

A decorative header image featuring a red-tinted view of the Statue of Liberty's head and crown on the right, and a perspective view of a grid pattern of lines extending towards the left.

Redesign Medicaid in New York State

Implementing Medicaid Behavioral Health Reform in New York

MRT Behavioral Health Managed Care Update

October 4, 2013

Agenda

- ❑ Introductions
- ❑ Timeline
- ❑ Review of BH Benefit Design
- ❑ Project Update
- ❑ MCO Data Book Highlights
- ❑ Children's Workgroup Update
- ❑ Discussion and Feedback
- ❑ Highlights of Draft RFQ
- ❑ Discussion and Feedback
- ❑ Regional TA Sessions
- ❑ Next Steps

NYS MEDICAID BEHAVIORAL HEALTH TRANSFORMATION IMPLEMENTATION TIMELINE



*Rest of State (ROS) - Implementation for ROS will take place six months later starting with plan submission of RFQs.

Review of BH Benefit Design

BH MRT Workgroup Recommendations

Recommendation	In Progress
Create risk-based managed care for high-need populations	√
Financing for Behavioral Health Managed Care	√
Formal mechanism for reinvestment	√
Governance of behavioral health managed care entities	√
Work with local government/NYC oversight role	√
Contract Requirements	√
Care coordination and Health Homes into new plans	√
Addition of nonclinical services promoting recovery	√
Standardized assessments	√
Improving Behavioral Health Care in Primary/Non-specialty settings	√
Evaluate mainstream MC on more BH performance measures	√

BH MRT Workgroup Recommendations

Recommendation	In Progress
Promote HIT and HIE	Separate DOH initiative
Specialty Managed Care (HARP) Performance Measurement	√
Track spending on BH and other services separately	√
Children, Youth and Families Recommendations	Separate schedule
Peer Services and Engagement	√
Peer Services should be part of benefit in specialty managed care	√
Advance and Improve the Peer Workforce	Separate OMH and OASAS initiatives
Services for the Uninsured	Separate MRT initiative

Principles of BH Benefit Design

- ✓ Person-Centered Care management
- ✓ Integration of physical and behavioral health services
- ✓ Recovery oriented services
- ✓ Patient/Consumer Choice
- ✓ Ensure adequate and comprehensive networks
- ✓ Tie payment to outcomes
- ✓ Track physical and behavioral health spending separately
- ✓ Reinvest savings to improve services for BH populations
- ✓ Address the unique needs of children, families & older adults

BH Benefit Design Models

Behavioral Health will be Managed by:

- ✓ Qualified Health Plans meeting rigorous standards (perhaps in partnership with BHO)
- ✓ Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs

Qualified Plan vs. HARP

Qualified Managed Care Plan

- ❑ Medicaid Eligible
- ❑ Benefit includes Medicaid State Plan covered services
- ❑ Organized as Benefit within MCO
- ❑ Management coordinated with physical health benefit management
- ❑ Performance metrics specific to BH
- ❑ BH medical loss ratio

Health and Recovery Plan

- ❑ Specialized integrated product line for people with significant behavioral health needs
- ❑ Eligible based on utilization or functional impairment
- ❑ Enhanced benefit package. Benefits include all current PLUS access to 1915i-like services
- ❑ Specialized medical and social necessity/ utilization review approaches for expanded recovery-oriented benefits
- ❑ Benefit management built around expectations of higher need HARP patients
- ❑ Enhanced care coordination expectations
- ❑ Performance metrics specific to higher need population and 1915i
- ❑ Integrated medical loss ratio

Proposed Menu of 1915i-like Home and Community Based Services - HARP's

❑ Rehabilitation

- ❑ Psychosocial Rehabilitation
- ❑ Community Psychiatric Support and Treatment (CPST)

❑ Habilitation

❑ Crisis Intervention

- ❑ Short-Term Crisis Respite
- ❑ Intensive Crisis Intervention
- ❑ Mobile Crisis Intervention

❑ Educational Support Services

❑ Support Services

- ❑ Case Management
- ❑ Family Support and Training
- ❑ Training and Counseling for Unpaid Caregivers
- ❑ Non- Medical Transportation

❑ Individual Employment Support Services

- ❑ Prevocational
- ❑ Transitional Employment Support
- ❑ Intensive Supported Employment
- ❑ On-going Supported Employment

❑ Peer Supports

❑ Self Directed Services

Project Update

Behavioral Health Progress Report

Completed:

- ❑ Finalized initial HARP selection criteria
- ❑ Finalized list of State Plan Services added to scope of benefits including:
 - ❑ *PROS, ACT, CPEP, CDT, IPRT, Partial Hospitalization, TCM*
 - ❑ *Opioid Treatment*
 - ❑ *Outpatient Chemical dependence rehabilitation*
 - ❑ *Clinic*
 - ❑ *Inpatient (SUD and MH)*

Behavioral Health Progress Report continued...

