MEDICAID INSTITUTE
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Implementing Behavioral Health Care Reform in New York's Medicaid Program

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Medicaid is a principal source of financing and delivery of behavioral health services for individuals with severe mental health and substance abuse conditions. In 2010, about 400,000 enrollees with these conditions accounted for $6.3 billion in spending, which represents more than 10 percent of total spending on New York's Medicaid program.[1]

The level of Medicaid spending on this population reflects not only the extent of its behavioral health challenges but also its complex medical needs. As documented by a 2011 analysis of Medicaid beneficiaries with mental health or substance abuse conditions, conducted for the Medicaid Institute at United Hospital Fund by the Urban Institute, this population has higher rates of physical health challenges, including chronic conditions, than its Medicaid counterparts without behavioral health issues.[2] These beneficiaries also had higher levels of service use and spending on mainstream health care services, including inpatient hospital care.

Whether from the standpoint of providing effective, high-quality care and producing more positive outcomes for these vulnerable and high-need beneficiaries, or of managing Medicaid's scarce resources more efficiently, reforming the financing and delivery of behavioral health care services is a top Medicaid priority for New York State. This report discusses the changes in both State policy and in roles and responsibilities that will foster such reform, and the challenges associated with implementing those changes.

Background

Medicaid primarily pays for behavioral health services under a fee-for-service (FFS) methodology, especially for beneficiaries with significant behavioral health services needs, even when their physical health services are provided through managed care. Outpatient chemical dependence and methadone treatments, and all specialized mental health services, are paid for under FFS.[3] Disabled enrollees receiving SSI benefits, including those with serious and persistent mental illness—some of the heaviest users of behavioral health services—receive both outpatient mental health services and inpatient treatment for chemical dependence on an FFS basis. For beneficiaries enrolled in mainstream Medicaid managed care (MMC), only inpatient detoxification services are included under that managed care. All

[1] New York State Department of Health. July 21, 2011. New York State Health Home State Plan Amendment and Provider Application (webinar). http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/nys_health_home_spa_and_app_summary.ppt Enrollment and spending figures do not include mental health/substance abuse beneficiaries who receive long-term care services.

[2] Coughlin TA and B Shang. February 2011. *New York Medicaid Beneficiaries with Mental Health and Substance Abuse Conditions.* New York: United Hospital Fund.

[3] Specialized mental health services include Intensive Psychiatric Rehabilitation Treatment Programs (IPRT), Day Treatment, Home and Community-Based Service Waivers, Case Management, Assertive Community Treatment (ACT), and other related programs.

behavioral and physical health services for beneficiaries who are exempt or excluded from MMC are paid for under FFS.

Most Medicaid beneficiaries with significant behavioral health challenges thus receive services from two distinct sets of providers—mental health and substance abuse practitioners for their behavioral health needs, and primary care providers and specialists, clinics, emergency departments, and hospital inpatient facilities for their physical care. This bifurcation creates uneven, discontinuous, and often poor-quality care that focuses on management of symptoms instead of promoting functioning, wellness, and health maintenance.

Despite the fact that Medicaid beneficiaries with behavioral health conditions, on the whole, have more complex and demanding health care challenges, they rarely have a meaningful relationship with a primary care physician or care manager whose responsibilities include both their physical and behavioral health care needs. Additionally, these beneficiaries often have multiple social-service needs, such as assistance with housing and employment.

Changes in State Policy

In January 2011, Governor Andrew Cuomo called for the creation of a Medicaid Redesign Team (MRT) drawn from state officers, members of the legislature, leaders in the health plan and provider communities, and business, labor, and consumer representatives. With the State facing a significant budget deficit, the MRT was initially charged with achieving savings while increasing quality and efficiency in the Medicaid program for the 2011-12 State fiscal year. Through the MRT, the New York State Department of Health (DOH) and Office of Mental Health (OMH) have taken action to significantly change the way Medicaid behavioral health care is financed and delivered.

