



**The Coalition of Behavioral Health Agencies  
Recommendations to NYS Medicaid Redesign Team  
February 1, 2011**

The Medicaid Redesign Team (MRT) is charged with improving the quality and lowering the cost of care for New York State's Medicaid program. The MRT must recommend a strategy to restructure care delivery to special needs populations that will reduce expenditures, while improving their health status and outcomes. People with serious mental illness (SMI), many of whom also have other chronic chemical dependency and medical disorders, are among the 20% of New York's special needs Medicaid recipients who are driving 75% of the spending. People with SMI are not the highest cost special needs population. They comprise a third (300,000) of the 865,000 Medicaid recipients with multiple chronic illnesses, and use 20% of the \$24.3 billion annual Medicaid expenditure for special needs populations. Nevertheless, many of them are high users and significant quality improvements and savings are achievable.

The Coalition of Behavioral Health Agencies (The Coalition) is a membership organization comprised of not-for-profit mental health and substance abuse treatment providers in New York City, Westchester and Long Island. Predicated upon years of experience with this population, The Coalition believes that the strategy most likely to fulfill the MRT's mandate is a carve out of the behavioral health benefit for adults with SMI and or substance abuse disorders, and children with serious emotional disturbances (SED) who are now in the fee-for-service system. The capitated carve-out should be administered by regional specialized care programs with the responsibility for managing and integrating the mental health and substance abuse benefit.

Additionally, certain behavioral health providers with specialty service capacity should be designated as Health Homes for the SMI and substance abusing population. Outpatient mental health and substance abuse licensed programs should provide some primary medical assessment and care to quickly increase accessible primary care capacity and facilitate the integration of medical and behavioral health. Both changes will reduce costs for the medical benefit that is currently ineffectively managed by Medicaid Managed Care (MMC) plans. With this approach, the MRT would propel short and near term improvements in the system of care that would start producing savings in FY 2011-12 by quickly reducing inpatient days and emergency room visits for behavioral and medical reasons, while improving the quality of care. Through an effectively designed capitated carve out, The Coalition believes that NYS can save at least 5% on Medicaid expenditures for preventable hospitalizations and emergency room visits for this population in FY 2012.

**There is strong evidence that “carving in” the behavioral benefit for people with SMI, SED and substance abuse disorders to general population MMC Plans will actually lead to a less efficient system.**

If MMC organizations had the capability of effectively managing care and costs for the SMI, SED and chemically dependent populations, the plans could provide evidence of their successes. In fact, there is no evidence in NYS or other states that managed health plans have the experience, system capability or even a viable plan for managing these populations. They actually have been shown to do a poor job in New York at preventing, identifying and averting high cost medical care for SMI and substance abusing populations.

- Even though health care for the SSI population is now “managed” by MMC providers, almost half (\$395M) of the \$814 million spent in NYS in 2007 on potential preventable hospital readmissions was for medical readmissions of people with mental health and substance abuse disorders<sup>1</sup>.
- The Chronic Illness Demonstration project (CIDP) population<sup>2</sup> illustrates the plans’ failures. Over 93% have a mental illness or substance abuse disorder, and over 65% have both. Of that population, from 83.8 to 94.7% had one chronic medical disease and 61.4-81.1% had multiple chronic diseases, yet over 25% did not have a primary care visit in the baseline 12 month period and over 70% did not have a specialty care visit.<sup>3</sup>
- NYC’s Care Management Initiative (CMI) has documented that 40% of the individuals in the CMI who triggered an alert for disengagement with treatment were enrolled in MMC plans operated by 10 companies. Half were in full benefit plans. **Individuals in full benefit plans were as likely to trigger alerts as those in medical only plans and fee-for-service. In every case, their MMC case managers were not aware of or attempting to coordinate mental health services for a disengaged individual.** This project illustrates that general population MMC plans are not even effectively managing medical services for adults with SMI and substance abuse disorders.

