PRESERVE SPECIALTY BEHAVIORAL HEALTH OPTION FOR THE DUAL ELIGIBLE POPULATION

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Individuals who are enrolled in both Medicare and Medicaid, commonly referred to as "dual eligibles," are more likely than non-dual eligible beneficiaries to have cognitive impairments and mental disorders. Dual eligible beneficiaries account for a disproportionately high amount of expenses under both Medicare and Medicaid, and yet, due to historically inadequate care coordination services, have also suffered from poor health outcomes.

Current federal initiatives to integrate Medicare and Medicaid services for dual eligibles are intended to improve care coordination and health outcomes. The instinctual reaction is to develop a single entity that is responsible for all services. However, paradoxically (and, as many states are learning), a specialty behavioral health organization (BHO) is also a viable option for dual eligible beneficiaries with behavioral health disorders, particularly those with serious and persistent mental illness. A specialty behavioral health organization (BHO) is a distinct organization or entity that can either be freestanding or part of a managed care organization and has specific financial resources to provide programs that manage behavioral health care benefits. Both the quality and cost of care for the dual eligible population could be improved through such an option.

We strongly recommend preserving the specialty behavioral health organization option for dual eligibles.

Background:

There currently exist a variety of approaches for behavioral health care delivery in both private insurance and Medicaid. In private insurance, a common approach is for care to be provided by a specialty behavioral health organization. These companies may or may not be affiliated with an insurance company that is providing an individual's medical coverage. Another method is for the medical insurer to offer coverage for both medical and behavioral.

In Medicaid, as states have increasingly turned to managed care approaches, individuals with serious mental illness have often been left in the fee-for-service system or placed into a specific carve-out for behavioral health care (and sometimes the carve-out will provide all mental health or substance use care for all conditions, not just for those with serious mental illness).

Each of these scenarios is a viable option for the Medicare-Medicaid enrollees. The important outcome is that they receive quality, seamless, integrated care.

Specialty behavioral health organizations (BHOs) provide comprehensive integrated care:

Integrated care at the clinical level of patient-provider interaction can occur in any financing scenario. Uncoordinated care can also occur in financing arrangements that appear to be integrated because funds flow to one entity that is responsible for both medical and mental health care. The devil, it turns out, is in the details.

In fact, BHOs offer integrated care in many ways:

- BHOs coordinate/integrate the array of benefits offered to many individuals, including medical/surgical benefits, employee assistance programs, work-life programs, short term disability, long term disability, disease management programs, worker's compensation programs and pharmacy benefit programs.

- BHOs co-locate staff in community mental health centers, federally qualified health centers, group practices and primary care offices to promote collaboration with providers and provide comprehensive services to consumers. They work with these and other primary and specialty physical health care providers to identify recovery barriers and develop innovative solutions to support each member's individualized recovery.

- BHOs work with peer leaders and others to provide wellness management, coping, independent living, and social skills.

- BHOs have care managers on the ground (either on staff or in their networks) to ensure that care is coordinated between providers and appropriate health information is exchanged.

Dual eligibles need specialized quality care:

Dual eligibles include individuals on Social Security Disability Insurance (SSDI), a significant percentage of whom are disabled by mental illness, and elderly people who frequently have depression or other mild or moderate mental disorders. In either case, specialized services that often need to be different from the mental health services required by a working population can be needed.

For those on SSDI coordinated care is essential and the intensive community services covered by Medicaid are the key to maintaining or improving a person's function and ability to remain in the community. Medicare, unfortunately, does not cover any psychosocial rehabilitation services. However, in addition to other approaches to develop coordinated care systems, BHOs can be one way to ensure that the Medicaid community services and the Medicare clinical services are woven into a single treatment plan. Moreover, some states provide BHOs with authority for additional services (either using the Section 1915(b) authority or allowing flexibility to furnish services such as peer supports).

Thus, for dual eligibles, BHOs have and can continue to:

- Improve access to community based care and alternative services. They have increased the time that members spend living in the community rather than being in restrictive inpatient settings or involved with the criminal justice system.

- Established robust quality measurement programs that strive to manage care so that each consumer is provided with the best, most appropriate care available. The care provided is evidence based and uses clinical practice guidelines developed by behavioral healthcare professionals. BHOs take the time to educate providers about the latest research, and encourage and facilitate coordination of care among providers. Additionally, these organizations voluntarily seek accreditation and oversight from accrediting bodies like the National Committee for Quality Assurance and URAC. Surveys are continuously given to consumers to measure and ensure high satisfaction with the delivery of care.

- Build highly specialized networks of providers and ensure that providers are qualified to provide care, and that their licenses and credentials are verified and free of sanctions or other issues that could potentially harm consumers. BHOs establish access and availability standards for their providers, and measure performance on quality metrics through methods such as provider profiling. BHOs promote the use of evidenced based practices and nationally recognized practice guidelines to ensure that the care consumers receive actually works.

BHOs have influenced the health care delivery system to provide better collaboration with all medical specialties, and enhanced care coordination and intensive case management. BHOs have created effective treatment, early intervention systems, employee assistance programs (EAP), and other wellness programs that aim to reduce the incidence and severity of mental illness and substance use disorders and promote recovery. BHOs collaborate with leading academic and research programs to promote the best technological methods and the best evidence based practices to serve consumers. BHOs have partnered with managed care organizations to help educate primary care physicians and pediatricians as they provide a substantial part of behavioral health care with only limited training.

Specialty behavioral health organizations (BHOs) provide cost effective care:

There is significant evidence that BHOs provide cost effective care in the public sector through their Medicaid contracts. In addition, comparisons of integrated financing under Medicaid with BHOs have found that integrated financing systems devote fewer resources to mental health services (exacerbating an already critical situation of underfunding by states) and fail to offer the intensive community services that those with serious mental illness require. On the other hand:

- In one county, a BHO reported that its behavioral health plan achieved a 26% increase for 1 year in the number of Medicaid recipients served; a 19.5% reduction in hospitalization; a 32% reduction in readmission rates, and a 38.2% reduction in inpatient bed days.

- In one county, a BHO was responsible for 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.

- Another BHO 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.

Preserve Specialty Behavioral Health Option for the Dual Eligible Population

Despite the instinct to develop only fully integrated care systems for dual eligibles, research has shown that specialty behavioral health organizations are well suited for those beneficiaries with behavioral health disorders, especially those with serious mental illness. Specialty behavioral health organizations typically have a history of dedicating attention to development of specialty services, provider networks, recovery-oriented treatment planning, and enhanced care coordination, including for medical services.

Each jurisdiction has a unique set of opportunities and challenges when considering how to best integrate services for dual eligibles in their state, but we strongly recommend preserving the specialty behavioral health option for dual eligibles with behavioral health disorders as a viable option for each state.

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Association for Behavioral Health and Wellness
Bazelon Center for Mental Health Law
Mental Health America
National Alliance on Mental Illness
National Council for Community Behavioral Healthcare