Redesign Medicaid in New York State

Implementing Medicaid Behavioral Health Reform in New York

Applicant's Conference

May 2, 2014

Agenda

- Introduction
- Purpose
- Rates
- Performance Measures
- Process
- Questions and Answers
- Next Steps/Timeline

Purpose

- Review Purpose of the HARP
- Review Answers to Selected RFQ Questions

BHO Phase I Summary: Service Gaps and Opportunities

1. Inpatient providers had low rates of communicating with outpatient providers and arranging for follow-up after discharge.

2. Health Home care coordinators typically were not notified of inpatient admissions and rarely visited hospitalized enrollees to coordinate care.

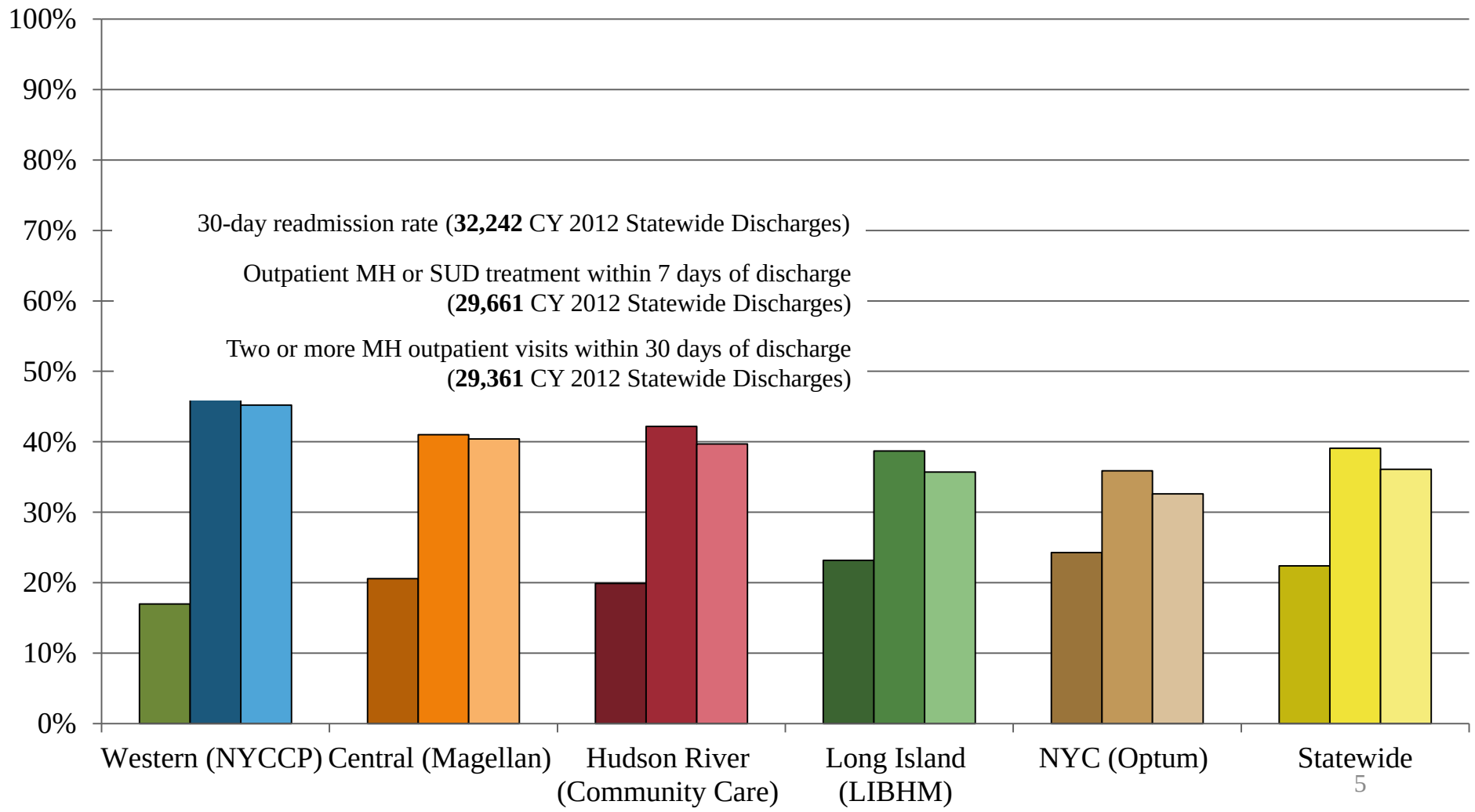
3. Inpatient providers had low rates of referring individuals for physical health follow-up when medical problems requiring follow-up were identified.