The behavioral health care sector can be a valued leader to improve quality, reduce health care costs and integrate medical and behavioral health care for the SMI population if the MRT advances the following four pronged plan:

**1. Create a capitated behavioral health carve-out operated by regional specialty care management plans to manage Medicaid-reimbursed mental health and substance abuse services for people with chronic behavioral disorders.** The regional behavioral plans should be challenged to creatively use the current behavioral health system, evidence based strategies, Medicaid data and local health information exchanges to generate New York’s answers to improving quality and reducing cost. A behavioral carve out could be implemented in FY 2012 by NYS Office of Mental Health (OMH) by temporarily waiving competitive procurement requirements to ensure timely implementation. With the necessary beneficiary protections, strong purchasing requirements and oversight by the

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<sup>1</sup> NYS Medicaid 2007

<sup>2</sup> The initial cohort was a mix of high cost Medicaid recipients in MMC plans and the FFS system.

<sup>3</sup> NYS Department of Health, 2009.

state, the interests of the public and consumers would be protected. Participating behavioral managed care companies should be mandated to use 90% of the available funding for services, ensuring that public funds are used for their intended purpose and service recipients do not experience a diminution in access to needed ambulatory and rehabilitation services. Typically, MMC plans charge up to 25% overhead and profit, which would drain essential resources needed to bend the curve on system costs. One of the advantages of a behavioral health plan is that experienced specialty providers understand and would incorporate into service delivery the successful strategies of recovery, and make critical use of peer specialists, health coaches and other cost-effective resources not funded by Medicaid. For children with SED, specialty providers would focus on engagement with other human services agencies that impact upon children. Both a recovery-focused, skills-building care system, and a children's plan that thinks broader than the approval of outpatient visits and inpatient admissions can make a big impact on Medicaid expenditures for adults with SMI and children with SED.

Appropriate incentives and risk sharing by the regional plans and provider system would align care management and service providers with the desired NYS outcomes. These plans and their provider systems should be responsible for clearly articulated and measurable outcomes (e.g. increased numbers of Medicaid recipients with Health Homes, and fewer ER visits/inpatient days). NYS behavioral health providers have developed expertise with risk bearing and sharing models during development of Mental Health Special Needs Plans. Their expertise and history of public/private partnerships with behavioral health care organizations on the Chronic Illness Demonstration projects (CIDP) and other initiatives will facilitate an expeditious reshaping of the care delivery system so that the MRT can achieve its objectives.

**2. Integrate medical and behavioral health services for the SMI and/or substance abusing population in New York's thousands of licensed mental health programs and substance abuse treatment programs.** In order to effectively address the medical needs of the SMI/substance abusing populations, NYS has to effectively expand access to health care. Sixty percent of adults with SMI have at least 1 chronic health condition (e.g. asthma, diabetes, cardiovascular disease and/or cancer), and 30% have 2 or more. OMH's Part 599 mental health clinic regulations and the Part 822 OASAS clinic regulations, which are now under consideration for a Medicaid waiver at the federal level, will allow delivery of basic primary care services and complex case management in these clinics. OMH's and the OASAS regulatory changes, which can be implemented quickly after the waiver is granted, create the ideal opportunity for behavioral and medical service integration. A physician or nurse practitioner providing health assessment, health monitoring and closely coordinated referrals for specialty care would create a "friendly front door" into the health system for Medicaid recipients with multiple chronic disorders. Complex case management, also a new service, would facilitate specialty care coordination. More than half of the "high cost" enrollees have no meaningful connection with a primary care provider or effective care coordination<sup>4</sup>, but are more likely to have relationships with one or more behavioral health programs. By utilizing the behavioral health infrastructure to provide entry level health

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<sup>4</sup> NYU Wagner School, NYS OHIP, 2009

services and medical care coordination, NYS can see a meaningful increase of people with behavioral disorders making effective use of ambulatory care services in FY 2012. This approach will engage people who have dropped out or been lost to care, and should immediately begin to reduce unnecessary use of emergency and inpatient services.

