

CHCS

Center for
Health Care Strategies, Inc.



Integrating Behavioral Health Under Medicaid



United Hospital Fund

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Providing Behavioral Health Services to Medicaid Managed Care Enrollees

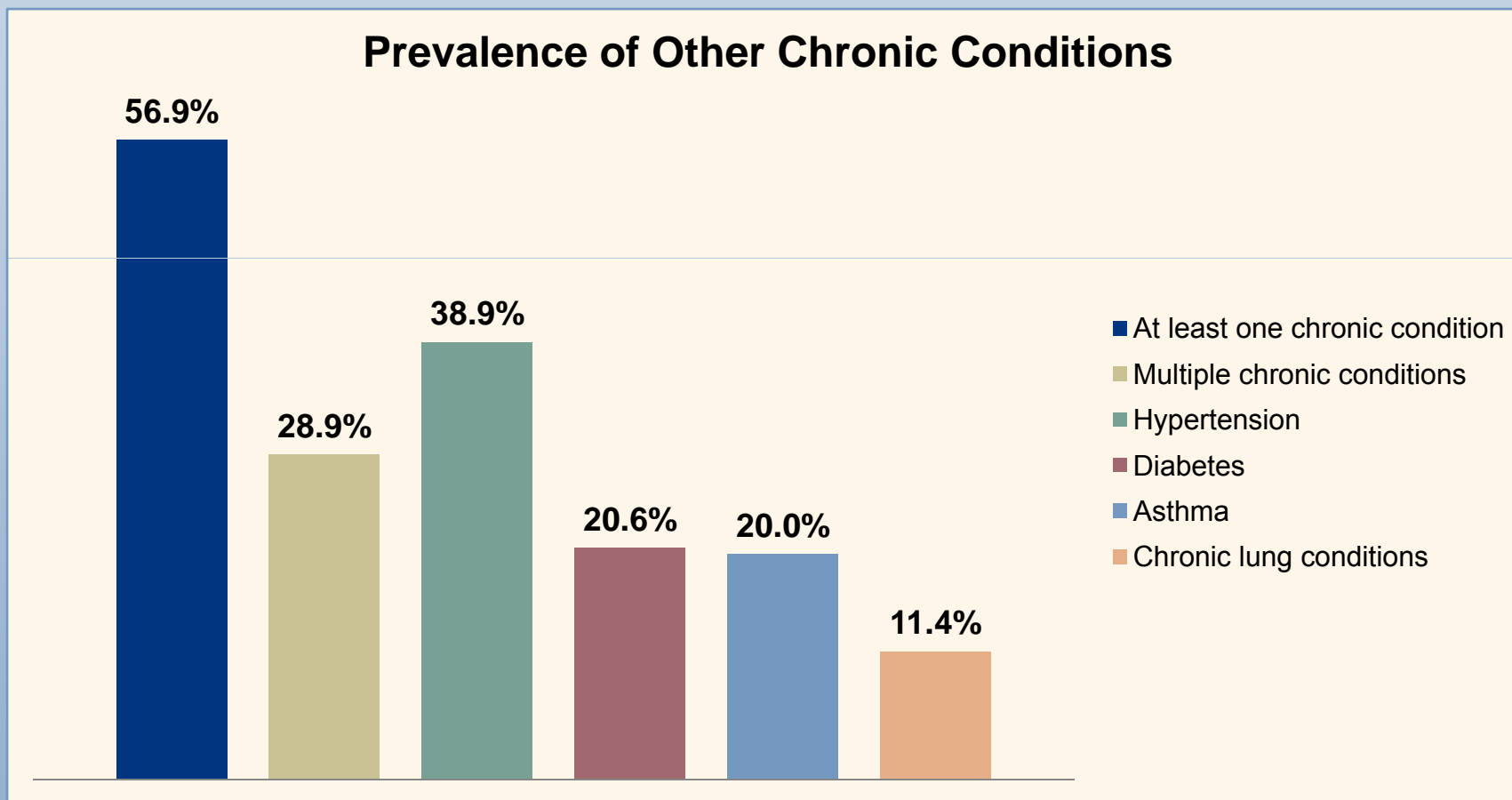
- Policy Imperative
 - ▶ Current systems for delivering publicly financed physical and behavioral health services are “broken”.
 - ▶ Fragmentation does a disservice to beneficiaries, communities, providers and health plans, state and local governments, and taxpayers.
- Purpose of Report
 - ▶ To identify best practices in the organization, financing, and delivery of behavioral health services for Medicaid managed care beneficiaries with SPMI.