4. Rates of individuals attending outpatient appointments in within 7- and 30-days of discharge from inpatient behavioral health units were under 50% for all service types and markedly lower than those seen in current NYS Medicaid managed care covered populations.

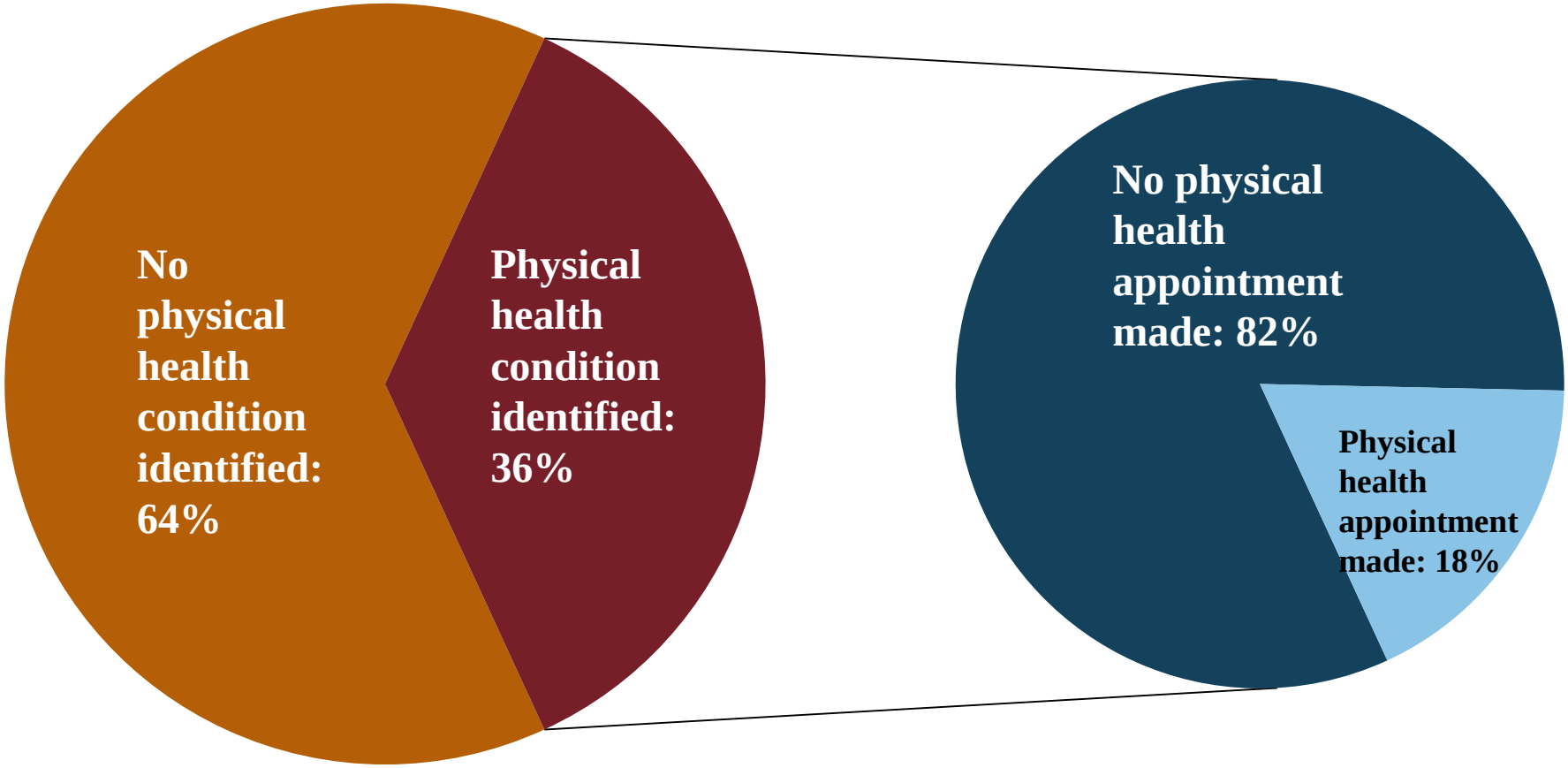
5. Outpatient providers demonstrated little incentive to engage recently discharged individuals or follow-up when individuals missed appointments following inpatient care.

