

Medicaid Managed Care for Persons with Severe Mental Illness: Challenges and Implications

JULY 2007

The Medicaid Institute at United Hospital Fund is working to improve the Medicaid program in New York by providing information and analysis and developing a shared vision for change.

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Some 25,000 New York City adults with serious and persistent mental illness, enrolled in New York's Medicaid program, face a significant change in how they receive health care services, through a new requirement that they choose or be assigned to a managed care plan. In a \$45 billion Medicaid program serving more than four million state residents, this population—accounting for about \$600 million in annual Medicaid spending—represents a small share of enrollment and costs. But this policy change demands attention because of the challenges it poses for vulnerable Medicaid beneficiaries, and for the health plans and providers that must meet their substantial and complex needs.

These 25,000 beneficiaries with serious and persistent mental illness (SPMI) are part of a larger population of disabled and elderly beneficiaries—often referred to as Supplemental Security Income (SSI) Medicaid beneficiaries (see “FAQs,” opposite)—who are now required to join a managed care plan. Their enrollment in managed care is part of New York’s implementation of the Federal-State Health Reform Partnership (F-SHRP) Medicaid waiver, an agreement that will bring the State up to \$1.5 billion in new federal funding over the next five years.

Under this new policy, these particularly vulnerable individuals will access some Medicaid services under managed care, while continuing to rely heavily on the fee-for-service delivery system for mental health services, substance abuse treatment, and outpatient prescription drugs—all of which are carved out of their Medicaid managed care benefits package. This analysis examines the diagnoses, service use, and spending patterns of the non-elderly adult SPMI cohort under Medicaid fee-for-service, and assesses the potential implications of their move to managed care.

Spending patterns

Annual Medicaid spending for the 25,000-person SPMI cohort averages \$24,773 per person (Table 1). Ultra-high-cost beneficiaries in the top 5 percent (\$115,183) and high-cost beneficiaries in the next 15 percent (\$49,979) of the cohort drive higher levels of spending. Lower-cost beneficiaries in the SPMI cohort’s bottom 80 percent also drive significant per capita costs (\$14,395). On average, the beneficiaries that make up each cost group have remarkably consistent costs from year to year. As is the case with other groups of SSI beneficiaries, the vast majority of the SPMI cohort (97 percent) has Medicaid coverage for all 12 months of the year.

Table 1
Annual per capita costs, 2004

	<u>SSI adults (18-64) facing mandate</u>			
	All	Lower	High	Ultra-high
SSI with SPMI facing mandate	\$24,773	\$14,395	\$49,979	\$115,183
Other SSI facing mandate	\$11,158	\$3,809	\$24,643	\$88,276
Spending ratio	2.2	3.8	2.0	1.3

FAQs:

Medicaid Managed Care for SSI Beneficiaries with SPMI

Who are New York’s SSI Medicaid beneficiaries?

New York State’s Medicaid eligibility requirements for the disabled and elderly are pegged to the federal Supplemental Security Income (SSI) program, which provides cash assistance to disabled or elderly persons who meet financial and functional criteria. As a result, disabled and elderly Medicaid enrollees in New York are often referred to as SSI Medicaid beneficiaries. These individuals are members of families with low incomes—no more than \$8,400 for one-person families or \$10,800 for two-person families—and very few assets. They are either elderly or have a long-term disability—including blindness, a range of circulatory, respiratory, and musculoskeletal conditions, mental illnesses, and/or developmental disabilities—preventing substantial gainful activity by adults or causing marked and severe functional limitations in children.

Have any SSI Medicaid beneficiaries enrolled voluntarily in MMC?

Prior to the State’s initial SSI mandate, first implemented in early 2006, about 50,000 of New York City’s 600,000 SSI Medicaid beneficiaries had voluntarily joined a managed care plan.

Which SSI beneficiaries faced mandatory managed care before those with SPMI?

The State’s initial SSI mandate applies to about 125,000 SSI beneficiaries who are living in New York City, enrolled in fee-for-service Medicaid, and do not satisfy any Medicaid managed care exemptions or exclusions.* Major exemption and exclusion categories include dual Medicare-Medicaid enrollment, a diagnosis of HIV/AIDS, residence in a nursing home or other residential facility, and eligibility for Medicaid only after spending down a portion of income. Upon implementation of the initial SSI mandate, adults with a serious and persistent mental illness (SPMI) and children with a serious emotional disturbance (SED) remained exempt from Medicaid managed care.†

Who is affected by the new SSI mandate for beneficiaries with SPMI?