The State's Enacted Budget for 2011-12 included a major reform of Medicaid behavioral health services. Within the next three years, the financing and delivery of mental health services and substance abuse treatment will shift from an FFS methodology into a managed care framework. The vision for behavioral health care services is consistent with the State's stated Medicaid goals of "care management for all" and "getting out of the... FFS business."[4]

As part of its ongoing Medicaid reform activities, in June 2011 the State appointed an MRT Behavioral Health Reform Work Group of experts and stakeholders in the field, to guide implementation of enacted reforms. The Group's specific charge was to develop guidance on

[4] Helgerson J. July 14, 2011. New York Medicaid Redesign: A Progress Report. Presentation at United Hospital Fund conference, Medicaid in New York: Implementing a New Vision.

service integration, co-location of services, and Medicaid health homes, a care coordination mechanism created by the Affordable Care Act of 2010 (ACA). In turn, the Work Group developed a set of principles as a foundation for behavioral health reform, including tying payment of services to patient outcomes, prioritizing patient choice, reinvesting savings into services for behavioral health populations, and promoting coordinated and efficient clinical care.

Under the Work Group's recommendations, the State will make regional behavioral health organizations (BHOs) responsible for managing benefits for Medicaid beneficiaries with significant behavioral health needs. In addition to those care management responsibilities, BHOs will undertake utilization reviews, quality improvement efforts, provider network development, and claims processing.

Currently, BHOs dominate delivery of behavioral health services in the U.S. across all payers, including Medicaid. Because of an emphasis on controlling the high costs of inpatient psychiatric care in particular, BHOs developed as entities that could apply clinical expertise to redirect patients to more appropriate and cost-effective mental health services, in addition to being large-scale purchasers of behavioral health services. They were built, in effect, on the economic principles of specialization, economies of scale, and price negotiation.

Today, the State envisions regional BHOs as entities that will manage and pay for those behavioral health services now provided under FFS, and that will also coordinate with mainstream Medicaid managed care plans that provide physical health services. This means that, ultimately, behavioral health providers who have long been paid by the State under an FFS arrangement will need to contract with BHOs in order to continue participating in the Medicaid program.

This vision does allow for a policy variation in New York City, where State officials have determined that capacity will exist for one or more Special Needs Plans (SNPs) to provide both the managed behavioral health benefit and managed physical health services in an integrated fashion. Behavioral health SNPs will perform all the roles of BHOs, as well as having the responsibilities of mainstream MMC plans. This approach builds on Medicaid's experience with HIV SNPs. Since 2003, three HIV SNPs have operated in New York City as fully capitated managed care plans designed to meet the unique needs of beneficiaries living with HIV/AIDS, across the full spectrum of health and social services. For the long term, whether the State will pursue integration of physical and behavioral health services through SNPs in regions outside New York City is an open question.

Transitional Implementation Phase

Anticipating the complexity and the dramatic transitions involved in implementing behavioral health reform—for beneficiaries and their families, providers, new care management entities, and the State itself—this policy shift begins with an interim step, based in what are being designated Phase I BHOs. In this first phase of reform, OMH is contracting with five organizations selected through competitive bidding to operate regionally: Community Care Behavioral Health in the Hudson Valley region; Long Island Behavioral Health Management LLC in the Long Island region; Magellan Behavioral Health in the Central region; New York Care Coordination Program in the Western region; and OptumHealth in New York City.

Phase I regional BHOs are responsible for four main tasks as they serve Medicaid beneficiaries with behavioral health conditions who are not dually eligible for Medicare: monitoring inpatient care and length of stay through concurrent review; profiling providers; creating linkages to community-based mental health providers and health homes; and tracking children with serious emotional disturbances. Importantly, in Phase I, behavioral health providers will maintain their existing FFS relationship with the State.

During this phase, providers are required to contact the regional BHO about each FFS hospital admission in order to ensure the timely exchange of information about service use and improve discharge planning. The goal of these interactions is a reduction in unnecessary admissions and readmissions. The State sees Phase I BHOs as assets in facilitating a statewide shift toward a behavioral health delivery system that is recovery-focused, accountable, and less fragmented. Within three years, the State expects a level of readiness for its second, more comprehensive phase of behavioral health reform, in which BHOs and SNPs perform the key responsibilities of managed care plans.