- ❑ Completed Tasks Continued...
 - ❑ Provided Plans with member specific files showing initial FFS and MMC expenditures
 - ❑ Provided Plans with specific information on services and volume
 - ❑ Identified recommended 1915(i)-like services
 - ❑ Established initial network requirements
 - ❑ Selected functional assessment tool

Behavioral Health Progress Report Continued....

□ In Progress:

- Continue Plan/Provider readiness meetings
- Finalize year 1 quality and performance measures
- Set premiums (Plan data book should be released shortly)
- Determine other financial expectations
- Finalizing draft 1115 Waiver amendment for submission to CMS
- Finalizing RFI (questions and draft RFQ) for October release

Open Issues

- ✓ Finalizing Plan experience and staffing requirements
- ✓ Finalizing standards for Plan utilization and clinical management criteria
- ✓ Defining final network adequacy and access requirements
- ✓ Assessments and conflict free case management
- ✓ Finalizing transitional payment provisions for OMH/OASAS licensed or certified providers
- ✓ Rate setting including the 1915i-like services
- ✓ Finalize benefit package including 1915i-like services and care coordination
- ✓ Determine mechanism for BH reinvestment
- ✓ Obtaining approval from CMS



FIDA

Fully Integrated Dual Advantage
Program

FIDA Background

- August 26, 2013, CMS announced State/Federal Partnership to implement a demonstration to better serve persons who are eligible for Medicare and Medicaid.
- DOH & CMS will contract with Fully Integrated Dual Advantage (FIDA) Plans that will provide integrated benefits to members residing in NYC, Nassau, Suffolk and Westchester Counties.
- The demo will begin July 1, 2014 and continue until December 2017.

FIDA Background

- The FIDA demo will provide enrollees a better care experience by offering person-centered, integrated care that is more easily navigable to all covered Medicare and Medicaid services.
- NYS is the 7th State to establish a FIDA MOU with CMS
- FIDA will be a capitated model serving 170,000 Medicare-Medicaid enrollees—about 15% will be persons with BH service needs.



Memorandum of Understanding (MOU)

- ❑ The Memorandum of Understanding between CMS and NYSDOH was signed on August 26, 2013
- ❑ Demonstration is approved and implementation will proceed in accordance with the terms of the MOU – running from July 2014 through December 2017
- ❑ Through this Demo, NYSDOH and CMS are testing the delivery of fully integrated items and services through a capitated managed care model



MOU - Network Adequacy and Access

- Highlights of the Network Adequacy standards listed in Appendix 7 of the MOU. Networks:
 - Have at least 2 of every provider type necessary to provide covered services;
 - All providers' physical sites must be accessible;
 - Must meet minimum appointment availability standards;
 - Must have an adequate number of community-based LTSS providers to allow Participants a choice of at least two providers of each covered community-based LTSS service within a 15-mile radius or 30 minutes from the Participant's ZIP code of residence; and
 - Ensure that Participants with appointments shall not routinely be made to wait longer than one hour.



MOU – Covered Benefits

- Covered Benefits Include:
 - Services covered under Medicare
 - Medicaid State Plan services including OMH/OASAS certified
 - HCBS Waiver Services, e.g. TBI, LTHHCP, NHT&D
 - All Medically Necessary services as defined in social services law.
 - FIDA Plans will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines.
 - FIDA plans will have discretion to supplement covered services with non-covered services or items where so doing would address a Participant's needs, as specified in the Participant's Person-Centered Service Plan.



