



Behavioral Health Management of Substance Use Disorder Services

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SAMSHA:

**New York State should remain
consistent with SAMSHA policy
philosophy**



“The good and modern system must account for the different functions that are performed within various parts of the mental health and addiction delivery system”.

SAMHSA



SAMHSA Good and Modern System of Care

- Healthcare Home/ Physical Health
- Prevention and Wellness
- Engagement Services
- Outpatient and Medication Services
- Community and Recovery Support(Rehabilitative)
- Other Supports (Habilitative)
- Intensive Support Services
- Out-of-Home Residential Services
- Acute Intensive Services



No Matter the Contract Arrangement

- Many large states manage Medicaid behavioral health (BH) benefits through a specialized behavioral health entity whether they are carved in or carved out.
- New York State Medicaid for SUD is a combination of carved in / out services and patients.
- The plan benefits vary greatly from state to state.
- Small group of experienced BH management entities.



Medicaid Managed Care

- MBHO organizations offer the experience, infrastructure, data capabilities that are very attractive.
- How you capitate payments to the MCO/BHO has to take into account population specific needs.
- Integration of physical health and behavioral health has many advantages but has rarely been achieved on a large scale.
- 12 MBHO control 90% of the Behavioral Health covered lives in commercial insurance.
- Most Behavioral Health in commercial and Medicaid plans are managed by BHO entities with some level of at-risk sub-contracting.



New York State

Medicaid and Commercial Managed Care Experience with SUD services



The New York State Medicaid Managed Care SUD Benefit Package
 What is the current Medicaid Managed Care benefit package for SUD services?
 OR
 What's Carved-In and What's Carved-Out (FFS)?

Service	Covered by MMC Plan	Additional Comments
Medically Managed Detoxification	Yes for all enrollees**	
Medically Supervised Inpatient Withdrawal	Yes for all enrollees	
Chemical Dependence Inpatient Rehabilitation	Yes for Non SSI enrollees No, for SSI enrollees	Available through Medicaid FFS for SSI enrollees **
Opioid Treatment (MMTP)	No	Carved-out service, available through Medicaid FFS for all enrollees
Chemical Dependence Outpatient Clinic Programs	No	Carved-out service, available through Medicaid FFS for all enrollees
Medically Supervised Outpatient Withdrawal	Yes for all enrollees	
Outpatient Chemical Dependency for Youth Programs	No	Carved-out service, available through Medicaid FFS for all enrollees



The New York State Medicaid Managed Care SUD Benefit Package
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OR

What's Carved-In and What's Carved-Out (FFS)? (cont'd)

- **** Homeless individuals in NYC are exempt from enrollment in managed care. New York Social Services Law §364-J**
- **Outside of NYC mandatory enrollment in managed care is subject to the discretion of the LDSS**



Commercial Rules: History and Future Considerations with Parity

- Any large group (50 or more employees) commercial/HMO, Blanket or Article 43 insurer **must provide outpatient chemical abuse and dependence services as a benefit under its contract. Coverage must include:**
 - 60 out-patient visits per year (including at least 20 visits for family members)
 - Any Group (commercial/HMO), Blanket or Article 43 insurer that provides coverage for inpatient hospital care must also **make available inpatient coverage for the diagnosis and treatment of alcohol and substance abuse and dependence. Coverage must include at least:**
 - 7 days detoxification per year
 - 30 days of in-patient treatment per year
 - In New York State coverage for the treatment of chemical abuse and dependence must be provided for services rendered in an OASAS certified facility, even if the services were rendered by a practitioner who would not otherwise be reimbursed under a policy. An insurer may restrict coverage to facilities which are certified by OASAS.
- With Parity the intent is to equalize access to behavioral health and physical health services. However as parity details are under development, lessons learned from past experience must continue to inform policy.



Commercial Rules: History and Future Considerations with Parity (cont'd)

- NYS Department of Insurance issued a Circular letter in 2009 (#20) that makes clear that the interplay between the Federal Parity law and the NYS Insurance Law results in the following:
 - The NYS visit limits are a floor and not a ceiling – you can go higher.
 - The make available provisions (7days detox, 30 days in-patient treatment) are now mandates.
- NYS DOH also issued guidance clarifying that the Federal Parity law applies to the state Medicaid system including the benefits currently being managed.



