experience managing behavioral health care for people with serious mental illness, but (with the exception of the Massachusetts program), almost no experience managing physical health benefits. They have been able to control utilization and shift spending from more to less costly behavioral health services, but have been less successful demonstrating improvement in the quality of treatment at the provider or patient level.

¹⁵ Laszlo A, et al. Evaluation of Mass Health Essential Care Programs. Center for Healthcare Policy Research, CHPR# 2005-202, January 2006.

Conclusion

New York needs a managed system of care for its SSI population with SPMI, and the more integration (i.e., benefits not carved out, one funding stream, etc.), the better. As CHCS has discovered in its national review of care models serving the SSI population, there is much variation in these systems' organization and financing. They all, however, have data-mining capacity, accept some degree of care management and monitoring responsibilities, and are in some way financially accountable for the system's outcomes.

The implementation of either of these options would require the full engagement and collaboration of stakeholders at every level — consumers and families, primary care and community behavioral health providers, hospitals, health plans, and state officials. The challenges of moving forward may be great, but the rewards could be substantially greater for all concerned.

Acknowledgments

Following is a list of state and local stakeholders who were interviewed by the Center for Health Care Strategies in the preparation of this report:

Don Allen (Department of Health Services, Minnesota), Cara Bailey (Department of Health Services, Minnesota), Susan J. Beane (Affinity Health Plan, New York), George Braunstein (Fairfax-Falls Church Community Service Board, Virginia), Richard H. Dougherty (DMA Health Strategies), Tammy Driscoll (Department of Medical Assistance Services, Virginia), Barbara Edwards (Health Management Associates), Matt Ferrara (Department of State Health Services, Texas), Harold H. Goldman (Department of Psychiatry, University of Maryland School of Medicine), Catherine Hancock (Department of Medical Assistance Services, Virginia), Mike Head (Department of Community Health, Michigan), Carolyn Ingram (Department of Human Services, New Mexico), David Labby (CareOregon Health Plan, Oregon), Tricia Leddy (Executive Office of Health and Human Services, Rhode Island), John Lovelace (UPMC Health Plan, Pennsylvania), Barbara Demming Lurie (Integrated Behavioral Health Project, California), Deb Maruska (Department of Health Services, Minnesota), Alice Mirk (Department of Health and Family Services, Wisconsin), Mary Mitchell (Department of Medical Assistance Services, Virginia), John O'Brien (Technical Assistance Collaborative), Pamela Parker (Department of Health Services, Minnesota), Harold Pincus (Department of Psychiatry at Columbia University, New York), K.J. Scheib (Department of State Health Services, Texas), Richard Surles (APS Healthcare), Marshall Thomas (Colorado Access Health Plan, Colorado), and James Verdier (Mathematica Policy Research, Inc.).

Medicaid Institute at United Hospital Fund

Empire State Building
350 Fifth Avenue, 23rd Floor
New York, NY 10118-2300
(212) 494-0700
www.medicaidinstitute.org
www.uhfnyc.org



*Shaping New York's Health Care:
Information, Philanthropy, Policy*