Under the expansion of the SSI mandate now being implemented, an additional 40,000 SSI beneficiaries in New York City will lose their mental health-related exemption from mandatory Medicaid managed care. About 5,000 have other exemptions or exclusions, and will not be required to enroll in managed care at this time. The remaining 35,000 consist of:

- 25,000 adults (18 and over) with SPMI who must now join a managed care plan
- 10,000 children (17 and under) with SED who must now join a managed care plan

Which SSI beneficiaries are included in this analysis?

This analysis focuses on the 25,000 adults with SPMI who now face the mandate. The 10,000 children with SED facing the mandate are not included because they have different diagnoses, service use, and spending patterns than their SPMI counterparts. Because the vast majority of elderly SSI Medicaid beneficiaries with SPMI have Medicare coverage, they do not face the mandate; therefore, this analysis focuses exclusively on SSI adults ages 18 to 64.

What’s the significance of the new SSI mandate for beneficiaries with SPMI?

The new policy’s importance does not derive from the number of beneficiaries affected or the volume of spending being shifted into Medicaid managed care. The policy is significant because it requires individuals with substantial and complex health care needs—who may have particular challenges navigating the health care system due to severe mental health conditions—to join a managed care plan for most physical health services while continuing to rely on fee-for-service Medicaid for mental health services, substance abuse treatment, and outpatient prescription drugs, which are all carved out of the Medicaid managed care benefits package for all SSI enrollees, including the SPMI cohort.

* Exempt beneficiaries can only enroll voluntarily in managed care; excluded beneficiaries are barred from enrolling.

† New York’s Medicaid program classifies children under age 18 with severe mental illness and other behavioral health conditions as seriously emotionally disturbed (SED), rather than SPMI.

Average spending for the SPMI cohort is more than double that for their adult SSI counterparts without SPMI who already face the managed care mandate. It is lower-cost SPMI beneficiaries who principally drive this difference in costs, reflecting the fact that all SPMI beneficiaries have needs that require a significant level of care. Ultra-high-cost beneficiaries with SPMI account for 30 percent more spending than their SSI counterparts without SPMI. By contrast, high-cost beneficiaries with SPMI account for two times, and lower-cost beneficiaries with SPMI nearly four times, the spending on their non-SPMI counterparts. Among adult SSI beneficiaries without SPMI who face the mandate, the bottom 80 percent drive 27 percent of that cohort's spending. In the SPMI cohort, however, the bottom 80 percent drive 46 percent of spending.

Diagnostic profile

Medicaid beneficiaries with SPMI have a long-term functional impairment due to mental illness that requires ongoing treatment.¹ They are typically diagnosed with major depression, bipolar disorder, schizophrenia, another psychosis, or some combination of these conditions. These individuals account for a small subset of Medicaid beneficiaries with mental health conditions, most of whom have either less severe diagnoses, such as low-grade depression or general anxiety disorder, or comparable conditions with less long-term functional impairment.

Nationally, individuals with SPMI suffer from worse physical health, higher rates of chronic physical conditions, and shorter life expectancy than other mentally ill individuals and those without a mental illness.² In this SPMI cohort of Medicaid beneficiaries in New York City, most beneficiaries face significant, ongoing physical health challenges. Sixty percent have at least one chronic health problem—defined here as a physical health condition that is continuous or persistent over an extended period of time—and about 30 percent have two or more chronic conditions (Table 2).³ About one in five has asthma, one in five has diabetes, and two

¹ For a detailed definition of the SSI beneficiaries with SPMI included in this analysis, see Appendix: Data and Methods.

² McAlpine DD and D Mechanic. 2000. Utilization of specialty mental health care among persons with severe mental illness: The roles of demographics, need, insurance, and risk. *Health Services Research* 35(1):277-292. Dembling BP, DT Chen, and L Vachon. 1999. Life expectancy and causes of death in a population treated for serious mental illness. *Psychiatric Services* 50(8):1036-1042.