**3. Convert behavioral health programs with specialty service capacity into Health Homes for people with SMI and/or chemical dependency.** The continuum of case management capacity in NYS's comprehensive behavioral health system can be the foundation of a care coordination initiative supported by the new federal Health Home model. Many mental health programs--Assertive Community Treatment, Blended Case Management, community residences, PROS, Article 31 mental health clinics and Article 822 Chemical Addiction Treatment Programs-- have or will soon have Medicaid-reimbursed case management capacity supported by 50% state/local Medicaid match. By converting them into Health Homes with 90% of the calculated premium for 2 years, the additional federal funding would provide a revenue neutral funding stream to support the needed enhancements and expansion. After the 2 year Health Home funding cycle, the Behavioral Health Home could be supported by a proportion of the Medicaid savings realized through their work, which should be significant by the time federal funding expires. Some of the Coalition's members are already demonstrating that health/mental health/substance abuse service integration can best be delivered through program initiatives by organizations serving these populations. The agencies running the programs understand the target population. In collaboration with behavioral health plans and health providers, they are already piloting strategies to improve their recipients' health status and use of the health care system.

**4. Utilize NYS's tens of thousands of community residence (CR) and supportive housing beds for people with SMI and Mentally Ill Chemical Abusers as alternatives and preventive strategies to costly inpatient psychiatric care.** A small number of licensed CR beds are currently used as crisis beds to divert patients at risk of psychiatric hospitalization to a safe, less costly alternative. By enriching CRs and supportive housing at a very small incremental cost, these beds can provide less expensive hospital diversion and step-down capacity that can be used to reduce the number and length of hospitalizations.

**This four part approach would help address NYS's unsustainable Medicaid system by reducing costs associated with preventable medical, psychiatric and substance abuse-related hospitalizations and rehospitalizations, inpatient length of stay, unnecessary emergency room visits, and untreated chronic illnesses like diabetes and asthma.** By dramatically increasing the number of high risk people with primary care providers, providing Health Homes that offer medical care coordination and building a step down/admission diversion resource in community residences, a specialized behavioral health plan can begin to significantly reduce the numbers of potentially avoidable hospitalizations in FY 2012 impacting both behavioral and medical admissions. The high-cost Medicaid population with SMI and/or substance abuse disorders represents a high proportion of hospitalizations for ambulatory care sensitive conditions (ACSC) like diabetes, hypertension, asthma, bacterial pneumonia and congestive heart failure. Of the \$814 million spent in NYS in 2007 on potential preventable hospital readmissions, almost half (\$395M) were for medical readmissions of people with mental health and alcoholism

disorders, and another third (\$270M) were for mental health and drug abuse stays.<sup>5</sup> In 2007, an astonishing \$651 million was spent, potentially unnecessarily, on inpatient care for people with mental health disorders, and that amount is much higher in 2012 dollars. Almost 50% occurred for medical admissions, though many have “managed” health benefits through MMC plans.

**Recent findings from an OMH pilot program show that successful care coordination for the SMI population requires a proactive approach using hands-on case management.**

Telephone calls to a “disengaged” population (which characterizes many of the high cost Medicaid recipients) did not help facilitate use of ambulatory care. Managed health care providers depend on telephone communication to assess needs and refer to services. They have absolutely no experience or track record delivering client-centered case management. While a “phone bank” approach may work for non-special populations, it has proven to be wholly ineffective for people with SMI, as evidenced by the findings of the NYC Care Management Initiative (CMI) discussed earlier.

**Specialty carve-out plans have had demonstrated success in improving access to and responsibly reducing unnecessary service utilization of behavioral services.** Many managed behavioral health companies have also brought about **dramatic declines in state and local spending on homeless, criminal and juvenile justice services** as a result of better coordination of behavioral health services. If poorly “managed” New Yorkers lose access to the mental health/substance abuse treatment system, it could jeopardize gains already made, resulting in cost increases in these and other state and county programs.

There are instructive models around the country and in New York of successful behavioral health care management plans, as well as effective care coordination programs operated by behavioral health providers.