6. 30-day inpatient readmission rates were over 20% for adult individuals hospitalized on mental health units. 45-day readmission rates were over 30% for individuals treated on inpatient SUD units.

Post-discharge outcomes for Adult Mental Health fee for service discharges, 2012 YTD



Integrated care: How often did behavioral health inpatient providers identify general medical conditions requiring follow-up, and did they arrange aftercare appointments?



Based upon 56,167 behavioral health community discharges (all service types), January 2012—June 2013

Data submitted by BHO

Health Home Highest Risk Population – Multiple Co-occurring Complex Disease so Care MUST Be Integrated

Chronic Episode Diagnostic Categories
Health Home Eligibles Adults 21+ Years
With a Predictive Risk Score 75% or Higher (n=27,752)

Percent of Adult Recipients with Co-Occurring Condition

Condition	Total	Severe Mental Illness	Mental Illness	Subst-ance Abuse	Hyper-tension	Hyper-lipidemia	Diabetes	Asthma	Congest-ive Heart Failure	Angina & Ische-mic Heart Disease	HIV	Obesity	Osteo-arthritis	COPD & Bronch-iectasis	Epilepsy	CVD	Kidney Disease
Severe Mental Illness	43.5	100.0	74.7	77.2	33.8	28.1	23.2	34.1	6.8	8.5	9.6	14.8	23.2	13.9	20.1	31.9	10.9
Mental Illness	46.2	70.4	100.0	70.9	42.0	33.7	28.0	35.8	11.0	12.6	8.7	16.9	29.9	17.8	19.4	41.0	16.4
Substance Abuse	54.4	61.9	60.3	100.0	35.4	25.9	21.4	32.8	7.5	9.4	11.2	10.7	23.1	14.5	16.4	34.4	11.2
Hypertension	37.6	39.1	51.6	51.1	100.0	47.4	41.4	30.7	28.2	22.1	5.6	17.8	29.3	22.6	13.9	62.2	30.8
Hyperlipidemia	29.8	41.0	52.2	47.1	59.8	100.0	54.9	37.7	27.8	33.4	5.6	23.6	30.9	25.1	15.0	70.4	31.5
Diabetes	27.8	36.3	46.5	41.8	56.0	58.8	100.0	35.4	25.7	25.3	5.4	24.3	28.1	22.8	13.2	64.9	34.3
Asthma	28.3	52.4	58.5	62.9	40.8	39.7	34.8	100.0	15.3	17.4	12.3	22.0	34.3	33.0	16.7	47.7	18.4
Congestive Heart Failure	13.4	22.1	37.9	30.6	79.5	61.9	53.5	32.3	100.0	41.2	4.1	21.1	26.1	33.9	8.9	100.0	50.3
Angina & Ischemic HD	12.2	30.5	47.8	41.8	68.2	81.5	57.6	40.3	45.1	100.0	4.6	24.1	33.8	31.5	11.7	100.0	41.9
HIV	8.3	50.2	48.4	73.5	25.2	20.0	18.1	41.9	6.7	6.8	100.0	4.9	26.6	16.4	13.2	31.1	17.9
Obesity	12.7	50.5	61.4	45.8	52.6	55.4	53.1	49.0	22.2	23.1	3.2	100.0	39.3	25.7	16.5	60.1	27.2
Osteoarthritis	22.1	45.7	62.7	56.8	49.9	41.8	35.5	44.0	15.8	18.7	10.0	22.7	100.0	25.5	15.1	52.0	24.9
COPD & Bronchiectasis	15.5	38.8	53.0	50.6	54.7	48.1	40.7	60.1	29.2	24.8	8.7	21.0	36.1	100.0	14.0	67.2	27.0
Epilepsy	13.5	65.1	66.6	66.3	38.8	33.2	27.2	35.1	8.9	10.6	8.1	15.6	24.8	16.2	100.0	41.1	16.3
CVD	41.9	33.2	45.3	44.6	55.9	50.2	43.1	32.3	32.0	29.2	6.2	18.3	27.4	25.0	13.2	100.0	35.4
Kidney Disease	18.8	25.2	40.4	32.4	61.5	49.9	50.6	27.6	35.8	27.2	7.9	18.3	29.1	22.3	11.7	78.6	100.0
Total	**100.0**	**43.5**	**46.2**	**54.4**	**37.6**	**29.8**	**27.8**	**28.3**	**13.4**	**12.2**	**8.3**	**12.7**	**22.1**	**15.5**	**13.5**	**41.9**	**18.8**