³ This analysis uses six years of Medicaid claims data (1999 through 2004) to measure whether a beneficiary has a specific health condition. This method may lead to an undercount of diagnoses, largely because Medicaid has incomplete records for beneficiaries who enroll during the latter part of the period or who have gaps in their enrollment.

Table 2
Diagnoses, 1999-2004

	<u>SPMI cohort (18-64) facing mandate</u>			
	All	Lower	High	Ultra-high
<u>Prevalence of any chronic conditions</u>				
None	40%	43%	31%	32%
One	31%	31%	28%	24%
Two or more	29%	26%	41%	44%
<u>Prevalence of common chronic conditions</u>				
Asthma	20%	19%	25%	26%
Diabetes	21%	18%	30%	31%
Cardiovascular condition	42%	40%	50%	51%
<u>Prevalence of other select conditions</u>				
Cancer	19%	20%	18%	17%
Substance abuse	28%	23%	48%	54%

in five have a cardiovascular condition, defined here as coronary heart disease, congestive heart failure, or hypertension.

In addition, many of these individuals face a range of other significant diseases and conditions. For example, one in five has a current or recent diagnosis of cancer. One in four—including about half of those in the top 20 percent of the cost distribution—has a substance abuse condition, defined here as either a drug or alcohol dependency. Providing appropriate mental health treatment is a vital component of serving Medicaid beneficiaries with SPMI, but it is only part of the challenge. Providing appropriate treatment for chronic conditions and other diseases, and ensuring that all care is coordinated effectively, are important components as well.

Service use

Nearly all members of the SPMI cohort use outpatient mental health care (Table 3). The majority see an outpatient mental health provider at least 25 times per year (an average of more than two visits each month). Four out of five average at least 13 visits per year (an average of more than one visit each month). Only 3 percent go without a single visit each year. But this share increases to 9 percent—or one in eleven—among ultra-high-cost beneficiaries in the cohort, who are more than four times more likely to go without an outpatient mental health visit than lower-cost beneficiaries. Ultra-high-cost beneficiaries also average fewer outpatient mental health visits than their high-cost counterparts.

Some outpatient mental health care is delivered in hospital-based clinics, which provide a range of services including day treatment, continuing day treatment, partial hospitalization, and intensive psychiatric rehabilitation programs. In general, while hospitals are licensed by the Department of Health (DOH) under Article 28 of the New York State Public Health Law, their clinics are licensed separately by the State Office of Mental Health (OMH) under Article 31 of the New York State Mental Hygiene Law. Other outpatient mental health services are delivered in freestanding facilities licensed only by, or operated directly by, OMH. These include 16 State psychiatric centers for adults, providing not only outpatient treatment and rehabilitation services but also community-support services that help enable patients to live outside an institutional setting.

Table 3
Annual service use, 2004

	<u>SPMI cohort (18-64) facing mandate</u>			
	All	Lower	High	Ultra-high
<u>Outpatient mental health visits</u>				
None	3%	2%	5%	9%
1 to 12	17%	16%	18%	27%
13 to 24	26%	30%	14%	15%
25 or more	54%	53%	63%	49%
<u>Primary care visits</u>				
None	14%	13%	13%	20%
One to five	38%	38%	36%	37%
Six or more	49%	49%	51%	43%
<u>Outpatient prescription drugs</u>				
None filled	3%	2%	3%	7%
Some filled	97%	98%	97%	93%
<u>Specialty visits</u>				
None	45%	45%	45%	50%
One	20%	21%	19%	17%
Two or more	35%	34%	36%	33%
<u>Emergency department visits</u>				
None	56%	60%	44%	34%
One	20%	20%	21%	21%
Two or more	24%	20%	34%	46%
<u>Hospital admissions</u>				
None	71%	82%	34%	10%
One	15%	13%	24%	16%
Two or more	14%	5%	42%	74%

Note: Figures may not sum to 100% due to rounding

Most beneficiaries in the SPMI cohort have frequent contact with the primary care delivery system, although some go long periods without any such contact. About half visit office- or clinic-based primary care providers more than five times each year—visits that often include mental health treatment and medication management. On the other hand, roughly one in seven—and one in five ultra-high-cost beneficiaries—goes a full year without a primary care visit. The significant share of beneficiaries going without regular primary care may reflect the findings that, in general, individuals with SPMI are more likely to perceive barriers to care⁴ and often report that providers dismiss their physical health complaints.⁵

Use of outpatient prescription drugs is expectedly high, as medication is an important component of treating severe mental health conditions. Ninety-seven percent of the SPMI cohort fills at least one outpatient prescription each year; however, the share drops slightly to 93 percent among ultra-high-cost beneficiaries.⁶ The cohort's most costly members are slightly less likely to use this component of care for managing mental illness.

