

**MEDICAID
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Providing Care to Medicaid Beneficiaries with Behavioral Health Conditions: Challenges for New York

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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.

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Providing Care to Medicaid Beneficiaries with Behavioral Health Conditions: Challenges for New York

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Medicaid plays the lead role in serving individuals with behavioral health issues—mental health (MH) and substance abuse (SA) conditions—both nationally and in New York. In providing a broad range of services to individuals who face not only behavioral health conditions, but also greater physical health needs than their counterparts, Medicaid faces complex challenges. This issue brief highlights the key characteristics of Medicaid beneficiaries with behavioral health conditions. It then considers the challenges serving these beneficiaries that Medicaid faces in the areas of service delivery, care management and provider payment, and administration. Finally, it considers the potential implications of federal health care reform for Medicaid’s provision of services to beneficiaries with behavioral health conditions, as well as critical questions for New York State policymakers.

Understanding the Beneficiaries

Adult Medicaid beneficiaries with mental health or substance abuse conditions are sicker, use more services, and are more costly to Medicaid than similar enrollees without these conditions, according to a recent study conducted by the Urban Institute for the Medicaid Institute at United Hospital Fund (Coughlin and Shang, 2011). The study examined approximately 117,000 Medicaid beneficiaries with MH conditions¹ and 50,000 people with substance abuse issues² receiving MH/SA treatment. Subjects of that study included those suffering from the most serious and debilitating forms of mental illness, like schizophrenia and bipolar disorder, as well as drug abuse. The study compared adult beneficiaries with MH conditions (MH beneficiaries) to those without MH conditions (non-MH beneficiaries), and similarly compared those with SA conditions (SA beneficiaries) to those without such conditions (non-SA beneficiaries).³ Below are some of the report’s key findings:

Patient Characteristics

- Twenty-two percent of MH beneficiaries had substance abuse issues, while 56 percent of SA beneficiaries had a mental health condition.
- Thirty-four percent of MH beneficiaries had hypertension, 31 percent had heart disease, and 24 percent had asthma or chronic obstructive pulmonary disease (COPD). These rates are about 30 percent to 60 percent higher than those of non-MH beneficiaries.
- Thirty-three percent of SA beneficiaries had heart disease, 26 percent had asthma/COPD, and 22 percent had HIV/AIDS. These rates are about 50 percent to 300 percent higher than those of non-SA beneficiaries.

¹ These beneficiaries were identified following the federal Substance Abuse and Mental Health Services Administration (SAMHSA) protocol that relies on specific MH primary diagnosis codes assigned by a medical professional at any medical encounter during the year. Among the diagnostic categories included are schizophrenia, major depression and affective conditions, childhood psychoses, neurotic and other depressive conditions, and personality conditions.

² These beneficiaries were identified using the same SAMHSA protocol as used for MH beneficiaries. The population includes individuals with alcohol abuse, drug abuse, tobacco use condition, pregnancy/childbirth conditions, and drug poisoning.

³ For MH and non-MH beneficiaries, the population was drawn from adults 22 years of age and older who were on fee-for-service Medicaid for all 12 months of 2003 and who were not dually enrolled in Medicare. The SA and non-SA population was drawn from the same cohort, except that it included adults 18 and older.

Service Use

- In both MH and SA populations, over 80 percent used psychiatric services and over 90 percent used prescription drugs.
- Forty-five percent of SA beneficiaries had at least one hospital inpatient admission (whether related to physical health services, behavioral health services, or both), compared to only 18 percent of the non-SA population. For MH beneficiaries, 28 percent had an admission, compared to 18 percent of non-MH beneficiaries. Average annual spending on hospital inpatient care for MH populations was \$7,017, compared to \$3,629 for non-MH beneficiaries. For SA beneficiaries, average annual inpatient spending was \$11,738, compared to \$3,301 for non-SA beneficiaries.
- The seven-day hospital readmission rate of MH beneficiaries was 50 percent higher than that of non-MH beneficiaries. SA beneficiaries' rate was 150 percent higher than that of non-SA beneficiaries.