Note: Diagnosis History During Period of July 1, 2010 through June 30, 2011

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

NYC HIV HARP RATES

Region:	New York City
Rating Group:	HIVSNP HARP
Contract Period:	January 1, 2015 - December 31, 2015
2012 Member Months:	47,908
Trend Months:	36

Expense Type	Final Medical PMPM with Trend
Behavioral Health Medical Expenses	$ 589.29
Acute Care Medical Expenses	$ 1,868.73
Gross Medical Expenses	**$ 2,458.02**
Managed Care Savings	$ (34.72)
	-1.4%
New Benefits Adjustments	
Pharmacy	$ 2,893.82
FHPlus Additional Benefits	$ -
SUD SPA Services	$ 0.66
Stop-Loss Adjustments	
Inpatient Psych Estimated Recoveries	$ (0.55)
General Inpatient Estimated Recoveries	$ (25.94)
Gross Medical Expenses	**$ 5,291.30**
Non-Medical Expense Loads	
Administrative Expenses	**$ 301.22**
	5.3%
Underwriting Gain	**$ 56.49**
	1.0%
Rates with Admin/Underwriting Gain	**$ 5,649.01**

Notes:

1. CY 2012 member months are based on eligibility data for HARP eligible FFS and MC enrollees.
2. Data reflects only members age 21 and over.
3. In some cases totals may not equal the sum of their respective column components due to rounding.
4. The Inpatient Psych Stop-Loss reflects estimated recoveries under the current Inpatient Psych Stop-Loss proposal with expected managed care savings.
5. The General Inpatient Stop-Loss adjustment reflects net estimated recoveries with expected managed care savings, but does not yet reflect updates to the premium to include SUD services.
6. All maternity services are excluded from this exhibit.
7. Health Homes and Medical Homes are excluded from this exhibit.
8. The rates do not include consideration for State/HIPF taxes.

NYC HARP Rates

Region:	New York City
Rating Group:	Non-HIVSNP HARP
Contract Period:	January 1, 2015 - December 31, 2015
2012 Member Months:	943,429
Trend Months:	36

Expense Type	Final Medical PMPM with Trend
Behavioral Health Medical Expenses	$ 855.36
Acute Care Medical Expenses	$ 1,146.81
Gross Medical Expenses	**$ 2,002.17**
Managed Care Savings	$ (134.01)
	-6.7%
New Benefits Adjustments	
Pharmacy	$ 445.51
FHPlus Additional Benefits	$ 4.28
SUD SPA Services	$ 44.06
Stop-Loss Adjustments	
Inpatient Psych Estimated Recoveries	$ (19.34)
General Inpatient Estimated Recoveries	$ (35.28)
Gross Medical Expenses	**$ 2,307.39**
Non-Medical Expense Loads	
Administrative Expenses	**$ 184.49**
	7.3%
Underwriting Gain	**$ 25.17**
	1.0%
Rates with Admin/Underwriting Gain	**$ 2,517.05**

Notes:

1. CY 2012 member months are based on eligibility data for HARP eligible FFS and MC enrollees.
2. Data reflects only members age 21 and over.
3. In some cases totals may not equal the sum of their respective column components due to rounding.
4. The Inpatient Psych Stop-Loss reflects estimated recoveries under the current Inpatient Psych Stop-Loss proposal with expected managed care savings.
5. The General Inpatient Stop-Loss adjustment reflects net estimated recoveries with expected managed care savings, but does not yet reflect updates to the statewide premium to include SUD services.
6. All maternity services are excluded from this exhibit.
7. Health Homes and Medical Homes are excluded from this exhibit.
8. The rates do not include consideration for State/HIPF taxes.

Year 1 HARP Performance Measures

- Year One Performance Measures
  - Existing HEDIS/QARR measures for physical and behavioral health for HARP and MCO product lines
  - Development of a limited number of new behavioral health measures
    - New measures can be derived from claims and encounter data
    - First year in QARR will be reported in aggregate only
    - Measures include MH outpatient engagement, MH and SUD readmission, linkages to ambulatory care for SUD, and medicated assisted treatment for SUD. Specifics are under development.
  - BHO Phase One measures will continue to be run administratively
  - Measures are also being proposed for HARPs that are based on data collected from HCBS eligibility assessments. These measures are related to social outcomes – employment, housing, criminal justice, social connectedness, etc.