Nearly half the SPMI cohort's members make no outpatient specialty visits—defined here to exclude mental health care and substance abuse treatment—each year. Given the prevalence of chronic conditions among these patients, this aggregate utilization rate suggests some under-use of specialty care. More than half of these beneficiaries go a full year without a visit to a hospital emergency department (ED); however, use of EDs varies within the SPMI cohort. Among lower-cost beneficiaries, three in five have no ED visits, and only one in five has multiple visits. By contrast, among ultra-high-cost beneficiaries, nearly half have multiple ED visits.

⁴ Dickerson FB, SW McNary, CH Brown, J Kreyenbuhl, RW Goldberg, and LB Dixon. 2003. Somatic healthcare utilization among adults with serious mental illness who are receiving community psychiatric services. *Medical Care* 41(4):560-570.

⁵ Horvitz-Lennon M, AM Kilbourne, and HA Pincus. 2006. From silos to bridges: Meeting the general health care needs of adults with severe mental illness. *Health Affairs* 25(3):659-669.

⁶ Providing greater detail on use of prescription drugs is problematic, as there is a lack of standardization in the duration of prescriptions, and there is uncertainty regarding compliance with prescribed regimens.

Rates of Medicaid hospital admissions,⁷ which in great part drive overall costs, vary considerably within the SPMI cohort. Among lower-cost beneficiaries, more than four-fifths go a full year without an admission, and only 5 percent have multiple admissions. Among high-cost beneficiaries, two-thirds have at least one admission and two-fifths have more than one. Among ultra-high-cost beneficiaries, 90 percent have at least one admission and three-fourths have more than one—including 30 percent who have five admissions or more. More than half the SPMI cohort’s hospital admissions (54 percent) are for mental health treatment.⁸ With substance abuse treatment also accounting for a significant share (13 percent), behavioral health admissions account for two out of every three hospital stays.

Spending by service sector

Medicaid spending varies considerably within the SPMI cohort; however, in each cost group, behavioral health services—including mental health and substance abuse inpatient and outpatient treatment—and prescription drugs drive about three-fourths of total costs (Table 4). Because these services remain carved out of the managed care benefit,⁹ enrolling members of the SPMI cohort in managed care plans will shift only \$1 in every \$4 of their Medicaid spending from fee-for-service.

Levels of Medicaid hospital inpatient spending¹⁰ vary dramatically within the SPMI cohort, but the treatments that drive inpatient costs do not. Among lower-cost beneficiaries, overall hospital inpatient spending averages \$1,816 and accounts for only 13 percent of Medicaid costs. By contrast, among ultra-high-cost beneficiaries, inpatient spending averages \$77,970 and accounts for 68 percent of costs. Behavioral health admissions account for three-fourths of inpatient costs for the SPMI cohort as a whole.

⁷ Some members of the SPMI cohort have inpatient mental health admissions that are not covered by Medicaid, because federal Medicaid law, in general, prohibits federal contributions for the cost of care provided to Medicaid beneficiaries ages 21-64 in institutions for mental disease (IMD). As a result of this federal policy—often called the IMD exclusion—New York’s Medicaid program generally does not cover the SPMI cohort’s admissions to State psychiatric centers and other freestanding psychiatric hospitals. Mental health admissions covered by Medicaid, therefore, undercount mental health admissions, as well as overall hospital admissions, for the SPMI cohort.

⁸ Inpatient hospital admissions with multiple diagnoses are classified by their primary diagnosis.

⁹ Detoxification and withdrawal services are the only behavioral health services included in the Medicaid managed care benefits package for all SSI enrollees, including those with SPMI. In addition to behavioral health and prescription drugs, personal care services are also carved out of the benefits package.