OASAS Experience with Behavioral Health Management

- OASAS conducted a survey in 2009-10 of its providers regarding their experience with commercial insurance and the following issues were identified as:
- Stringent use of Medical Necessity Criteria that was not known to SUD providers and/or appeared more relevant to MH care (danger to self or others) to approve inpatient care.
- Medicated Supported Recovery not fully supported by plans. Including but limited to: Denials of Methadone and Buprenorphine treatment as a non-covered service.
- Denial of coverage for services performed by a CASAC: despite law prohibiting plan denials based on practitioner certification / licensure.
- Questionable criteria for higher levels of care –for example, failure at lower level of care.
- Denial of court ordered services as non medically necessary. State statute / Medicaid contract resolved issue by requiring plans to honor court orders but implementation continues to be problematic.



Lessons Learned

- There must be some consideration of high utilizers of BH services and capitation must include risk adjustments.
- Calculations of capitation need to be transparent.
- Existing providers should be protected through relatively open panels but held to outcomes.
- Benefit package should be well defined and reflective of effective practice.
- Prices need to support cost.
- APG exercise may be a good place to start in looking at population ambulatory service utilization patterns and cost.
- Integration should not be achieved at the expense of specialization.



Summary of Consideration Areas for SUD Services in a Managed Care Environment: SUD Considerations/Further Discussion

- Population
- Access
- Benefit
- Utilization Review and Level of Care Determination
- Workforce
- Evidence-based Treatments
- System
- Performance Measures



Population

SUD Population is:

- Less likely to have Medicaid/Medicare as a payer (40% of patients are non-Medicaid).
- More likely to be referred by criminal justice or other social mandating agency.
- Have shorter lengths of stay.
- Need more visits within an episode of care.
- Access “Medication Supported Recovery” including methadone treatment.



Access

SUD System has:

- More reliance on public funded and non-profit OASAS certified facilities—few private options
- Generally short wait for outpatient care – Community Residence or other housing supports can be much more difficult to access
- Lower caseloads
- Shorter episodes of outpatient care



Benefit

- Access to continuum of care including: Crisis/Detox services; inpatient, long-term residential, supportive housing and outpatient services
- Care Coordination is a lacking resource in SUD treatment
- Peer-based services are critical
- APG exercise for both OMH and OASAS has identified a starting point for outpatient services benefit
- Benefit package should support Medicated Supported Recovery: including but not limited to Methadone; Buprenorphine; and, other medications as appropriate.
- Methadone Maintenance treatment in the benefit
- Parity needs to be enforced through both benefit package and capitation rates.



Utilization review and Level Of Care

SUD treatment:

- Tools for determining medical necessity and level of care determination should: be specific to the clinical needs of the SUD populations; and, consistent with accepted SUD clinical assessment tools (ASAM PPC)
- Court-ordered vs. MCO clinical necessity criteria
- Visit thresholds that acknowledge the differences in patterns of SUD service delivery
- Reviewers with specific SUD credentials and experience



Workforce

The SUD workforce:

- Clinical staff that are not licensed working on a physician led multidisciplinary team
- Scope of practice that is more narrow but specialized
- Many recovering clinical staff as role-models
- Staff are less familiar with managed care requirements, MCO language and expectations



Evidence-based Practices (EBPs)

- Some EBP's have shown efficacy across behavioral health conditions eg: cognitive behavioral therapy(CBT); Dialectical behavior therapy(DBT); and motivational interviewing(MI).
- EBP's have addiction specific manuals, protocols and issues that require specialized knowledge of addiction disorders essential to service delivery.
- Addiction treatment should see an increase in the use of Medication Supported Recovery options as new medications are discovered and current medications continue to show efficacy.



System

- Need for coordination with criminal justice and other social mandating agencies
- Lack of case management resources
- Continuum of care differs across SUD and MH
- Social and Recovery supports essential to positive outcomes



Performance Measures

- Behavioral Health and particularly SUD indicators lacking in the Healthcare Effectiveness Data and Information Set (HEDIS).
 - NOTE: (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.
- The Washington Circle has some treatment initiation and continuation metrics specific to SUD treatment.
- There is a need for good measures of quality treatment and patient outcomes specific to SUD treatment.