Year 1 HARP Performance Measures

- Member Satisfaction – all are existing QARR measures
  - Based on CAHPS survey
  - A recovery focused survey for HARP members is also being developed. Measures derived from this survey may be created in the future

RFQ: Questions and Answers

FAQ Review Process

- We will review questions received by April 30th and provide answers.
- Answers will be forthcoming to questions received by close of business April 30 if they were not answered today.
- Answers will be posted on the DOH, OMH and OASAS websites as quickly as possible.
- You will be able to ask additional questions today. However, all answers provided by NYS must be considered preliminary answers.
- Final answers will be posted as soon as possible on the DOH, OMH, and OASAS websites.

1915(i)

Q: With expanding the BH/SUD benefits and adding the 1915(i) like services, can NYS provide direction regarding possible services that are duplicates?

- Federal rules require that, with the exception of crisis services, the need for 1915(i) services must be identified in a person centered plan of care.
- The person centered plan is developed based on information obtained through a comprehensive assessment as well as other sources.
- The plan of care must identify the need for Medicaid state plan services, non-Medicaid services and any 1915(i) services.
- To the extent that a person's needs can be met through state plan services, the individual would not receive 1915(i) services.

1915(i)

Q: Will physicians from the higher levels of care BH/SUD be able to recommend 1915(i) like services without utilizing the assessment?

A: No. The need for 1915(i) services must be identified in a person centered plan of care. Providers cannot just prescribe 1915(i) services.

1915(i)

Q: What role is the plan expected to play in creating provider capacity to deliver new 1915(i) services if there are gaps?

A: NYS has committed to the initial development of 1915(i) services.

- For the first two years of implementation, 1915(i) Home and Community Based Services will be paid on a non-risk basis by the Plans. Plans will act as an Administrative Services Organization (ASO) for NYS with regard to these services.
- NYS will identify and designate 1915(i) providers, provide a services manual, and establish initial 1915(i) payment rates. Plans will be able to recommend additional 1915(i) providers, subject to review by NYS.
- Plans will need to contract with a sufficient network of 1915(i) providers to meet the needs of their members.

1915(i)

Q: § *Crisis Services.* Please provide additional information on the options available to providers to develop crisis/step-down beds and to convert existing residential beds into crisis beds?

- Some OMH licensed housing providers are requesting to convert some of their group home physical plans to crisis residences.
- The existing funding for the housing services would fund the same number of units in rental housing freeing up the building.
- Providers will need a business plan to demonstrate the crisis residence is sustainable from funding by health Plans.

1915(i)

Q: Are 1915 Services excluded from the Mainstream Plans but included in the HARP?

- 1915(i) services are only available to individuals enrolled in the HARP and only if they are identified in their person centered plan of care.
- "In-lieu of" services could be identical to 1915(i) services for individuals in Mainstream Plans where 1915(i) services are not available.
- A HARP may also chose to use "in-lieu of" services to pay for additional 1915(i) services beyond those allowable under the per person hour or dollar cap established by NYS.
- Dollars for "in-lieu of" services will be paid by the Plans from their premium and are not separately reimbursed by NYS.

1915(i)

Q: What will the process be for authorizing providers to offer 1915i services? Will this require licensure or certification? (Section 1.9/3.6)

A: NYS will designate 1915(i) providers and licensure is not required.

Health Home

Q: Please clarify the definition of "health home care coordination" and the difference between the role of the health home and the role of plan.

A: NYS continues to work with Plans and Health Homes to clarify the roles and responsibilities of Plans and Health Homes regarding care coordination. The general expectation is that Plans and Health Homes work as a team to improve the care that is delivered to Medicaid members:

- Health Homes provide care coordination services, including comprehensive care management and the development of person centered plans of care; health promotion, comprehensive transitional care; patient and family support; and referral and connection to community and social support services, including non-Medicaid Services.

- Plans use data to identify individuals in need of high touch care management; identify patients disconnected from care, notify Health Homes when members show up in ERs and inpatient settings; and, monitor Health Home performance under a set of standards to be developed.

Health Home

Q: What type of entity will provide the conflict free assessment?

- Subject to CMS approval for members enrolled in a Health Home, the assessment will be completed by the Health Home with appropriate firewalls approved by CMS.
- Individuals who are not enrolled in a Health Home will have the assessment administered by the enrollment broker.
- NYS will be providing additional guidance on this subject.