¹⁰ Because of the IMD exclusion (see footnote 7), Medicaid spending on inpatient mental health services undercounts inpatient mental health costs, as well as overall inpatient costs, for the SPMI cohort.

Table 4
Annual costs by service, 2004

	SPMI cohort (18-64) facing mandate			
	All	Lower	High	Ultra-high
<u>Hospital inpatient</u>	\$8,346	\$1,816	\$19,955	\$77,970
Physical health	\$1,890	\$641	\$4,574	\$13,818
Mental health	\$5,831	\$1,037	\$13,419	\$59,753
Substance abuse	\$625	\$138	\$1,963	\$4,399
Outpatient mental health	\$5,898	\$4,378	\$11,041	\$14,778
Outpatient substance abuse	\$355	\$270	\$767	\$483
Prescription drugs	\$5,489	\$4,975	\$7,895	\$6,488
All other	\$4,686	\$2,955	\$10,320	\$15,464
Total spending	\$24,773	\$14,395	\$49,979	\$115,183
Hospital inpatient as % of total	34%	13%	40%	68%
Behavioral health as % of hospital inpatient	77%	65%	77%	82%
Key sectors remaining FFS	\$18,197	\$10,798	\$35,084	\$85,901
Key FFS sectors as % of total spending	73%	75%	70%	75%

Note: Highlighted cells denote carved-out services.
Figures may not sum to totals due to rounding.

Spending on outpatient mental health care varies significantly by cost group—although by much less than spending on inpatient costs. High-cost beneficiaries (\$11,041) and ultra-high-cost beneficiaries (\$14,778) account for double and triple the level of outpatient mental health spending of lower-cost beneficiaries (\$4,378). The fact that ultra-high-cost beneficiaries drive more outpatient mental health spending than their high-cost counterparts, despite fewer visits on average, is a possible indication that their outpatient treatment is of greater intensity.

Spending on outpatient prescription drugs is relatively stable across cost groups. Unlike inpatient and outpatient mental health services—for which high- and ultra-high-cost beneficiaries account for many times more spending than lower-cost beneficiaries—prescription drug costs vary by smaller increments. This narrower range is consistent with the frequent use of medications by the vast majority of those in each cost group. As a result, prescription drugs account for a substantial share (35 percent) of Medicaid spending among lower-cost beneficiaries and a far smaller share (6 percent) of spending among ultra-high-cost beneficiaries.

Pursuing Medicaid savings

Designing new strategies and approaches for reducing the cost of treating complex and costly beneficiaries is a policy priority; however, realizing Medicaid savings in managing the care of the SPMI cohort may be particularly difficult. At first glance, this may seem counterintuitive: the fact that even the lower-cost beneficiaries in this group account for substantial spending might suggest the entire group as likely candidates for a care management intervention designed to reduce costs. But looking closely at these lower-cost SPMI beneficiaries—who account for four of five cohort members—raises a difficult question: where would the savings come from? About two-thirds of these individuals' baseline costs are accounted for by outpatient mental health treatment and prescription drugs—services that would be cornerstones of any intervention—and only a small share of costs are driven by inpatient hospital care. An intervention designed to reduce admissions may struggle to pay for itself.

For the SPMI cohort's high-cost and ultra-high-cost beneficiaries, who drive substantial levels of hospital inpatient spending, a care management intervention designed to reduce admissions has more potential for achieving cost savings. But designing a successful intervention for those who are already regular users of outpatient care is a major challenge. Replacing, rather than supplementing, existing outpatient care with more effective treatment would require some combination of quality standards, provider evaluations, and selective contracting. If these policies were successful, they could improve patient outcomes as well as realize Medicaid savings.

It is also worth noting that confining the pursuit of budget savings to the sphere of Medicaid policy will have limitations. Many beneficiaries within the SPMI cohort receive additional health care services that fall outside the scope of Medicaid, through OMH, the State Office of Alcoholism and Substance Abuse Services, and the New York City Department of Health and Mental Hygiene. They also rely on a range of non-health care services—including cash assistance, supportive housing, vocational services, psychosocial clubhouses, and other community support programs—that involve multiple government agencies, direct service providers, and funding streams.