Issues for this Group

- Capitation and contract requirements will either support and improve the system or can limit access and negatively impact quality of care.
- Mental Health and SUD treatment have many commonalities and some significant differences that need to be considered for both capitation and contracting.
- Electronic Medical Records: e.g. single shared record and related confidentiality / privacy concerns.



Integration

1. What is the best way to achieve integration without risking resources or specialization?
2. What role for the BHO in Health Homes? Should BHOs serve as Health Homes? Serve as identifiers and referents?
3. Should BHOs manage all non-commercial patients regardless of payer source?
4. Is it time to allow for significant primary care in behavioral health settings? Currently capped at 5% due to CON reform



Additional Consideration

Recommendations for BH Services (SUD and MH)

- Transparency in setting capitation – especially in an “all-in” arrangement to ensure that BH and PH dollars are spent in those areas and not used to offset losses.
- Consideration of similarities in behavioral health and distinct needs/specialty in each discipline – BHO must show expertise in each.
- BHO to provide Health Home services and play an active role in referring and perhaps as a payer for care coordination services.
- BHO, if it is to maintain separation, must find ways to integrate care with MCO and PCP.
- Recommend removing cap for PC services in BH settings.
- Anchor clinic role for MH and SUD (Methadone) programs in Health Homes.



Additional Consideration

Recommendations for BH Services (SUD and MH) (cont'd)

- Existing providers should be protected through relatively open panels but held to outcomes.
- Screening/ Brief Intervention (SBIRT) for SUD and MH in all Health Homes for all chronic populations; and, other service venues as appropriate.
- Use the Phase I BHO to bring plans and treatment providers together to develop common definitions of treatment, outcome measurements, and assessment tools that lead to common agreement of need for and expected lengths of stay based on risk factors and then manage the benefits of those who exceed the norm.
- Savings on BH and PH spending should be reinvested particularly in other Recovery Support Services i.e. housing, vocational, etc.



What are some of the most promising Management Strategies?

- Health Navigators
- Health Homes
- Nurse/Clinician managers for chronic conditions
- Carve-in arrangements that allow for integration of Physical Health and Behavioral Health Management while maintaining the specialization of Behavioral Health providers: eg. one approach is to allow the BHO to manage the whole care of the patient with co-morbidity and assume the whole risk



General Patient Statistics

- 261,775 unique individuals were treated in the OASAS system in 2010. Many individuals were seen in multiple modalities.
 - 172,734 individuals received outpatient services
 - 50,962 individuals received crisis (detox) services
 - 45,631 individuals received outpatient Methadone services
 - 34,212 individuals received inpatient rehabilitation services
 - 25,319 individuals received residential services



How much Fee For Service Medicaid is spent annually on SUD treatment services?

<u>SUD Service Type</u>	<u>Dollars in Millions spent in SFY 2010</u>
All SUD services	\$870.1
Crisis/Detox Services (all levels)	\$191.3
Inpatient Rehabilitation Services	\$170.3
Outpatient Services	\$284.8
Opioid Treatment Services	\$202.4
Residential Rehab Services for Youth	\$ 21.3



OASAS Medicaid Fast Facts

(based on SFY 2008,2009 and 2010 eMedNY data)

- SUD services were provided to 159,429 unique recipients (60% of the total Medicaid population served) in 2010 (FFS claims only). Many recipients received services at multiple modalities.
 - The greatest number of recipients were served in outpatient programs (115,104), followed by Opioid Treatment (36,115), Crisis/Detox (25,102), inpatient (18,440) and Residential Rehab Services for youth (1,373)
 - Over 1.75 billion dollars was spent to provide non-SUD services to recipients of SUD services in SFY 2010
- Of the approximate 2.5 million people in NYS age 18 and over eligible for Medicaid, 5.5% received SUD services in SFY 2008
- Statewide trends indicate the number of individuals served and Medicaid dollars spent on Crisis/Detox, Inpatient and Opioid treatment services has been steadily declining; while the units of service and Medicaid dollars spent on non-SUD services for the SUD population has increased.



Key Recommendations for the SUD System

- SBIRT must be part of all Health Home patient assessments
- Phase I BHO's must be active participants in Health Home enrollment, assignment and service delivery
- The 5% cap on physical health services provided in BH setting must be eliminated
- The existing MATS program must be preserved and care coordination must be expanded throughout the SUD system via Health Homes