Spending

- Mean Medicaid spending for MH beneficiaries (\$28,451) was nearly twice that for non-MH beneficiaries (\$15,964). MH beneficiaries' mean Medicaid spending on physical services (\$21,002) was 32 percent higher than comparable spending for non-MH beneficiaries (\$15,964).
- Only 25 percent of spending for MH populations was for mental health treatment, including inpatient hospital care, prescription drugs, and outpatient psychiatric services.
- Mean Medicaid spending for SA beneficiaries was \$27,839, while spending for non-SA beneficiaries was \$18,051. SA beneficiaries' mean Medicaid spending on physical health services (\$21,053) was 17 percent higher than comparable spending for non-SA beneficiaries (\$18,051).
- Only 24 percent of mean Medicaid spending for SA beneficiaries was for substance abuse treatment; inpatient care and psychiatric services were the two major drivers of spending.

The patient characteristics, service use, and spending patterns of Medicaid beneficiaries with behavioral health conditions pose important and complex challenges for Medicaid policy and administration. These findings show high rates of co-occurring behavioral health and physical health conditions, as well as high levels of service use and spending—not only on behavioral health services, but also on physical health services like inpatient hospital care.

Key Challenges

The provision of publicly financed behavioral health services in the U.S. is marked by several key challenges in how care is delivered at the point of service, how it is coordinated and managed, and how it is administered by the responsible public agencies. Like all states, New York must address these challenges to care for its most chronically ill Medicaid beneficiaries.

Service Delivery

One of the main challenges facing behavioral health (BH) beneficiaries is a fragmented delivery system. People with MH and SA conditions rely on specialized services that are isolated from the physical health care delivery system because they are not needed by the general public. Beneficiaries' behavioral health needs are treated separately from their physical health needs, and there is limited sharing of data and information among their distinct providers. At the same time, outpatient capacity for some needed services is lacking, which leads many into more costly and less effective inpatient care. Finally, as a result of the deinstitutionalization facilitated by the pharmaceutical revolution, many BH beneficiaries struggle to meet one of their most basic needs—affordable housing.

Integrating Behavioral and Physical Health Services. New York's Medicaid beneficiaries with behavioral health conditions receive services from two distinct sets of providers. They rely on primary care physicians and specialists in offices, clinics, hospital outpatient departments, and emergency departments to address their physical health care needs; and they rely on mental health practitioners and substance abuse providers in the specialty system to address their behavioral health needs. In general health settings, issues related to mental health and substance abuse are often ignored. Similarly, in the behavioral health system, providers tend to focus exclusively on MH/SA issues. Coordination between these categories of providers is extremely limited or nonexistent. As a result, Medicaid beneficiaries do not receive integrated care at the point of service.

This bifurcated system of service delivery has deep roots. Historically, all mental health care services were provided in state-run and state-funded institutions. The introduction of antipsychotic drugs in the 1960s revolutionized mental health treatment by allowing those suffering with serious mental illness to remain in their communities. Individuals started moving out of institutions and into community-based care. This shift in the care setting for this population was profoundly accelerated by the establishment of Medicaid, which by design promoted coverage of services in community settings (Shirk, 2008). Furthermore, specific Medicaid policies promoted care in one setting over another—for instance, the “IMD exclusion.” Institutions of Mental Disease (IMDs) are inpatient facilities of more than 16 beds where more than 51 percent of patients have a severe mental illness. Federal Medicaid matching payments to IMDs are prohibited for individuals between the ages 22 and 64,⁴ a policy

⁴ IMDs for people under age 22 and over age 64 may draw federal Medicaid matching funds, if the state allows it.

enacted to ensure that new Medicaid dollars were not supplanting state and local resources already going to this population.⁵ The result of this policy is that Medicaid covers a stay in the inpatient psychiatric unit of a general hospital but not at a state mental hospital.