The State is simultaneously contracting with networks of health home providers that will receive per-member-per-month payments to provide care coordination services for high-need and high-cost beneficiaries. Under the ACA, health homes will facilitate access to an interdisciplinary array of medical care, behavioral health care, and social services for individuals with chronic conditions. For the first two years, the federal government is providing states with a Medicaid matching rate of 90 percent for care coordination services, to incentivize rapid development of health homes. In New York's first round of health home assignments, about 300,000 Medicaid beneficiaries with mental health and/or substance abuse conditions, along with beneficiaries with other chronic illnesses, are eligible for enrollment. Because health homes explicitly include beneficiaries with behavioral health conditions, they will potentially play an important role—along with regional BHOs, behavioral health SNPs, and mainstream MMC plans—in these beneficiaries' care.

Behavioral Health Reform: Changes in Roles and Responsibilities

Transitioning to a managed care framework for behavioral health services offers significant potential benefits and poses real challenges—for the high-need and high-cost beneficiaries who rely heavily on behavioral health services under Medicaid; for the providers that serve them; for the BHOs and SNPs responsible for managing service delivery and coordinating care; and for the State, which will retain ultimate responsibility for accessibility and quality of services and overall system performance.

Phase 2 of the State's behavioral health reform—completing the move to managed care—will change the way money flows in two distinct yet related ways. First, risk-sharing will need to be arranged between the State and the BHOs. Second, BHOs will have to negotiate and establish payment arrangements with behavioral health providers. These changes have the potential for significant savings—particularly from a reduction in unnecessary inpatient care and the promotion of improved service delivery and greater accountability. Switching to a managed care entity such as a BHO also allows for more flexibility in the provision of services, as health plans can go beyond services laid out in New York's Medicaid State Plan, as long as the alternatives are deemed cost-effective.

There are challenges, however. These arrangements will alter the way Medicaid funding flows to behavioral health providers, who may not have the experience needed to successfully negotiate and manage risk-based contracts. The need to adapt to new payment and contracting systems—particularly utilization reviews—will also put pressure on behavioral health providers.

Although Phase 2 implementation details have yet to be finalized, the State plans to rely on BHOs as risk-bearing entities responsible for providing behavioral health services and managing Medicaid's behavioral health benefit, as noted above. This significant policy shift will, broadly speaking, bring four sets of changes. First, it will alter the way Medicaid finances and pays for services. Second, it will have implications for the delivery and integration of services. Third, it will establish a new framework for measuring the quality of care and monitoring the performance of plans and providers. And, finally, it will shift the locus of management and administration of related programs. Below, we consider the key implementation challenges posed by these shifts.

Financing and Provider Payment

Behavioral health reform's second phase will entail new Medicaid payment policies. The exact nature of these arrangements remains to be determined, but ultimately the State is changing

the way it does business with behavioral health providers. Under managed care, risk-sharing arrangements for BHOs and SNPs will have the potential to redistribute funding streams by changing the locus of authority for paying behavioral health providers. The State has indicated it will use some degree of capitation to pay BHOs to manage services. Capitation aggregates payments on behalf of enrollees and authorizes a health plan—in this case a BHO—to manage these dollars on an at-risk basis and to contract with behavioral health providers selectively. Few providers have experience with this, having instead operated under more predictable FFS contracts with the State.

Provider reimbursement can flow through a BHO in different ways, which may vary both among BHOs and within BHOs by provider. One is a capitation arrangement between the BHO and providers, essentially a per-member-per-month payment. Under this scenario, the State would need to ensure that capitation rates take into account beneficiaries who are likely to rely on more intensive, higher-cost services. More likely, BHOs will pay providers using a case rate, a fixed sum to provide care for individual patients for a specified treatment, episode of care, or period of time. Case rates can be adjusted for severity of illness, given the broad range of needs in this population and the differences in time and effort required to treat patients because of that variability. Under either scenario, the incentives and disincentives for providers will likely differ from those in effect under FFS.

