



Testimony

of

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before the

**New York City Council Committee on Mental Health, Developmental Disability,
Alcoholism, Drug Abuse & Disability Services**

on

Oversight: Medicaid Managed Care and Behavioral Health Services

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Good morning Chairman Cohen and members of the Committee. I am Gary Belkin, Executive Deputy Commissioner of the Division of Mental Hygiene for the New York City Department of Health and Mental Hygiene. Thank you for the opportunity to testify on the important issue of Medicaid Managed Care and mental health and substance use services, an area I will refer to as ‘behavioral health services’.

Before I discuss the topic at hand, I want to acknowledge that this is my first time addressing the Council and this Committee, and I am honored to do so. To tell you a little bit about myself, I joined the Department in August, following 10 years at the City’s Health and Hospitals Corporation, which is the largest provider of mental health services in the City. I most recently served as the Corporation’s Medical Director for Behavioral Health. As a psychiatrist with over 20 years of work in the field of behavioral health, I have focused on ways to improve service delivery and develop effective public policy in urban health systems. I am thrilled to have joined the Health Department and to work with the Council to improve behavioral health outcomes for all New Yorkers.

Background

The issue before us today is pressing and far-reaching: Medicaid costs in New York State have grown exponentially over the last several decades and are no longer sustainable. Part of the problem is that State dollars spent on behavioral health services have not always been used efficiently. To start with, New Yorkers with behavioral health conditions have received treatment and other clinical services on a fee-for-service basis, meaning a provider is paid for each specific service they provide an individual without adequate consideration for the quality, necessity, or effectiveness of the care that is received.

Historically, there has also been little systemic coordination of all these individually provided services, and an over-reliance on expensive hospital in-patient services. In-patient hospital stays in New York represent over 50 percent of behavioral health Medicaid costs and the State has some of the longest lengths of hospital stays in the country. The lack of coordination has also resulted in New Yorkers receiving their behavioral and physical health care separately, often engaging individuals in two distinct systems with different regulations, oversight bodies, reimbursement schemes and data. In addition, because of the common co-occurrence of behavioral health and medical conditions, and the destructive effects of those combinations, behavioral health outcomes have become a key driver of excess costs for physical health care. For example, the vast majority of overall hospital re-admissions statewide are by individuals with a behavioral health condition.

Through managed care, the State looks to address these issues. In a managed care approach, the State will pay a monthly per person rate to a managed care insurance plan, creating incentives for plans and providers to provide more preventive services, identify problems earlier,

and better coordinate care and recovery, with the end goals of improved overall health outcomes and reduced costs. While most of the physical health care paid for by Medicaid has been “managed” for several years, behavioral health services have not. So this will be a substantial change.

Managed Care and Behavioral Health

While there are potentially substantial gains to be made from this shift, putting this vision into practice will be neither easy, nor quick. Since 2011, when overall Medicaid reform began, the City has been working with the State on the oversight of integrated managed care services, and we have been deeply invested in preparing for how to apply these changes to the behavioral health system. The Administration was able to successfully advocate that plans manage and coordinate individuals’ behavioral health *and* physical care together. All Medicaid recipients who need behavioral health services, approximately 2.5-3 million New Yorkers, will have their care provided within such Medicaid managed care plans.

In addition, a subset of these plans, known as Health and Recovery Plans, or “HARPS” will also offer an enhanced package of benefits of psychosocial services and supports to eligible New Yorkers with particularly complex behavioral health needs, an estimated 85,000 individuals. Ten plans have applied to be certified as managed care plans generally, and seven of those have applied to also provide the HARP benefit. The Department is working closely with the State to ensure they all meet the required standards of care.

The move to managed care has the potential for enormous benefits for New Yorkers with behavioral health needs, but I want to acknowledge that it is not without its risks and uncertainties, and ensuring a successful transition will require a concerted effort by multiple parties on a number of fronts.

First, plans and providers must understand the new services. To that end, the Department has convened regular meetings with managed care plans; we have also submitted extensive information to the State to help inform development of a draft service plan, a document that describes Medicaid-billable services.

Second, providers and plans will need to develop strong relationships and a level of standardization in their interactions. In conjunction with our community partners, such as the Coalition for Behavioral Health Agencies, the Department has started to facilitate opportunities for plans and providers to come together to exchange information and build relationships. We will also convene the State’s Regional Planning Consortium, a group with representation from plans, providers, and service participants which will discuss issues of standardization, performance, service planning, and resource allocation.

Third, providers will need the infrastructure necessary to support documentation, data collection, and billing in the new system. To help with this, the Department has provided training in evidence-based practices that will help providers meet the anticipated demands of

Medicaid-reimbursable services. We recognize that there are providers struggling under the current system and we have met with many of them to problem-solve and recommend resources. The Department is also engaged in conversations with the State to explore whether there are other funds available to support the use of electronic health records by community providers. In recognition of the fact that many providers have not billed Medicaid before, starting this month the State will provide technical assistance opportunities to providers.

Fourth, the statute which establishes managed care for behavioral health under Medicaid authorizes and expects the Department to exercise “joint” oversight with the State Department of Health, Office of Mental Health and Office of Alcoholism and Substance Abuse Services. We are in the process of working with these State partners to more clearly define these oversight functions and understand what capabilities and expertise will be needed to take them on, and what aspects of plan performance, individuals’ experiences, and systems quality and resources, we need to keep track of. In this regard, the Department is an active participant in the plans’ readiness reviews, which are site visits to check all aspects of a managed care plan’s business, such as computer systems and staffing, as well as in the construction of performance metrics and the oversight process.

Finally, because individuals will need to qualify for and agree to enroll in a HARP, enrollment processes need to be easy to navigate, and care linkage must be quick. The Department is working with the State on a pilot to ascertain how well the State mandated screening tool identifies New Yorkers in need of these services. We are also currently assessing what additional resources the Department may need to ensure the effective dissemination of information to Medicaid beneficiaries, as well as perform the monitoring functions I just described. We are hopeful that the Council may be in a position to help support these efforts, and look forward to discussing this with you in the upcoming months.

The move to managed care for behavioral health services begins for New York City adults on April 1, 2015. But the Department is similarly engaged in the children’s managed care changes that are expected to take effect January 2016, including the development of adequate benefit packages, care coordination and transition planning, and outcome and quality measures.

We believe managed care can help individuals in New York City recover from behavioral health issues, reduce hospitalizations, and address many of the physical health conditions these patients also face. This transition provides real and rare opportunity for our system to substantially improve care. But it is also complex, evolving, and challenging. We look forward to working with the Council to educate and prepare the community on the impact of these changes and to realize their potential for improved outcomes and care.

Thank you for the opportunity to testify. I am happy to take any questions.