Adult Beneficiaries with SPMI in NYC: Utilization

Percent of Beneficiaries	Utilization
14%	Had no primary care visits (20% for top 5% cost patients); 45% had no specialty care visits.
29%	Had a hospital admission (90% for top 5% cost patients); 14% had 2+ admissions (74% for top 5% cost patients).
44%	Had an emergency department (ED) visit; 24% had multiple ED visits.
97%	Had an outpatient mental health visit (although 9% of top 5% cost patients had no outpatient mental health visits).

Source: Analysis done by the Center for Health and Public Services Research, New York University. 2007.

Adult Beneficiaries with SPMI in NYC: Chronic Disease Prevalence



Source: Analysis done by the Center for Health and Public Services Research, New York University. 2007.

Themes from the Field

- New York is not alone in struggling with the care of high-need, high-cost beneficiaries with serious physical and behavioral health comorbidities.
- Considerable variation in the financing, organization, and delivery of care.
 - ▶ Full risk, partial risk, and no-risk with care/utilization management.
 - ▶ 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 behavioral health care.

The “Gold Standard”

- Integrated Physical and Behavioral Health Services
- Financial Accountability
 - ▶ Performance Guarantees/Risk
 - ▶ Shared Incentives
- Accountable Care Home
 - ▶ Team of physical and behavioral health providers
 - ▶ Information exchange
 - ▶ System navigation and access to social supports

Ideal Elements of Integrated Care

1. Comprehensive physical and behavioral health screening.
2. Electronic data system.
3. Clear designation of physical and behavioral health home.
4. Engagement of consumers at multiple levels (e.g., program design, self-management, care plan development, maintaining existing provider relationships).
5. Shared development of care plans addressing physical and behavioral health.
6. Care coordination support for beneficiaries and providers (care homes).
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.
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 rewarding quality care.
11. Mechanisms for sharing savings from reductions in avoidable emergency and inpatient utilization across physical and behavioral care delivery systems.

Main Purchasing Options for Integration

1. Contract with existing managed care organizations to develop and support physical-behavioral homes.
 - ▶ 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 to support a network of behavioral health homes.
 - ▶ 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.

Contract with Existing Managed Care Organizations (MCOs)

- Risk-bearing MCO responsible for physical and behavioral health services
- Behavioral health services would be “carved in”
- Strong purchasing standards and contract oversight
 - ▶ Access
 - ▶ Network adequacy (physical and behavioral)
 - ▶ Credentialing (physical and behavioral specialties)
 - ▶ Utilization and financial tracking and reporting
- Considerations
 - ▶ MCOs, in general, have demonstrated limited ability to develop the necessary behavioral health expertise.
 - ▶ MCO may subcontract behavioral health service delivery to another entity.
 - ▶ State would want to address not only organizational structure and financial arrangements, but also the actual engineering of clinical strategies designed to change the provider (physical and behavioral) practices.

Contract with a New Behavioral Health Organization (BHO)

- Risk-bearing BHO responsible for behavioral health services only
- Behavioral health services would remain carved out
- Majority of components in BHO contracts are fairly uniform
 - ▶ Claims processing
 - ▶ Utilization management and quality improvement
 - ▶ Network development and provider relations
- Considerations
 - ▶ BHOs have demonstrated ability to manage utilization and costs but have not demonstrated consistent improvement in quality of care.
 - ▶ There have typically been no requirements for collaborative treatment with primary care and little is done proactively or in real time.
 - ▶ State would want to structure purchasing specifications and contract language to move beyond reactive, one-way communication toward deeper collaboration and shared care.

Models Worth Watching

- Tennessee: Carving behavioral health services back into its mandatory managed care program (includes SSI adults with SPMI).
- Pennsylvania: Implementing shared savings pool based on measures for which physical MCO and behavioral MCO are held jointly accountable.
- Washington: Contracting (full-risk) with a MCO for physical, mental health, chemical dependency treatment, and long term care services.
- Massachusetts: Contracting with a BHO for physical and behavioral services for small group of state-funded chronically unemployed adults.
- New York: Piloting Chronic Illness Demonstration Projects (CIDP) designed for persons with chronic medical and behavioral illness who are exempt or excluded from managed care.
- Indiana: Contracting with a Care Management Organization (Schaller Anderson/Aetna) that is working with a non-risk organization to broker arrangements with community mental health centers.

Closing Thoughts

- Although there is a strong desire for physical and behavioral systems to be fully integrated, we were unable to identify an integrated system with all of the elements listed earlier. However, the models listed on the previous slide show promise.
- Care management entities come in many, often overlapping, shapes and sizes.
- Promising examples from other states indicate that all the key players must have the potential to share in any realized savings.
- 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 optimal.