Health Home

Q: Will HARP plans be authorized to provide Health Home services? (Section 1.8/1.9)

A: No. However, the state is looking at allowing Plans to develop an interim care management approach for HARP members until all HARP members are enrolled in Health Homes.

Health Home

Q: With HARP initiation on January 1, 2015 in NYC, what will the timeframe be for members currently unassigned to be enrolled in a Health Home? (Section 1.8/1.9)

A: NYS is working to enroll as many NYC HARP eligible members as possible prior to January 1. The expectation is that Plans will work to enroll members in Health Homes as rapidly as possible.

Network

Q: In the initial draft of the RFQ, it states alternative "new" program to reduce costs would have to be approved by DOH prior to implementation, is that still the case?

- NYS is balancing the need to safely transition the behavioral health system and service recipients into manage care with the need to transform the system to a more effective, community based and recovery oriented system.
- The RFQ establishes several transitional network requirements including the following:
  - Contracts for a minimum of 24 months with OMH or OASAS licensed or certified providers serving 5 or more members
  - Payment of FFS government rates to OMH or OASAS licensed or certified providers for ambulatory services for 24 months
  - Plans and providers wishing to negotiate alternative payment methodologies for the first 24 months following implementation may do so pending State approval and subject to compliance with State and federal law.
  - During the first two years of implementation, alternative payment arrangements must further the states' behavioral health transformation objective.
- Guidance from NYS will be issued at a later date

Network

Q: If a plan can document a good faith effort, but is unable to agree to a contract with a provider, will these good faith efforts satisfy the requirement that plans contract with the specified type and required number of providers in Section 3.6?

- NYS expects that Plans make every effort to comply with the contracting requirements in Section 3.6.
- NYS recognizes that there may be some circumstances or areas of the State where the requirements in Section 3.6 cannot be completely met.
- If a Plan cannot meet all Section 3.6 requirements, NYS will review the reasons why on a case by case basis and work with the Plans to ensure that the intent of these requirements is met as effectively as possible.
- In the first 2 years government rates will be used, so price will not be an issue.

Network

Q: Will Medicaid FFS rates be applied to all outpatient services, not just clinic services? (Section 1.11)

A: Medicaid FFS rates will be applied to all OMH licensed and OASAS certified providers for 24 months.

Network

Q: Will members of HARP plans have access to the same medical and specialty networks as members of other service lines in the MCO? (Section 3.5)

A: Since HARPs are a line of business within existing Plans, NYS expects that HARP members have the same access to medical and specialty care as members in the mainstream Plan.

Eligibility and Enrollment

Q: Who does the assessments to determine HARP eligibility. Also what data was used to design the policy.

- In general, HARP eligibility is based on a combination of behavioral health diagnosis and behavioral health service history (both Medicaid reimbursed and other). These are explained on pages 16-18 of the RFQ.
- Additionally, other individuals eligible for Medicaid managed care may enroll in the HARP if they have a behavioral health diagnosis and serious functional deficits as identified through the completion of a HARP eligibility screen.
- These may be people with a first episode psychosis; people leaving jail or prison; people discharged from a State psychiatric hospital, or people identified by the Local Governmental Unit (LGU)

Enrollment and Eligibilty

Q: Is it anticipated that some HARP eligible members will move out of HARP plans in the future and, if so, what will be the process and criteria for such a determination? (Section 1.8/1.9)

A: HARP members are free to change Plans according to the current managed care rules. At this time, there is no mechanism for involuntary disenrollment of HARP members.

Integrated Care

Q: How will NYS modify provider expectations/requirements to align with plan expectations, e.g., integration of physical and behavioral health?

A: The integration of physical and behavioral health care is a key priority for New York State.

- NY is now developing an integrated license for providers and expects to issue these licenses throughout NYS in 2015.
- Over the next few years New York State DOH, OMH and OASAS will work with Plans to develop steps to achieve integration in primary care settings.
- The HARP will have an integrated premium and staffing requirements to reflect this priority.
- The RFQ also requires mainstream Plans to implement programs to manage complex and high-cost, co-occurring BH and medical conditions.
- Plans must also provide training for provides on integrated care.
- The RFQ has several integrated care requirements and specifically asks Plans to describe their experience with and/or planned approach to implementing BH-medical integration initiatives in section 4G.