The behavioral health provider system developed in relative isolation from the physical health delivery system, resulting in fragmentation of care for the beneficiary at the point of service. There is, however, increasing recognition among health care providers that physical and mental health care need to be integrated. In fact, more and more physical health providers have begun to screen for and treat mental health issues; however, this approach has not been very successful. For example, the 2000 National Comorbidity Survey found that primary care doctors treating patients for mental health issues provide “minimally adequate care” less than 15 percent of the time (Friedman, Furst, and Williams, 2010). Current best practices suggest a model where both primary/preventive care and essential behavioral health services should be available in both types of settings. The leading models for properly integrating mental health care into physical care follow four fundamental approaches. These include locating physical and mental health providers in the same place, coordinating communication between providers, using integrated teams, and establishing formal consultation relationships.

A key component to integrated care is the sharing of health information among different providers. While our health care system as a whole contains vast amounts of health-related information and the capacity to share and analyze it, systematically using data to target appropriate and effective treatments to individual beneficiaries is not standard practice; it remains a goal. For highly vulnerable people, such as MH/SA beneficiaries, a lack of information sharing can be even more costly, in terms of both health outcomes and unnecessary health care spending. One way in which the state is addressing the dearth of data sharing is through its development and testing of the Medicaid Information Service Center, which will serve as a repository of beneficiaries’ medical records, allowing providers to view claims-based health information electronically. Allowing providers to quickly access clinical data on their patients will facilitate better care management (Birnbaum, 2010).

Detoxification Services. Another very important component of the delivery system for SA beneficiaries is access to community-based detoxification (detox) in settings that can provide not only clinical services but also 24-hour supervision and support. While in recent years more and more care takes place in the community, most detox treatment is delivered in a hospital inpatient setting. In 2008, Medicaid paid for almost 50,000 hospital admissions for drug or alcohol detoxification, including repeat admissions for the same beneficiaries.⁶ Evidence suggests that hospital detox represents a revolving door for many SA beneficiaries. Detox itself is a short-term intervention, and only the first part of any comprehensive SA treatment protocol. Post-detox treatment is essential to preventing relapse; however, hospitals are not generally organized to coordinate such treatment.

⁵ Before Medicaid, state and local psychiatric hospitals housed a large number of people with severe mental illness at state and local expense.

⁶ United Hospital Fund analysis of Statewide Planning and Research Cooperative System (SPARCS) data, 2008.

Therefore, people often enter the hospital for detox through the emergency department and get discharged in relatively short order, only to return again when in need of more treatment.

Hospital detox, not surprisingly, is more costly than community-based detox. This fact helps explain the Urban Institute's finding that spending for acute inpatient care accounted for about half of the SA population's spending, a rate more than twice as high as that seen in the general population (Coughlin and Shang, 2011). Although there are certainly times when detox needs to take place in a hospital, it is also a fact that for many communities, the hospital provides the only source of detox. The lack of community-based detox services can be traced to low reimbursement rates. One particular problem that community-based detox centers face is the challenge of serving people who are eligible for Medicaid but unenrolled. Centers need full-time staff to ensure that Medicaid applications are completed and that people being treated are actually enrolled in Medicaid at the time of services, because once they leave the center they are often very difficult to track down.

The state has made efforts "to strengthen the ability of community-based detoxification providers to deal with less complicated detoxification episodes by enhancing rates of reimbursement to incentivize program expansion in this area."⁷ In a complementary fashion, the New York State Department of Health (DOH) is working toward reducing the current incentives to provide detox in a hospital setting. Advocates and providers caution that rates need to be high enough to compensate for quality detox services in the community, with services delivered in a hospital setting only when medically necessary.

Affordable Housing. Another significant issue presents itself in the 2009 federal district court ruling in *DAI v. Paterson*, which addressed placement in adult homes. In 2008, adult homes provided long-term residential care to about 11,000 people⁸ with mental illness in the state, 4,200 of whom lived in New York City.⁹ These homes are private, for-profit facilities; in most of them, more than 90 percent of residents have mental illness. In September 2009, the Court ruled that the placement of the DAI plaintiffs in adult homes violated federal law¹⁰ because these homes are not the most integrated setting possible for their residents. The Court asserted that virtually all of the lawsuit's constituents qualified for "supported housing," which constitutes a far more integrated setting. Supported housing encompasses a wide spectrum of health and social supports. This model allows for housing to be a constant for the recipient while the type and intensity of services vary to meet the changing needs of the individual. In such an environment, the supported housing provider, along with other community mental health providers, takes on a role in the coordination of care.