Individual Beneficiary Profiles

While aggregate data on diagnoses, service use, and Medicaid costs can illustrate the broad characteristics of the SPMI cohort, they cannot fully capture the group's diversity and complexity. The following individual snapshots—brief capsules of diagnoses, service use, and Medicaid spending for eight beneficiaries in the SPMI cohort—provide additional perspective on the challenges facing both these beneficiaries and the health plans and providers that will serve them.

Individual Beneficiary Profiles

Beneficiary	Mr. A*	Mr. B	Ms. C	Mr. D	Mr. E	Ms. F	Mr. G	Ms. H†
Age	59	24	49	42	48	52	28	50
<u>Total Medicaid costs</u>								
2004	\$146,619	\$117,845	\$195,836	\$25,865	\$46,996	\$21,828	\$105,786	\$110,661
2003	\$173,633	\$29,334	\$191,746	\$23,248	\$25,439	\$22,902	\$35,011	-
2002	\$124,433	\$6,127	\$183,296	\$44,900	\$60,229	\$33,196	\$55,787	-
<u>2004 service use</u>								
Hospital admissions	21	2	-	-	3	-	5	1
Of which MH	21	2	-	-	-	-	5	1
Hospitals visited	12	1	-	-	3	-	2	1
Inpatient days	246	158	-	-	32	-	63	148
Inpatient costs	\$144,695	\$109,197	-	-	\$19,545	-	\$69,362	\$91,198
Outpatient MH visits	3	72	51	2	4	169	197	72
Outpatient MH costs	\$646	\$7,424	\$3,366	\$164	\$329	\$12,898	\$15,097	\$7,735

* Mr. A had a hospital admission beginning in 2003 and ending in 2004. The days are allocated by year and the cost is prorated.

† Ms. H was transferred from a mental health bed to a medical bed for six days during her hospital admission.

- **Mr. A** received multiple mental health diagnoses during the year, including manic depression, bipolar disorder with psychosis, panic disorder, and paranoid schizophrenia. He had only three outpatient mental health visits (he had three in 2003 and none in 2002), no primary care visits, and ten emergency department visits. He had 21 mental health inpatient stays at 12 different hospitals, lasting, all told, eight months. Despite four months spent outside a hospital setting, there is no record of Mr. A filling any outpatient prescriptions. For the third consecutive year, Mr. A's Medicaid costs exceeded \$100,000.
- **Mr. B** has a schizoaffective disorder, for which he received regular outpatient mental health care. During the first part of the year, he saw a provider twice a week; after a mental health inpatient stay, he began seeing a different provider five days a week. Several months later, he returned to the first provider, but was re-hospitalized soon after. Mr. B filled outpatient prescriptions regularly during the first four months of the year, but there is no record of his filling a prescription during his last three months outside a hospital setting. He went the entire year without a primary care visit. Mr. B's Medicaid costs exceeded \$100,000, a sharp increase from the previous two years.

Continued...

- **Ms. C** has a panic disorder, multiple sclerosis, asthma, and hypertension. She visited an outpatient mental health provider an average of once a week. She received home health care on a consistent basis, filled prescriptions regularly, had seven primary care visits, and one visit to a hospital emergency department for abdominal pain. Ms. C's Medicaid costs approached \$200,000 for the third consecutive year, without any inpatient admissions, with home health care accounting for about \$165,000—85 percent of total costs.
- **Mr. D** has a depressive psychosis, a chemical dependency, and asthma. He had no hospital admissions and only two outpatient mental health visits. He received regular case management and methadone maintenance treatment twice a week for his substance abuse condition. He filled prescriptions regularly, visited a primary care provider twice a month, and made five hospital emergency department visits—mostly for acute asthma. Mr. D's Medicaid costs totaled about \$25,000 for the second consecutive year.
- **Mr. E** received multiple mental health diagnoses during the year, including bipolar disorder, recurrent depressive psychosis, and prolonged posttraumatic stress disorder. He also has a cocaine dependency and chronic hepatitis C. He had four outpatient mental health visits in 2004 (he received minimal outpatient mental health care in 2002 and 2003, as well). Mr. E received case management, filled prescriptions regularly, and visited a primary care provider between two and six times per month. He had three inpatient admissions—each at a different hospital—for his substance abuse condition. (He had been receiving regular outpatient substance abuse treatment in 2003, but had not received treatment for six months prior to his admissions.) He resumed outpatient substance abuse treatment three months after his inpatient stays. Mr. E's Medicaid costs approached \$50,000.
- **Ms. F** has a schizoaffective disorder with psychosis, hypothyroidism, and congestive heart failure. She received outpatient mental health care about three times a week from the same provider and filled prescriptions regularly. The balance of her service use during the year consisted of one primary care visit and five dental visits. Ms. F's Medicaid costs exceeded \$20,000.
- **Mr. G** received multiple mental health diagnoses during the year, including depression, paranoid schizophrenia, psychosis, and bipolar disorder. He also has hypertension. He made four to five weekly visits to an outpatient mental health provider, received case management for the duration of the year and home care for four months, filled outpatient prescriptions regularly, and had two primary care and five hospital emergency department visits. He also had five mental health inpatient stays. Mr. G's Medicaid costs exceeded \$100,000, an increase from the previous two years.
- **Ms. H** has paranoid schizophrenia and hypertension. After receiving no services under Medicaid during 2002 and 2003, she had a lengthy mental health admission (with a brief stint in a medical bed for reflux). Following her discharge, she visited an outpatient mental health provider three times a week, received home care, filled prescriptions regularly, and made seven visits to a primary care provider. Ms. H's Medicaid costs exceeded \$100,000.