Court Ordered Services

Q: Regarding Section 1.7.B.viii,

- How will the state insure appropriate involvement of the responsible MCO in the legal aspects of psychiatric care and will the state be providing guidance to the plans allowing them to manage members through the legal system.
- Will MCOs be responsible for patients admitted through the judicial system? If so how will the criteria be established and will it be a collaborative effort between the health plans, law enforcement, judiciary and the state?

- Plans will be responsible for the costs of court-ordered services in the benefit packages.
- The criteria for court-ordered admissions are statutory.
- Plans are urged to engage all parties, including relevant legal and judicial entities, in collaborative dialogue to effectively manage the services provided to their enrollees.

Court Ordered AOT

Q: Regarding Section 4.0.G, question 11, how will the Plan know that a member has received an AOT?

- AOT plans are managed the Director of Community Services in each county. As required in Section 3.3Q, Plans will need to have liaison staff to work with a number of member serving systems including counties.
- Plans will be provisioned with information on who has an active AOT order.
- Details on data provisioning and data sharing agreement requirements will be forthcoming.

Court Ordered AOT

Q: Regarding Section 4.0.G, question 11, are plans expected to contract and coordinate with all AOT service providers similar to other provider types?

- Assisted Outpatient Treatment (AOT) is court-ordered participation in outpatient services for certain people with serious mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision.
- An AOT treatment plan may involve a variety of different services delivered by different providers. These providers may or may not be under a Plan contract.
- Plans must reimburse for these court-ordered services as per the terms of the model contract, provided that such ordered services are within the Plan's benefit package and Medicaid reimbursable.
- Plans are responsible for ensuring that the AOT plan of care is being met; that AOT reporting requirements are being met; and that people with an AOT court order are assigned to the proper level of care management.

Training

Q: Regarding training requirements in Section 4.0.E, relating to provider training, is there be an expectation that plans work jointly to provide universal training?

- Whenever possible, training and education for providers should be provided in coordination with the Regional Planning Consortiums (RPCs).
- In NYC, this function will likely be managed by the NYC Department of Health and Mental Hygiene.
- RPCs will be created in a number of regions of the State to guide behavioral health policy in that region, problem solve regional service delivery challenges, and recommend provider training topics.

Services

Q: Please clarify "In lieu" services (see page 14). Are these services different from 1915i services? What is the approval process?

- Federal rules require that, with the exception of crisis services, the need for 1915(i) services must be identified in a person centered plan of care. Access to these services is also capped by hours and total dollars.
- Once a 1915(i) service is in an approved plan of care, the individual is entitled to receive that service.
- In contrast, unless they are prevented by contract, a Plan may provide cost-effective alternative services ("in-lieu of") that are in addition to those covered under the Medicaid State Plan. These "in-lieu of" services are alternative treatment services and programs.
- "In-lieu of" services could be identical to 1915(i) services for individuals in Mainstream Plans where 1915(i) services are not available. A HARP may also chose to use "in-lieu of" services to pay for additional 1915(i) services beyond those allowable under the per person hour or dollar cap established by NYS.
- Dollars for "in-lieu of" services will be paid by the Plans from their premium and are not separately reimbursed by NYS.

Services

Q: Is there a process for plans to seek approval for "in lieu of" services? (Section 1.10)

A: No specific process is necessary. Plans may provide "in-lieu" of services unless such services are prohibited by the federal government or by their contract with the State.

Services

Q: Item G.1 states, "Please attach your proposed clinical management guidelines for all levels of BH care." And item F.1 states: "Attach the responder's proposed utilization review criteria for all levels of BH care."

By clinical management guidelines, is the State referring to level-of-care utilization review criteria or another type of guideline?

- Question F.1 asks plans to submit their UM/level of care guidelines.
- Question G.1 asks plans to tell us which guidelines they will adopt, disseminate, and implement to support specific evidence-based practices.
- Plans should tell us what guidelines they will use for the EBPs listed in 3.10.K.vi and add others they to propose to use.

UM

Q: Will limits on opioid treatment services be allowed? (Section 1.10)

A: Opioid treatment should be managed based on medical necessity criteria with no mandatory limits applied. Long term opioid agonist and partial agonist treatment are evidence-based treatments for the management of opioid dependence.

Rates

Q: How will rates reflect the costs for administering and managing BH HARP requirements?

- HARP rates in NYC include 7.3% for administration and 1.5% for year 1 start-up costs. In NYC, this amounts to approximately $184.49 per member per month.
- This compares quite favorably to mainstream plans that only provide about $25 per member per month.