- From 2009 to 2010 in Pierce County, Washington, OptumHealth reported that its behavioral health plan achieved a 1 year increase in number of Medicaid recipients served (12,121 to 15,262); **a 19.5% reduction in hospitalization; a 32% reduction in readmission rates, and a 38.2% reduction in inpatient bed days.**
- ValueOptions reports **a 50% reduction in outpatient and ER visits, and a 71% reduction in psychiatric inpatient admissions** for Massachusetts Medicaid enrollees, on average, over a 3 year period.
- In Pennsylvania, there are about 2 million people enrolled in a specialty carve out behavioral managed care plan—HealthChoices. Five specialty plans--for profit and not-for profit--serve dozens of counties. All regions with 3 years of data report increased access to behavioral health services. Behavioral Medicaid costs were managed well below the projected fee-for-service levels, while serving more people with a broader array of services. **A major reduction in inpatient use occurred from 1998 to 2008, with a major decline in the proportion of Medicaid expenditures going for inpatient care, from 38% in 1998 under a FFS system to 16% in 2008.**
- In Monroe and Erie Counties, the NYS Care Coordination Program (NYCCP) reported in 2009 **a 46% reduction in ER visits and a 53% reduction in days spent in the hospital,**

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<sup>5</sup> Lloyd I. Sederer, MD, *Patient Care: Managing High Need, High Cost Medical Patients*, Huffington Post 1/26/2011.

while also reporting multiple positive client outcomes. In 2008, Medicaid mental health costs for the NYCCP enrollees **compared with Medicaid recipients in other counties showed 92% lower cost for inpatient care and 42% lower for outpatient care.**

- The Care Monitoring Initiative in NYC is currently demonstrating the efficacy of using a COMSTAT approach on a cohort of high need Medicaid recipients. “Alerts” are generated to a care coordination team based on “data flags”—prescriptions not filled, medical appointments missed, emergency room visits and hospitalizations. An interdisciplinary team of case managers, health coaches and peer counselors —provide targeted help to address treatment needs and compliance.

**In this system redesign, NYS should address the unhealthy behaviors of this population or they will continue to be disproportionately more ill than the general population, despite improved access to primary health care.** The Coalition is advocating that wellness/self management initiatives be a responsibility of a Behavioral Health Plans. Compared with the general population, people with SMI are much more likely to be obese, to smoke and not to exercise. The reasons for this disparity have been well documented. Symptoms of mental illness and medication side effects can impair an individual’s ability to engage in physical activity and maintain a healthy diet. This population is poor, with economic and cultural impediments to eating healthy and exercising. They are more likely to engage in health-impairing activities like smoking. Tens of thousands live within, spend some of their days at and/or receives treatment from the behavioral health sector, where wellness self-management education can be provided and supported. Promising evidence based strategies like Wellness Self Management have been implemented by both OMH and OASAS providers. A Diabetes Self-Management Initiative has been pioneered for this population by a group of behavioral health care providers, and could be expanded to include OASAS providers. Health coaches and peer specialist have already proven effective in working with this population to adapt healthier lifestyle behaviors and effectively utilize ambulatory care. A more robust and far-reaching initiative anchored in where the population lives and spends their days (and for many it is in a behavioral health program) can reduce near and long term health costs.

**Managing behavioral health service for children with serious emotional disturbances requires a systemic knowledge of all the child-serving sectors (e.g. education, juvenile justice and/or social services), an expertise lacking in private MMC plans.** The multi-system challenge requires expertise and relationships in the purview of behavioral children’s providers and specialized behavioral oversight agencies. If done poorly, managed care of behavioral services for high risk children will have far-reaching disastrous human and financial implications, not only for Medicaid, but also for the juvenile justice, foster care and educational sectors.

**General population MMC Plans are ill-suited to managing care for people with complex behavioral and medical profiles.**

The New York Health Plan Association, in its January 2011 position paper “Managing the Future of New York’s Medicaid Program,” recommends an incremental approach” to capitating the behavioral health benefit for adults with SMI and children with SED. They acknowledge that “there nonetheless may be populations or particular services that

would benefit from a different approach.” The HPA cautions that “further consideration ... be given as to whether other SMI populations should be added (to capitated managed care benefit).” Clearly, they don’t feel prepared to manage this population, and there are good reasons for their concern.

As distinct from the HPA, The Coalition supports a capitated carve out of the behavioral health benefit for the fee-for-service population into specialty regional plans. Our members’ experience with the identified population makes us confident that we can lead a responsible and successful system redesign to a more efficient and less costly system of care.