Because many members of the SPMI cohort rely on combinations of multiple services, non-Medicaid policy levers can have a direct impact on Medicaid spending. For example, the availability of supportive housing has been shown to reduce rates of hospital admission and length of stay among individuals with severe mental illness.¹¹ Because Medicaid policymakers seeking to reduce the cost of caring for complex and costly beneficiaries do not control all the policies that ultimately affect Medicaid spending, comprehensive solutions will require broad-based approaches that consider the full range of public services available to these New Yorkers. This will require leadership, vision, and coordination across multiple State and local agencies.

Policy implications

From one perspective, unless there is an opportunity for the State to renegotiate the F-SHRP waiver agreement, the mandate that SSI beneficiaries with SPMI enroll in managed care may not merit significant discussion. As it stands, provisions in the waiver's terms and conditions make extending the mandate to the SPMI cohort contingent on their behavioral health services remaining in fee-for-service. The State is thus bound to implement the mandate without crafting an expanded role for managed care plans in delivering these services. Moreover, the policy affects relatively few individuals, and will change how they receive only a small share of their care.

From another vantage point, however, this new policy illustrates the need for new ways to deliver services to Medicaid's most vulnerable, complex, and costly beneficiaries, because the two off-the-shelf options both have major weaknesses. Fee-for-service Medicaid, among other shortcomings, provides no mechanism for managing beneficiaries' service use, no financial incentives to reduce spending, and no single entity for government to hold accountable. Nor is the Medicaid managed care program as currently structured able to serve the SPMI cohort effectively. With the vast majority of care remaining in fee-for-service, it is unclear how health plans will have the leverage to pursue some of managed care's core goals—coordinating service delivery, improving health outcomes, and

¹¹ Culhane DP, S Metraux, and T Hadley. 2002. Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate* 13(1):107-163.

containing costs—for these new enrollees. In addition to lacking leverage, health plans will face diluted incentives to prevent hospital stays: they will not be responsible for the vast majority of the SPMI cohort’s inpatient costs, since these are related to behavioral health. Furthermore, the State will have no way to meaningfully assess managed care’s performance in serving these beneficiaries, because health plans have no impact on vital and costly components of their care.

The experience of the SPMI cohort illustrates how Medicaid beneficiaries with physical and mental health challenges rely on a fragmented delivery system with limited coordination or accountability. Because mental health providers play the central role in treating most individuals with SPMI throughout the U.S. health care system, they have a unique ability to improve their patients’ physical health outcomes. These providers do not, however, typically provide general health counseling or screening, nor do they systematically share information with other providers treating the same patients.¹² At the same time, they generally lack information on their patients’ physical health challenges and service use.