HIV

Q: Some behavioral health providers have interpreted certain sections of the RFQ to mean that HIV SNPs could only manage the HARP benefit for people enrolled in the HIV SNP (not HIV negative populations).

- At this time, an HIV/SNP approved to be a HARP would only be a HARP for its HIV members.
- NYS is considering options for non-HIV positive populations enrolled in an HIV/SNP.

Regulations

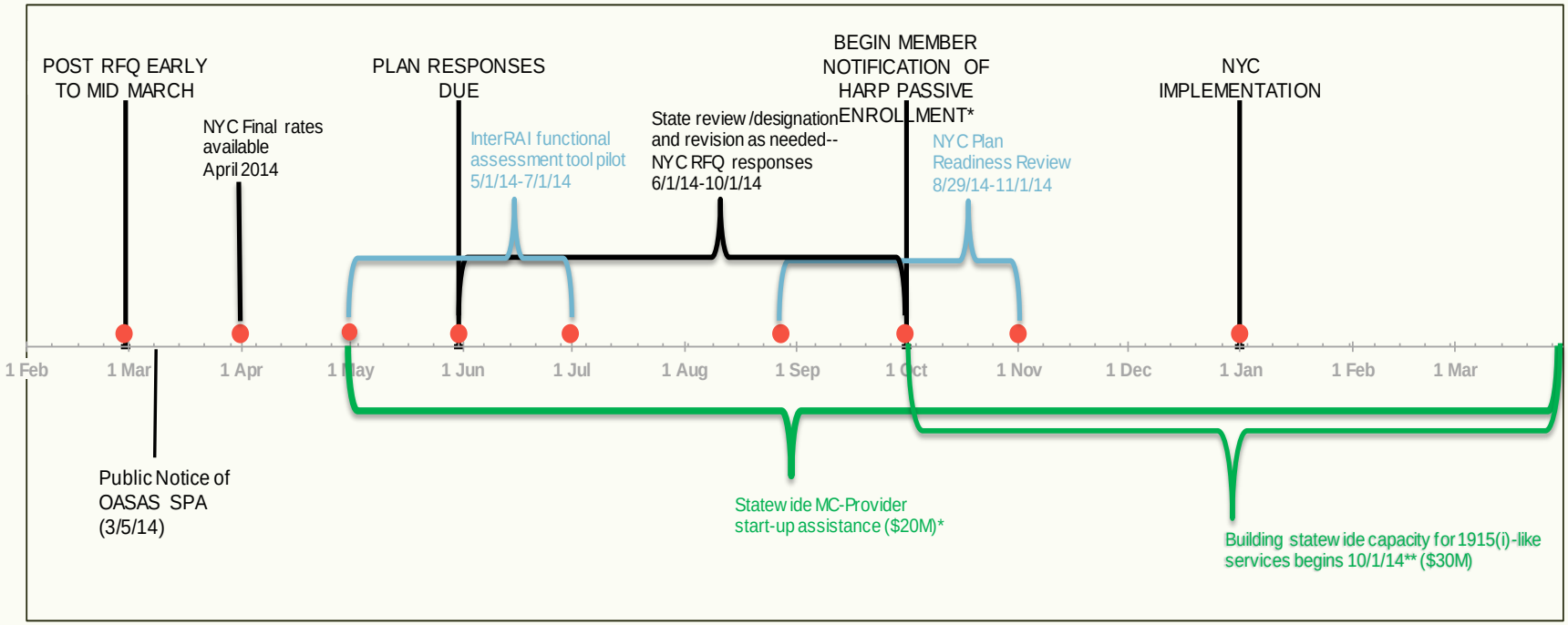
Q: What steps will NYS take to review and revise program regulations to insure consistency with managed care and encourage integrated services? (Section 1.10/3.5/3.6)

A: NYS will be creating a regulatory reform workgroup. Currently, NYS expects to begin this work in the fall of 2014.

Next Steps

Behavioral Health Manged Care Transition Timeline

NYC implementation 1/1/15



*Statewide MC-Provider start-up:
- Funds to ensure adequate networks are in place prior to implementation of BH MC
- Plan/Provider/HH technical assistance for electronic medical records and billing
- Funds to build BH provider (Children and Adults) infrastructure

**Building statewide 1915(i)-like service capacity involves:
- 1915(i)-like network development
- Funding 1915(i)-like functional assessments
- Funding for 1915(i)-like services starting January 1, 2015

2/11/2014