⁷ New York State Division of the Budget. 2009-10 Executive Budget Agency Presentations. Office of Alcoholism and Substance Abuse Services. Available at <http://www.budget.state.ny.us/pubs/archive/fy0910archive/eBudget0910/agencyPresentations/pdf/oasas.pdf> (accessed February 1, 2011).

⁸ "Adult Homes in NYC," Coalition of Institutionalized Aged and Disabled. Available at <http://www.ciadny.org/Adult%20Homes%20in%20NYC.htm> (accessed February 1, 2011).

⁹ Court decision in *Disability Advocates, Inc. v. David A. Paterson, et al.*, citing the New York State Department of Health 2008 Adult Care Facility Annual Census Report.

¹⁰ The Americans with Disabilities Act and the Rehabilitation Act.

One of the primary reasons, however, that many MH beneficiaries are in adult homes in the first place is because of the severe shortage of supported housing options in New York. Essentially, adult homes have provided the state with a viable housing solution for people coming out of psychiatric hospitals. In fact, the adult home sector was formed as a result of the closing of several large state-run psychiatric hospitals in the 1960s and 1970s. The state turned to private adult homes because little had been done to prepare for the challenge of housing patients formerly residing in the facilities that closed; in subsequent years the state has struggled to provide supported housing. This ruling unearthed the very real struggle that can occur in the system when there is limited capacity or infrastructure. Choice is constrained and beneficiaries often end up in the wrong settings.

Care Management and Provider Payment

Central to any discussion about the provision of behavioral health services is the question of how Medicaid purchases those services for its beneficiaries. For disabled Medicaid beneficiaries, who are the heaviest users of BH services, nearly all MH and SA treatments are currently carved out of managed care contracts and are paid for under a fee-for-service (FFS) methodology. This model has faced increased scrutiny in recent years as policymakers have begun looking for better ways to manage care for the most chronically ill beneficiaries. Similarly, the way in which providers are paid has been reexamined, resulting in payment reform policies that have made provider reimbursement more rational.

Benefit Design. New York’s Medicaid program currently employs a complex approach to managing care for beneficiaries with behavioral health conditions. In the 1990s, the state began moving many beneficiaries into managed care to coordinate care and control costs. At first, elderly and disabled people were excluded from the requirement to enroll in a managed care plan. The population that enrolled in managed care, made up largely of adults and children, had some behavioral health care needs, but it did not include seriously and persistently mentally ill Medicaid beneficiaries, who are generally disabled and often eligible to receive Supplemental Security Income payments. Plans were responsible for covering most behavioral health services, contracting with providers, and managing the benefit. Importantly, these responsibilities were given to plans for a population that explicitly did not include beneficiaries with the most substantial behavioral health care needs.

Beginning in 2006, under New York’s Federal-State Health Reform Partnership (F-SHRP) Medicaid waiver, the state required many disabled and elderly beneficiaries to join managed care plans, including those with serious and persistent mental illness (Bachrach, Lipson, and Bhandarkar, 2006; Birnbaum and Powell, 2007). While these beneficiaries would access their physical health services through their managed care plan, their mental health and substance abuse services would remain a fee-for-service benefit—along with their outpatient prescription drugs. As a result, three-quarters of Medicaid spending for elderly and disabled people enrolled in managed care remained in FFS (Birnbaum and Powell, 2007).

New York's primary goals in "carving out" mental health and substance abuse services from the managed care benefit package were to protect patients' freedom to choose a provider and to safeguard the financial viability of community-based and safety-net behavioral health providers, who could have difficulty negotiating contracts with managed care plans. In addition, the state wanted to shield Medicaid managed care plans from the risks and high costs associated with managing behavioral health treatment for those with severe mental illness and chronic substance abuse conditions, which was thought to be outside their scope of expertise. Therefore, the state continued to purchase BH services for its Medicaid managed care beneficiaries through FFS.