Meeting these Medicaid patients’ physical and mental health care needs is not the current system’s central organizing principle. As the SPMI cohort enrolls in Medicaid managed care, the State should address the significant limitations of a managed care strategy that excludes key services and is limited to one-fourth of the group’s Medicaid spending. Facilitating linkages by sharing information—among plans and providers, both within and between the behavioral and physical health systems—may help promote more effective, efficient, and patient-centered treatment. However, as the Institute of Medicine notes, “the simple sharing of information, by itself, is insufficient to achieve care coordination.”¹³ Improving quality of care and realizing Medicaid savings for the SPMI cohort—which would advance the State’s long-term policy priority of designing new models for delivering care to complex and costly Medicaid beneficiaries—will require a more comprehensive strategy.

¹² Horvitz-Lennon M, AM Kilbourne, and HA Pincus. 2006. From silos to bridges: Meeting the general health care needs of adults with severe mental illness. *Health Affairs* 25(3):659-669.

¹³ Institute of Medicine. 2005. Improving the quality of health care for mental and substance-abuse conditions: Quality chasm series. Washington: National Academy Press.

Appendix: Data and Methods

Data on Medicaid beneficiaries' spending, enrollment, utilization, and diagnostic patterns come from the Medicaid paid claims file provided to the United Hospital Fund by the New York State Department of Health (DOH) under a data exchange contract. Each fee-for-service Medicaid claim contains detailed data on the services rendered, including diagnoses, procedures, and reimbursement. Ancillary eligibility and provider files contain information regarding the beneficiary's basis of eligibility and enrollment status, as well as provider characteristics. The Center for Health and Public Service Research at New York University's Wagner School of Public Service conducted the statistical programming of the paid claims file.

This analysis is based on the identification of beneficiaries with SPMI who were enrolled in fee-for-service Medicaid in December 2004, and who were not exempt from mandatory managed care based on any other criteria related to eligibility status, diagnoses, or service use. To ensure maximum consistency between this analysis and the beneficiaries facing the mandate, the sample is based on the same DOH algorithm used to select beneficiaries with SPMI to receive mandatory notices. This algorithm is based primarily on utilization criteria: it requires "ten or more encounters, including visits to a mental health clinic, psychiatrist or psychologist and inpatient hospital days relating to a psychiatric diagnosis; or one or more specialty mental health visits (i.e., psychiatric rehabilitation treatment program; day treatment; continuing day treatment; comprehensive case management; partial hospitalization; rehabilitation services provided to residents of the New York State Office of Mental Health licensed community residences and family-based treatment and mental health clinics for seriously emotionally disturbed children)" during the twelve-month period prior to scheduled enrollment.

These identification criteria will not create a perfect match with the State's clinical definition of individuals with SPMI, defined by OMH as "persons aged 18 and older who have a current DSM-IV designated mental illness diagnosis and experience substantial impairments in functioning due to the severity of their clinical condition. These adults currently experience substantial dysfunction in a number of areas of role performance or are dependent on substantial treatment, rehabilitation, and support services in order to control or maintain functional capacity. Furthermore, they have experienced substantial impairments in functioning due to mental illness for an extended duration on either a continuous or episodic basis."

Some beneficiaries meeting the clinical definition, who would otherwise be subject to the mandate, will not meet the utilization criteria and will not be part of the SPMI cohort. In the sample for this analysis, 88 percent of the individuals assigned to the 2004 SPMI cohort were diagnosed with a mental health condition between 1999 and 2004. Among ultra-high- and high-cost members of the cohort, 99 percent and 98 percent, respectively, had a mental health diagnosis—a near perfect match; among lower-cost members of the cohort, however, the share drops to 85 percent. In addition to including some beneficiaries in the SPMI cohort who do not meet the clinical standard, it is also possible that some excluded beneficiaries not meeting the utilization criteria do meet the clinical definition for SPMI.

Of the 26,675 SSI beneficiaries with SPMI facing the mandate, 26,313 (98.6 percent) were non-elderly adults aged 18-64; this issue brief therefore reports findings exclusively for this age group. The analysis reports data on spending, enrollment, and utilization from calendar year 2004, and data on beneficiaries' diagnoses on a cumulative basis from 1999 through 2004. Because the average duration of enrollment for SSI beneficiaries facing the mandate approaches 12 months, per capita spending levels would not change significantly if adjusted for full-year enrollment; therefore, this analysis reports actual unadjusted costs.

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