Resources

FIDA e-mail:

FIDA@health.state.ny.us

Subscribe to our listserv:

http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm

'Like' the MRT on Facebook:

<http://www.facebook.com/NewYorkMRT>

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MCO Data Book Highlights

MCO Data Book Highlights

- ❑ Data book based on CY 2011 and CY 2012 data
- ❑ Data book includes:
 - ❑ NYS eligibility data
 - ❑ Managed care encounters
 - ❑ Fee-for-service (FFS) claims
- ❑ Covered populations:
 - ❑ Limited to adults ≥ 21
 - ❑ Encompasses managed care eligibles during CY 2011 and CY 2012
 - ❑ Includes individuals who will be eligible for managed care by January 2015

MCO Data Book Highlights

□ Data summaries:

- Displayed by region and current premium group
- Separate premium group for HARP eligibles
- Separate BH and physical health components of the HARP integrated premium
 - ▣ OMH and OASAS have identified service criteria to define the Behavioral Health (BH) component of the premium
- Detail shown so that utilization and dollars based on managed care encounters is distinguishable from utilization and dollars from FFS claims

MCO Data Book Highlights

- ❑ Mercer will need to make adjustments to the data book for premium setting. Adjustments will be made for:
 - ❑ Trend factor increases, managed care adjustments, and administrative load
 - ❑ Planned changes in the State Plan for the coverage of certain services
 - ❑ Adjustments for the additional 1915(i) services available to HARP eligibles
 - ❑ Any other changes in covered services or covered populations that are not reflected in the base data, but will be covered prior to or upon implementation of the BH/HARP changes

Children's Managed Care Update

Children's Workgroup Update

- ❑ The Kids Leadership Team is meeting with the MRT Children's BH Subcommittee on October 21
- ❑ The Children's Managed Care Transition workplan has been revised to reflect the new January 2016 implementation date
- ❑ Mercer has begun to provide technical assistance to the Kids Workgroup on Phase 1 of the workplan to arrive at more detail with regard to Program and Policy Design
- ❑ A listserv has been launched to communicate on a regular basis with stakeholders

Discussion and Feedback?

Overview of Draft RFQ

RFQ Performance Standards

- ❑ Organizational Capacity
- ❑ Experience Requirements
- ❑ Contract Personnel
- ❑ Member Services
- ❑ HARP Management of the Enhanced Benefit Package (HCBS 1915(i)-like services)
- ❑ Network Services
- ❑ Network Training
- ❑ Utilization Management
- ❑ Clinical Management
- ❑ Cross System Collaboration
- ❑ Quality Management
- ❑ Reporting
- ❑ Claims Processing
- ❑ Information Systems and Website Capabilities
- ❑ Financial Management
- ❑ Performance Guarantees and Incentives
- ❑ Implementation planning

Experience and Personnel

- ❑ The RFQ establishes extensive BH experience and staffing requirements as recommended by the MRT. However,
 - ❑ Medicaid Managed Care Plans manage a limited range of behavioral health services in NYS
 - ❑ Many Plans have limited experience serving and providing care management for populations with high needs
 - ❑ Plan provider network may be inadequate or lack expertise to deliver specialty and recovery-oriented MH/SUD services
 - ❑ Covered populations needing BH services vary greatly by Plan and region
- ❑ NYS is considering accepting alternative demonstrations of experience and staffing qualifications for Qualified Plans and HARPS

Proposed Staffing Requirements

Table 1: Draft MCO BH Staffing Requirements

Qualified Managed Care Plan	HARP
<p>Key BH personnel:</p> <ul style="list-style-type: none"> • BH medical director: Psychiatrist • BH associate medical director: Addiction medicine/psychiatry • BH clinical director <p>Required personnel:</p> <ul style="list-style-type: none"> • BH UM administrator • BH UM supervisors • BH network development administrator • BH provider relations administrator • BH QM administrator • BH IT specialist: BH data systems experience • Governmental/community liaison <p>Other personnel:</p> <ul style="list-style-type: none"> • UM/care management staff: • Peer advisors: Psychiatrists, psychologists • QM specialists • Provider relations staff, in NYS • Agency liaisons • Additional staff to handle increased volume of claims, member service calls, grievance/appeals, reporting, etc. • Training administrator • Peer/family support specialists 	<p>All Staffing for Qualified Plans Plus:</p> <ul style="list-style-type: none"> • Chief executive officer: 10 years relevant BH experience • Chief medical officer: MD in internal medicine, family practice, etc. • HCBS administrator¹: Five years HCBS experience regulatory requirements, three years SMI experience preferred • Addictions administrator: • HARP UM/care management staff • Recovery specialists to monitor compliance with HCBS assurances and sub-assurances

Member Services

- The RFQ requires the creation of BH service centers with several capabilities such as
 - Provider relations and contracting
 - UM
 - BH care management
 - 24/7 capacity to provide information and referral on BH benefits and crisis referral
- These can be co-located with existing service centers

Preliminary Network Service Requirements

- ❑ Plan's network service area consists of the counties described in the Plan's current Medicaid contract
- ❑ There must be a sufficient number of providers in the network to assure accessibility to benefit package
- ❑ Proposed transitional requirements include:
 - ❑ Contracts with OMH or OASAS licensed or certified providers serving 5 or more members (threshold number under review and may be tailored by program type)
 - ❑ Pay FFS government rates to OMH or OASAS licensed or certified providers for ambulatory services for 24 months
 - ❑ Transition plans for individuals receiving care from providers not under Plan contract.