As the Urban Institute's findings confirm, MH/SA beneficiaries rely heavily on outpatient prescription drugs to manage both their behavioral and physical health conditions (Coughlin and Shang, 2011). This service is also carved out of Medicaid managed care. The rationale for a pharmacy carve-out, however, was different than that for MH/SA treatment. Removing prescription drugs from the health plans' jurisdiction allowed pharmacist groups to receive higher reimbursement from Medicaid than they would have from the managed care plans (Sparer, 2008). Additionally, the carve-out provided substantial federal Medicaid prescription drug rebates available to the state for drugs purchased under FFS. In recent years, however, the efficacy of the pharmacy carve-out has increasingly been questioned; carving in the benefit would affect health plans' ability to coordinate care for their members. Furthermore, as a consequence of health care reform, managed care plans can now claim the federal drug rebate, thereby eliminating one of the rationales for carving out this benefit.

Payment Reform. In 2007, New York embarked on significant Medicaid payment reforms out of recognition that the Medicaid FFS reimbursement rates, including those for behavioral health services, were riddled with inconsistencies and inappropriate incentives. Notably, on the outpatient side, similar services were reimbursed at different rates, depending on the provider and its licensure, and many rates were not adjusted to reflect the relative complexity of cases. As part of this reform, the state adopted outpatient payment rates based on patient complexity and the intensity of services provided, using a payment system known as Ambulatory Patient Groups (APGs). At the same time, the state also moved almost \$600 million from hospital inpatient rates to outpatient rates in hospital and community clinics (Bachrach, 2010). The APG payment methodology, which will be fully implemented by 2011, allows for greater consistency across all ambulatory settings. Under this new system, the state makes consistent payments to providers, whether care is provided in a hospital outpatient department, a DOH-licensed clinic, a clinic operated by the New York State Office of Mental Health or Office of Alcohol and Substance Abuse Services, an emergency department, or an ambulatory surgery center.¹¹ Furthermore, an APG, by design, incorporates beneficiaries' diagnoses and intensity of the services they receive. This system therefore incorporates risk adjustment and ensures the collection of better diagnostic data, which can be used for care management activities.

¹¹ Office-based physicians fall outside the APG system and are instead reimbursed on a fee schedule.

The state also changed to a Medicare-style inpatient payment system using “all-patient refined diagnosis-related groups” (APR-DRGs), an approach that captures patient variation as well as hospital-specific adjustments. This payment system uses a single statewide rate for each type of admission and makes adjustments for diagnosis and other hospital costs. New York Medicaid will also soon implement a new payment system for inpatient psychiatric services, also using an approach very similar to Medicare’s inpatient psychiatric payment system. As Urban’s findings show, one of the most costly services for MH/SA beneficiaries is inpatient care (Coughlin and Shang, 2011). Therefore, any reform that makes payment more rational could promote more efficient care for this population. However, as is the case with any FFS model, the new payment system reimburses for services by the unit without a care management component. This may not be the best approach to delivering costly services to medically complicated patients.

Because of the complex care needs and high costs of the MH/SA population, policymakers are considering moving toward a system of care that provides better care management and coordination. A central question before the state is what type of entity should be vested with the responsibility to manage the behavioral health benefit. One option is to contract with a managed behavioral health organization (MBHO), a practice widely used in the private sector and in other states’ Medicaid programs (Bella, Somers, and Llanos, 2009). Much like other managed care organizations, MBHOs would be responsible for managing care and could also engage in utilization reviews, quality improvement, provider network development, and claims processing. The other option is to turn over management of BH services to those Medicaid managed care plans currently serving beneficiaries with behavioral health conditions, thereby achieving a fully integrated managed care model with a single organization responsible for comprehensive benefits. In either scenario, how providers are paid and how management and accountability are built into the system will remain open and pivotal questions.