Managed care will essentially turn community-based health providers into subcontractors of the BHOs. Many of these providers are small nonprofit entities without significant capital reserves, management capacity, and information technology capabilities. Yet they are the backbone of the behavioral health specialty system, particularly in certain regions of the state. The State will need to strike a balance between helping providers transition to a new payment system and pursuing a more cost-effective service delivery model. A cautionary tale can be found in Tennessee's experience in the late 1990s with its TennCare Partners behavioral health reform. Under this reform, Tennessee moved all mental health and substance abuse services into two large managed BHOs. Shortly after the program became operational, many safety-net providers experienced a precipitous drop in revenue and stopped accepting new patients, laid off employees, and even sought buy-outs from out-of-state, for-profit providers.[5]

Advancing a sound managed behavioral health care framework also requires incentivizing the "right" services—and an economically viable and predictable rate structure is needed to do that. Although much is known about how best to deliver behavioral health treatments, there is a lack of evidence-based practice in the field. Considerable training of clinicians and case managers is still needed, as well as the use of continuous performance improvement techniques and, quite simply, time for practices to change.

[5] Chang CF, LJ Kiser, JE Bailey et al. March 18, 1998. Tennessee's Failed Managed Care Program for Mental Health and Substance Abuse Services. *Journal of the American Medical Association* 279(11): 864-869.

For example, screening for alcohol, drugs, or mental health problems in primary care settings is known to be worthwhile, based on available evidence as documented in 2005 by the U.S. Preventive Services Task Force. And the Substance Abuse and Mental Health Services Administration and the National Institute of Mental Health are continuously issuing evidence-based practices and standards of care. For the near term, however, the State still faces the difficult challenge of determining how to pay the right price for the right services, while external standards are increasingly adopted in practice.

Integration and Delivery of Services

The State's chosen payment model will profoundly affect the delivery of behavioral health services and the State's ability to promote the integration of behavioral and physical health care. Any carved-out behavioral health management structure in regions of the state that do not rely on SNPs will maintain the division between physical health and behavioral health, because providers will continue to be paid separately. This structure creates pressure to shift costs as patients receive their physical health care services from one at-risk managed care organization (MCO) and their behavioral health services from another (the BHO).

Other states' experience with this model can inform New York's implementation of behavioral health reform. In Tennessee, for example, after behavioral health reform led to turf wars between MCOs and BHOs over which was responsible for what services, the state moved to a fully integrated managed care model under the MCOs.[6] Arizona, on the other hand, is attempting to use the BHO as the locus for integration, with all physical and behavioral health services for a single county's Medicaid beneficiaries with serious mental illness managed by a regional behavioral health authority.[7] Pennsylvania, to align financial incentives within its carve-out system, recently established an incentive pool shared by the MCOs, BHOs, and county behavioral health systems in two regions.[8]

Studies across all payers generally have shown that managed behavioral health carve-outs have not reduced quality of care overall. But evidence suggests that low-income populations with complex health issues are more likely to experience declines in quality of care than those with less complex issues.[9] One study of Medicaid patients with schizophrenia who received their behavioral health care under a capitation arrangement through a managed BHO found sharp

[6] Center for Health Care Strategies, Inc. November 15, 2011. Integrating Physical and Behavioral Health: An Exploration of State Options (webinar). http://www.chcs.org/usr_doc/ICRC_PHBH_Slides_Final.pdf

[7] Ibid.

[8] Hamblin A, J Verdier, M Au. October 2011. *State Options for Integrating Physical and Behavioral Health Care* (technical assistance brief). Hamilton, NJ: Center for Health Care Strategies, Inc.

[9] Frank RG and RL Garfield. April 2007. Managed Behavioral Health Care Carve-outs: Past Performance and Future Prospects. *The Annual Review of Public Health* 28:303-320, Table 4.

decreases in the likelihood of their receiving psychosocial treatment.[10] In assessing service delivery during both the first and, especially, second phases of implementation, the State will be establishing quality standards and monitoring BHOs and their subcontractors for how they assure access and deliver services, given the incentives to make decisions that could result in cost-shifting and care fragmentation.

Service integration is a primary goal of the State's behavioral health reform policy, reflecting the fact that patients' clinical needs are interdependent, with physical health affecting behavioral health, and vice versa. Integration can take place within primary care settings or within behavioral health settings, or in both. Currently New York's delivery system is largely compartmentalized, as medical services and behavioral health care are provided separately. Because, at the payer level, two distinct entities will be at risk for physical and behavioral health care, the State is relying on care coordination at the clinical level as the glue that will hold together the two components of service delivery for these Medicaid beneficiaries. There are, therefore, several particularly challenging aspects to the coordination of service delivery, in the contexts of primary care, outpatient prescription drugs, and behavioral health care.