Preliminary Network Service Requirements

- ❑ Ongoing standards require Plans to contract with:
 - ❑ State operated BH “Essential Community Providers”
 - ❑ Opioid Treatment programs to ensure regional access and patient choice where possible
 - ❑ Health Homes
- ❑ Plans must allow members to have a choice of at least 2 providers of each BH specialty service
 - ❑ Must provide sufficient capacity for their populations
- ❑ Contract with crisis service providers for 24/7 coverage
- ❑ HARP must have an adequate network of Home and Community Based Services

Network Training

- ❑ Plans will develop and implement a comprehensive BH provider training and support program
- ❑ Topics include
 - ❑ Billing, coding and documentation
 - ❑ Data interface
 - ❑ UM requirements
 - ❑ Evidence-based practices
- ❑ HARPs train providers on HCBS requirements
- ❑ Training coordinated through Regional Planning Consortia (RPCs) when possible – RPCs to be created

Utilization Management

- ❑ Plans prior authorization and concurrent review protocols must comport with NYS Medicaid medical necessity standards
- ❑ These protocols must be reviewed and approved by OASAS and OMH in consultation with DOH
- ❑ Plans will rely on the LOCADTR tool for review of level of care for SUD programs as appropriate

Clinical Management

- The draft RFQ establishes clinical requirements related to:
 - The management of care for people with complex, high-cost, co occurring BH and medical conditions
 - Promotion of evidence-based practices
 - Pharmacy management program for BH drugs
 - Integration of behavioral health management in primary care settings
- Additional HARP requirements include oversight and monitoring of:
 - Enhanced care coordination/Health Home enrollment
 - Access to 1915(i)-like services
 - Compliance with HCBS assurances and sub-assurances (federal requirements)

Cross System Collaboration

- ❑ Plans will be required to sign an agreement with the RPC for purposes of:
 - ❑ Data sharing
 - ❑ Service system planning
 - ❑ Facilitating Medicaid linkages with social services and criminal justice/courts
 - ❑ Coordination of provider and community training
 - ❑ Ensuring support to primary care providers, ED, and local emergency management (fire, police) when BH emergent and urgent problems are encountered
- ❑ Plans must meet at least quarterly with NYS and RPCs for planning, communication and collaboration
- ❑ Plans work with the State to ensure that Transitional Age Youth (TAY) are provided continuity of care without service disruptions

Plan Quality Management

- ❑ BH UM sub-committee to review, analyze, and intervene in such areas as:
 - ❑ Under and over utilization of BH services/cost
 - ❑ Readmission rates and average length of stay for psychiatric and SUD inpatient facilities.
 - ❑ Inpatient and outpatient civil commitments
 - ❑ Follow up after discharge from psychiatric and SUD inpatient facilities.
 - ❑ SUD initiation and engagement rates
 - ❑ ED utilization and crisis services use
 - ❑ BH prior authorization/denial and notices of action
 - ❑ Pharmacy utilization
- ❑ Sub-committee monitors performance based on State established performance metrics
- ❑ HARP BH sub-committee also tracks:
 - ❑ 1915(i)-like HCBS service utilization
 - ❑ Rates of engagement of individuals with First Episode Psychosis (FEP) services

Claims Processing

- ❑ The Plan's system shall capture and adjudicate all claims and encounters
- ❑ Plan must be able to support BH services
- ❑ Plans must meet timely payment requirements

Discussion and Feedback

Regional TA Sessions

Potential Topics for Regional Technical Assistance Sessions

- ❑ Introduction to State Medicaid BH services and 1915(i) services
- ❑ Community options for detox
- ❑ Understanding the role of care coordination for high-needs populations
- ❑ Plan/Provider networking session
- ❑ Contracting and credentialing in a managed care environment
- ❑ Provider and Plan billing preparedness

Next Steps

Overview of Next Steps

- ❑ Release RFI
- ❑ Regional Plan/ Provider Technical Assistance Sessions
 - ❑ Establish Plan/Provider subcommittees to help organize regional TA sessions
- ❑ Facilitate Creation of Regional Planning Consortia
- ❑ Continue to Work with CMS on 1115 Waiver
- ❑ Post final RFQ/ qualify Plans