The state has also recently invested in developing care management models for medically complex beneficiaries in an FFS context. To do this, New York undertook the Chronic Illness Demonstration Project (CIDP) to test models that improve health outcomes and reduce costs for high-cost Medicaid beneficiaries, including many with behavioral health conditions (Birnbaum, 2010). The project’s goal is to provide patient-centered care for beneficiaries in the unmanaged FFS system using multidisciplinary teams of providers. While providers’ specific approaches under the CIDP vary, the common objectives are to help beneficiaries establish a medical home and achieve greater use of primary and preventive care, thereby averting unnecessary emergency department visits and hospitalizations.

Administration

Additional challenges to serving behavioral health beneficiaries lie in the administrative structure that governs their care. This structure includes multiple state agencies with overlapping funding streams and, at times, competing priorities.

The administration of behavioral health services for the MH/SA population—which includes but is not limited to Medicaid beneficiaries—falls to three main agencies. The New York State Office of Mental Health (OMH) is responsible for providing state-operated inpatient and outpatient mental health services, and for regulating, certifying, financing, and overseeing New York’s public mental health system. This system includes 58 local governmental units, each with individual directors and commissioners of mental health who oversee the planning and financing of each county’s network of mental health and other behavioral health services.¹² It consists of programs that are operated by OMH, as well as community programs certified and funded by the state but operated by local governments, nonprofits, or proprietary providers.¹³ OMH oversees services for approximately 600,000 people, 20 percent of whom are Medicaid beneficiaries (Coughlin and Shang, 2011).

The New York State Office of Alcohol and Substance Abuse Services (OASAS) is responsible for overseeing the delivery of services for the SA population. OASAS administers a comprehensive array of prevention, treatment, and recovery services for New Yorkers. This is accomplished through a qualified network of state and local government agencies, voluntary organizations, and school districts. OASAS licenses and regulates program providers and operates its own addiction treatment centers throughout the state. Approximately 260,000 people, roughly one-fourth of whom are Medicaid beneficiaries, receive services through the OASAS system. These services are provided by about 1,200 community-based programs.¹⁴

Given that so many beneficiaries with BH conditions are covered by Medicaid, the state’s lead Medicaid agency, DOH, is also actively involved in purchasing and administering services for them. As the “single state agency” for Medicaid, DOH has multiple administrative roles: it serves as the central resource for all other agencies on federal Medicaid requirements, and is the central liaison between the state and federal governments. It also oversees the local social service districts, controls Medicaid billing and information systems, implements and oversees eligibility and enrollment policies, and sets many provider reimbursement rates. DOH’s role in BH services is solely in a Medicaid context, which stands in contrast to OMH’s and OASAS’s broader focus on all those receiving mental health and substance abuse services.

Mental health and substance abuse treatment depends heavily on specialty providers that are licensed by New York’s state agencies. These include specialty units of general hospitals, specialty hospitals, psychiatrists, specialty substance abuse centers, and multi-service mental health organizations, which deliver a wide range of outpatient and residential MH services. Nationally, roughly half of spending on MH services and over three-quarters of SA spending goes to specialty providers (Mark et al., 2007). In New York, OMH and OASAS are the primary agencies involved in licensing these provider networks.

¹² New York State Conference of Local Mental Hygiene Directors. Available at <http://www.clmhd.org> (accessed February 1, 2011).

¹³ New York State Division of the Budget. 2010-11 Executive Budget Agency Presentations. Office of Mental Health. Available at <http://publications.budget.state.ny.us/eBudget1011/agencyPresentations/pdf/AgencyPresentations.pdf> (accessed February 1, 2011).

¹⁴ New York State Division of the Budget. 2010-11 Executive Budget Agency Presentations. Office of Alcoholism and Substance Abuse Services. Available at <http://publications.budget.state.ny.us/eBudget1011/agencyPresentations/pdf/AgencyPresentations.pdf> (accessed February 1, 2011).

