Behavioral Health Integration and Medicaid: has the Tipping Point arrived?

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Rationale for BH Integration

- Global disability
- Worse morbidity and mortality
- $293 Billion additional costs due to MH and SUD co-morbidity to medical disorders (Milliman report, 2014)
- Mental Health Parity
- ACA and focus on increasing value (improve quality and lower costs)
- Medicaid Reform
Medicaid Policy Levers

- DSRIP – Collaborative Integration in Primary Care and BH settings
- Qualified Behavioral Health (QBH) – Mainstream BH benefits for all patients must show evidence of integration
- Health and Recovery Plans (HARP) – BH benefits must show evidence of integration along with access to HH and HCBS services
DSRIP Challenges for Integration Projects

• Broad variation in models permitted but may not be attainable for many practices because of resource limits
• Quality Measures are NOT directly linked to integration process and outcome measures
• Workforce Training and Capacity
• Financial sustainability

PPS leadership and advocacy will be critical
Challenges for QBH and HARP

• Ability for managed care plans to foster integration at the implementation levels are limited in traditional FFS payment model
• Wide variation in patients that will need HH type care coordination but information sharing between treating organizations are severely limited
• Coordination between PPS entities who have PPS members that belong to multiple PPS entities presents confusion conundrum
• BH agencies may be under severe financial strain in the transition

Transition to value based payment and organizational partnership (formal and informal) will be tested
So Are We at a Tipping Point for BH Integration?