Primary Care. Primary care practice patterns pose significant obstacles to incorporating front-line behavioral health services. Even though about half of patients seen in primary care settings have behavioral health issues, very often their mental health and substance abuse conditions are not addressed.[11] It is therefore an important goal to develop behavioral health capacity in primary care practices that goes beyond referrals to include on-site screening and treatment. The challenges to this integration include a lack of training, limited access to psychiatric consultations, and the significant time pressures of an office visit. Although there is a body of experience on how to deliver integrated services and how to assist practices in achieving such integration, clear standards, training, and support are still needed.

Many primary care physicians do provide some behavioral health services. Primary care is now the sole form of health care used by more than one-third of patients with a mental health condition who access the health care system,[12] and primary care practices are a common setting for the treatment of depression and anxiety.[13] The BHO model has the potential to complicate this provision of services. First, primary care providers may not be reimbursed for

[10] Busch AB, RG Frank, AF Lehman. May 2004. The Effect of a Managed Behavioral Health Carve-out on Quality of Care for Medicaid Patients Diagnosed as Having Schizophrenia. *Archives of General Psychiatry* 61(5): 442-448. Examples of psychosocial treatment include talk therapy, substance abuse relapse prevention, and skill building to improve functioning.

[11] Hogan M. July 12, 2011. Managed Care Principles—Addendum: Special Issues for Behavioral Health (presentation to the Medicaid Redesign Team Behavioral Health Reform Work Group).

[12] Wang PS, O Demler, M Olfson, HA Pincus, KB Wells, RC Kessler. July 2006. Changing Profiles of Service Sectors Used for Mental Health Care in the U.S. *American Journal of Psychiatry* 163(7): 1187–1198. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1941780/

[13] Kroenke K. 2003. The Interface between Physical and Psychological Symptoms. *The Primary Care Companion to the Journal of Clinical Psychiatry* 5(suppl 7): 11–18.

depression screening or treatment if they are not in the BHO's provider network. Some public payers have addressed this by bringing PCPs into BHO networks. In Massachusetts, for example, the Medicaid program's BHO carve-out facilitates the management of mental health care in primary care settings by using the State's primary care case management program.[14] Second, PCPs will face an added layer of complexity in referring patients, since they may find it difficult to access BHO clinicians and such services may be outside the network of those familiar to the PCP. Ease of referrals through professional networks and ongoing communication between PCP offices and behavioral health providers are critical to successful service integration in a carve-out model. Finally, access to necessary medical records for a given patient may be limited, for both PCPs and behavioral health specialists. Information systems on both sides must enable the distribution of relevant patient data to all providers in a timely fashion.

Prescription Drugs. As of October 2011, the State moved Medicaid outpatient prescription drug coverage into the mainstream MMC benefit, a policy change that will have an impact on service delivery for Medicaid beneficiaries with behavioral health conditions. Prescribers—psychiatrists, primary care physicians, and nurse practitioners—are now subject to the formulary and prior approval requirements of the mainstream MMC plan. Under Medicaid reform, the BHOs and mainstream MMC plans must work together to share information and manage patients' use of medications—including prescription drugs used to treat behavioral health conditions. For BHOs, receiving this information in a timely fashion is critical, as appropriate medication management is essential to their enrollees' well-being and effective care. But in addition to creating an intersection between the MMC and BHO for information sharing, effective policy—and an acceptable quality of care—requires clarity for patients and providers on which entity is responsible and accountable for which services.

Behavioral Health Services. The structure of New York's behavioral health services presents its own set of challenges, with separate systems of care for mental health conditions and chemical dependency. Most mental health treatment is provided by specialized mental health hospitals and clinics, and by specialists, such as psychiatrists, psychologists, and social workers; most substance abuse treatment is delivered in separately licensed outpatient clinics, methadone programs, and therapeutic communities. Large State psychiatric hospitals no longer dominate the delivery system; now there are more than 2,500 community-based mental health programs collectively relying on a highly dispersed network of nonprofit service providers, county- and State-operated mental health clinics, private hospitals with psychiatric services, and 25 State-operated hospitals.[15] In 2009, the State began a clinic restructuring

[14] Frank RG and RL Garfield. April 2007. Managed Behavioral Health Care Carve-outs: Past Performance and Future Prospects. *The Annual Review of Public Health* 28:303-320.