OMH specifically licenses psychiatric centers, waiver services, community residences, and services provided in Article 31 clinics.¹⁵ OASAS licenses chemical dependency outpatient programs, non-hospital inpatient rehabilitation, non-hospital detoxification services, and its own addiction treatment centers (Bachrach, Lipson, and Bhandarkar, 2006).

Medicaid's decentralized administrative structure poses additional challenges for serving beneficiaries with behavioral health conditions in an effective and integrated fashion. The multiple agencies with critical roles in program administration can have competing or conflicting priorities, as well as overlapping funding streams. As already mentioned, DOH is the state's lead Medicaid agency; despite its other responsibilities, DOH is centrally focused on Medicaid, which accounts for the largest single item in New York State's budget. Therefore, the organizing principle of DOH's approach to Medicaid administration is to be a prudent purchaser of services.

For OMH and OASAS, Medicaid presents a different set of challenges and a smaller share of their overall responsibilities; consequently, their approach to Medicaid administration is different. OMH and OASAS directly oversee Medicaid-funded treatment and rehabilitation programs as well as their respective specialty provider networks through licensure. They determine what Medicaid services will be provided under their authority as well as the clinical qualifications for their Medicaid-funded services. Although many of their programs are Medicaid-funded, there are some important components to BH services that are entirely state-funded. These agencies therefore are constantly struggling to find ways to finance their programs with both Medicaid and non-Medicaid dollars. Furthermore, in many instances, they directly provide services as well as regulate other service providers. For example, OMH both operates and funds state psychiatric centers.

There is a central tension to these dual roles that OMH and OASAS play: they are both payers and providers of mental health and substance abuse services. Furthermore, their mission in a large part is to sustain a fragile provider infrastructure composed primarily of nonprofit and safety net organizations. As a result, these agencies are often advocates for the providers and the patients they serve. While all agencies have important regulatory responsibilities that are somewhat consistent, DOH's role as Medicaid purchaser is not consistent with OMH's and OASAS's perspectives as recipients of Medicaid funding.

This division within Medicaid administration leads to significant challenges. Experts in mental health and substance abuse are housed in their respective agencies, but need to have close working relationships with DOH in order to coordinate and effectively implement Medicaid policy. Furthermore, OMH and OASAS officials, as well as the behavioral health providers they license and

¹⁵ These facilities are community mental health clinics authorized under Article 31 of the NYS Mental Hygiene Law, which states that the "Commissioner of the Office of Mental Health has the authority and responsibility to set standards for the quality and adequacy of facilities and programs that provide services for the treatment and recovery of persons who suffer from mental illness." See <http://www.omh.state.ny.us/omh-web/licensing/> (accessed February 8, 2011).

regulate, must be able to define Medicaid services in a manner that complies with federal rules, and to determine what can and cannot be covered by Medicaid. Doing so requires a significant commitment of resources and cooperation.

Implications of Federal Health Care Reform

The Affordable Care Act (ACA)¹⁶ set important parameters and a new tone for the national discussion about health care management and service delivery. But this shift has been principally driven by—and is largely focused on—the experience of Medicare and private commercial payers, which serve a population that differs starkly from the one Medicaid serves. Medicaid is therefore pulled between two opposing options: increasingly following multipayer approaches, or asserting its uniqueness given the populations it serves and the benefits it covers. Behavioral health is clearly at the center of this debate.

ACA includes care coordination initiatives to promote better integration of service delivery for Medicaid beneficiaries with behavioral health challenges. One example is the Medicaid state option to permit enrollees with certain chronic conditions, including mental health and substance abuse issues, to designate a provider as a “health home.” States electing the option are given a 90 percent match for two years to provide care management, coordination, and health promotion. States can make payments to designated providers or health teams and are required to track avoidable hospitalizations and provide feedback on improving chronic care management and incorporating health information technology in care coordination.¹⁷ Another example is the grant program to support colocation of primary and specialty care services in community-based behavioral health settings.¹⁸ It remains to be seen how these provisions will play out in their implementation. However, they could represent important steps toward incorporating the behavioral health component into a national discussion on care coordination.

During the lengthy debate over federal health care reform, hopes were raised among behavioral health providers, particularly substance abuse treatment facilities, that the long-standing IMD exclusion would be eliminated. Because federal Medicaid regulations classify alcoholism and chemical dependency syndromes as mental disorders, these SA facilities are considered IMDs for the purposes of Medicaid reimbursement; therefore, they cannot claim Medicaid reimbursement even for the covered services they do provide (Rosenbaum, Teitelbaum, and Mauery, 2002). In the final version of health care reform, however, the only provision related to IMDs involved the enactment of a demonstration project beginning in 2011 to reimburse certain IMDs that provide services to Medicaid beneficiaries who require stabilization of an emergency condition.

¹⁶ On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (PPACA). On March 30, the President signed a second bill called the Health Care and Education Reconciliation Act. Together, the two bills constitute what is known as federal health care reform; they are collectively referred to as the Affordable Care Act (ACA).

¹⁷ Section 2703 of PPACA.

¹⁸ Section 5604 of PPACA.

Furthermore, another provision of health reform may actually hurt current funding for IMDs. In the wake of the exclusion, many states have used disproportionate share hospital (DSH) funds—intended to reimburse hospitals that serve a disproportionate share of uninsured, low-income patients—to support IMDs. It is estimated that between 2001 and 2006, states directed about \$3.3 billion per year in DSH payments to these institutions (Bachrach, 2010). Such a creative use of DSH funds has allowed states to circumvent the IMD exclusion from Medicaid (Frank, Goldman, and Hogan, 2003). Under health care reform, DSH payments to states are going to be reduced substantially beginning in 2014. It is unclear how these DSH reductions will affect funding for IMDs.

Another area of uncertainty is how behavioral health benefits will be incorporated into the health insurance exchange. The Affordable Care Act establishes an “essential benefit package” that includes coverage for mental health and substance abuse services. Participation in the health exchanges is limited to “qualified health plans,” with coverage guaranteed to meet minimum standards that include behavioral health benefits. However, these guarantees are modeled on benefits provided under the “typical employer plan.” This is a different set of benefits from what is provided under Medicaid, leaving many advocates and providers concerned about the comprehensiveness of BH coverage in the Exchange. As family incomes shift over time, the need for beneficiaries with behavioral health conditions to navigate coverage transitions between Medicaid and the Exchange could raise difficult policy challenges.

Considerations for New York

While federal health care reform ushers in a new era of national policy for Medicaid, as well as for the U.S. health care system more broadly, it is not a game-changer for the provision of behavioral health services under Medicaid. As the landscape of the broader health care delivery system begins to shift, New York must continue to take the lead role in efforts to improve how Medicaid serves beneficiaries with behavioral health conditions, and it must do so in an era of severe resource constraints. In meeting this challenge, the state’s health policy leaders face three related but distinct questions: first, how to integrate physical and behavioral health care delivery; second, how to manage and pay for Medicaid beneficiaries’ behavioral health services; and third, how to better coordinate Medicaid’s administrative responsibilities related to serving these beneficiaries.

Currently, state policymakers are focused on the second question: how to manage and reimburse behavioral health services for Medicaid beneficiaries who, by and large, receive their physical health services through managed care plans. Choosing from among the three available options—leaving the benefit in FFS, employing MBHOs, or carving behavioral health services into the Medicaid managed care benefit—is a complex and important decision.

The remaining two questions are also pivotal and may be even more challenging to address. The successful development and implementation of effective strategies for treating Medicaid beneficiaries with behavioral health conditions will require new policies and protocols that affect how care is delivered at the point of service. This requires a historical break from New York's established tradition of accepting two separate delivery systems—one for behavioral health and one for physical health. Moreover, designing and implementing effective strategies to change this powerful underlying dynamic may require changes to Medicaid's current administrative structure.

Ultimately, addressing all three components of behavioral health care—service delivery, care management and reimbursement, and administration—is necessary to promote and achieve high-quality and cost-effective care for Medicaid beneficiaries in the future.

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