[15] New York State Office of Mental Health. March 11, 2009. *Clinic Restructuring Implementation Plan.*

process to improve the provision of outpatient mental health services. This process, which seeks to align fiscal and clinical policy and drive improvements in care, is well timed, but the behavioral health delivery system is still years away from a full redesign and requires federal waiver approvals to get there.

Similarly, the State has recognized that it needs to alter not only *how* it pays for services but also, ultimately, *what* it pays for. To address capacity issues, the State seeks to spend less on inpatient services and reinvest this money in developing more robust community-based services. The challenge of achieving this goal is best captured in the example of hospital detoxification ("detox") services. Although in recent years detox services have been increasingly provided in the community, the system is still biased toward inpatient care. In 2008, Medicaid paid for almost 50,000 hospital admissions for drug or alcohol detoxification, including many repeat admissions; hospital detox has essentially become a revolving door for some Medicaid beneficiaries.[16] The delivery system's capacity for community-based detox services is hindered by a number of factors, including reimbursement policies and a lack of viable providers. Again, the State is in the process of addressing many of these barriers to care. The challenge is to balance these on-the-ground delivery system changes with the requirements of the policy transition to managed behavioral health care.

Performance Evaluation and Quality Measurement

Applying measures that reflect the performance of BHOs and behavioral health providers can strongly influence the quality and effectiveness of services for Medicaid beneficiaries and can thus help address many of the implementation challenges associated with behavioral health care reform. More importantly, meaningful performance evaluation is central to guaranteeing the quality of care provided under Medicaid. Quality measures built into administrative databases and clinical performance reviews can be used to evaluate the performance of BHOs and behavioral health providers. Their transparent and rigorous application will be necessary to ensure that behavioral health reform proceeds responsibly. Meaningful evaluation is possible but will put monitoring and clinical management demands on state agencies, BHOs, and providers.

The State is in the process of developing clinical and system performance assessments for behavioral health services, but reliable information systems—necessary for effective evaluation—are also still under development. Ideally, risk-bearing contracts between the State and BHOs would include outcome measures and performance standards in key areas: service delivery; clinical, functional, and consumer outcomes; consumer and family experiences with care; and financial performance.

[16] Patchias E and M Birnbaum. February 2011. *Providing Care to Medicaid Beneficiaries with Behavioral Health Conditions: Challenges for New York.* New York: United Hospital Fund.

The use of interim quality measures can mitigate this challenge, and such measures are built into Phase I BHO contracts. These include measures related to access, engagement and retention in treatment, and continuity of care—some of which require only Medicaid claims data to compute. Designing and implementing Phase 2 metrics will be more difficult, not just because of data challenges but also because the State will be monitoring risk-bearing entities that will have the authority to deny care.

In order to safeguard patients, the development of outcome measures is crucial. The MRT's Behavioral Health Reform Work Group has recommended measures from which the State can build an effective monitoring system. Its report to the full MRT identifies several examples of outcome measures for children with serious emotional disturbances, including metrics related to improvements in psychiatric and social service systems, patient and family satisfaction, and transitions to less-intensive levels of care.[17]

Developing standards for the integration of behavioral and physical health care services is problematic as well, because of a lack of widespread experience. New York has begun to define how to integrate physical and behavioral health using proven collaborative care models in primary care. Because there is limited experience with collaborative care in the state, clear and measurable standards of integrated care are even more important.

Finally, the option of using self-reported information to rate performance remains an unresolved issue. For this population, self-reporting poses an inherent challenge. Given their conditions, individuals with mental illness or chemical dependencies may be less willing to self-report, and less able to provide reliable assessments. Furthermore, clinicians and patients often value different outcomes. Clinicians often look more at symptoms while patients and their families are primarily concerned with functioning. Measures exist for both, but exclusive reliance on clinician-based measures will disenfranchise consumers and impair effective alliance with them in their ongoing recovery efforts.

Management and Administration

The administrative structure for overseeing behavioral health care in New York's Medicaid program is layered and complex. Low-income individuals with mental health and substance abuse conditions receive assistance through multiple channels, including separate State and local mental health and substance abuse agencies, the criminal justice system, public schools, the child welfare system, and public and private housing programs. Just in the context of Medicaid, there are three main administrative agencies, the Department of Health, the Office of Mental Health, and the Office of Substance Abuse Services (OASAS)—each with distinct

[17] New York State Medicaid Redesign Team, Behavioral Health Reform Work Group. October 15, 2011. *Final Recommendations*, p. 58. http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

regulatory functions but with overlapping funding streams and sometimes-competing priorities.

In general, as the lead state Medicaid agency, DOH is responsible for Medicaid billing, information systems, eligibility and enrollment policies, and many provider reimbursement rates. 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. OASAS licenses and regulates program providers and operates its own addiction treatment centers located throughout the state.

Additionally, local governmental units (LGUs) play a role in managing their respective county systems of behavioral health care for all consumers, not just those enrolled in Medicaid. LGUs include the commissioners, directors, and staff of each of the 57 county mental hygiene departments and the Bureau of Mental Health Services in the New York City Department of Health and Mental Hygiene. The core function of the LGUs, vested in Article 41 of the State's Mental Hygiene Law, is to develop plans to meet the needs of those diagnosed with mental illness and substance use disorders. LGUs receive State appropriations that provide a funding source for an array of services in the public mental health system. The LGUs also know their communities well. As such, they are important potential partners for regional BHOs as the State seeks to identify service gaps and unmet needs that contribute to hospital readmissions and unnecessary emergency department visits—a key Medicaid savings target for the State.

With the incorporation of BHOs, a new layer of administration is being added to the provision of Medicaid behavioral health services. In Phase 1, BHOs are largely invisible to patients, as their roles are essentially limited to monitoring services delivered by providers who do not answer to the BHOs and who continue to be paid directly by the State on an FFS basis. Once Phase 2 is fully operational, however, beneficiaries will be enrolled in BHOs just as they are in mainstream MMC plans. This may prove confusing for these extremely vulnerable beneficiaries, who often have trouble navigating the system and can't advocate effectively on their own behalf. A clear delineation of roles, responsibilities, and authority—in which patients understand what their BHO, their MMC plan, and the State each can and will provide—is essential.

The challenge of achieving a clear delineation of management and administrative authority is exemplified in the interaction of BHOs and Medicaid health homes. As New York phases in health homes for Medicaid beneficiaries with behavioral health conditions, the roles and responsibilities of health home providers, particularly related to care coordination, require further clarification. Furthermore, through its emerging policy on health homes, the State is

vesting another entity with responsibility for Medicaid beneficiaries, and paying separately for that responsibility, without connecting the health home to the actual provision of services.

The answers to many of these questions will flow from the level and types of contracting authority the State gives BHOs during Phase 2, and how much regulatory control over them the State will assert. The structure of BHO contracts is important on several levels. With multiple levels of management built into this new system—the BHO, the MMC plan, and, potentially, health homes—contracts are the most direct vehicles for preventing duplication of services. In essence, the State bears the important responsibility of managing multiple care managers. This will be a particular challenge if different State agencies, and perhaps different offices within the same agencies, hold the contracts for these care managers.

Conclusion

In the context of budget constraints and limited administrative resources, New York is engaged in an ambitious reform effort to improve how Medicaid serves beneficiaries with behavioral health conditions—how best, that is, to manage and pay for behavioral health services in a way that promotes the integration of service delivery and improves the quality of care.

The State seeks to achieve a coordinated, cost-effective Medicaid system that provides access to excellent behavioral health care for some of Medicaid's most complex, vulnerable, and costly beneficiaries, by relying on BHOs or SNPs as specialized vendors responsible for managing care and paying providers. During the current transitional period, which relies on Phase 1 BHOs, the State is poised to learn a great deal about how shifts in the delivery system will play out. Addressing many of the challenges now will allow the State to reap the benefits of risk-based capitation and specialized care management in the second phase of reform, without increasing administrative burdens, diminishing accountability, or compromising beneficiaries' access to needed care.

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