

## **MRT WAIVER AMENDMENT PROGRAMS TO BE IMPLEMENTED THROUGH STATE PLAN AMENDMENT AND MANAGED CARE CONTRACTS**

As discussed with CMS, implementation of the MRT Waiver Amendment reinvestment programs will be achieved in various ways. Many of the reinvestment programs will be implemented as part of New York's DSRIP plan, an overview of which accompanies this paper. Some MRT Waiver Amendment reinvestment programs will not be implemented through DSRIP. Instead, based on feedback from CMS, these programs will be implemented through State Plan Amendment (SPA) or contracts with managed care plans.

### **STATE PLAN AMENDMENT:**

New York would implement the **Health Home Development Fund** through the State Plan Amendment process, based on CMS feedback.

#### **Health Home Development Fund**

New York would implement the programs associated with the Health Home Development Fund through State Plan Amendment. The investment for all of the Health Home programs over five years would total \$525M. The State's Health Home program, which coordinates care for high need, high cost populations, is a permanent and critical part of implementing the "Care Management for All" component of the Medicaid Redesign Team's Action Plan and the "Triple Aim." In just about 20 months, 32 Health Homes, with comprehensive networks that include medical, behavioral, HIV, housing and social supports have been designated and are now operating. Each of those Health Homes have developed comprehensive networks designed to provide the six core care coordination services, including the use of HIT, mandated by the State Plan. Each of the Health Homes is at various stages in incorporating the use of Health Information Technology (HIT). As described in the approved State Plan, the success of the Health Home program in meeting its mission is dependent upon the efficient use and exchange of electronic health records and information to establish the required linkages between the Health Homes and their network partners.

Ensuring the long term stability and success of Health Homes will require significant State investments. To date, implementation resources available to these new and promising care coordination enterprises and their network partners have been limited to the Health Home per member per month fees and self-funded resources. Smaller providers, including behavioral health providers and community based organizations have not benefitted from HEAL and other technology investments. In many cases, this has presented implementation challenges and stymied efforts to build the infrastructure necessary to effectively transition Health Homes beyond their early stages of development. The ability to establish HIT and HIE linkages between Health Homes, care managers and other network partners is critical to communicate and share care management information.

Health Home Development Funds would support programs including:

**Member Engagement and Health Home Promotion** would help improve knowledge and awareness of the Health Home Program. Engagement would entail cultural competency in large cities with diverse linguistic and cultural demographics, transitions from criminal justice system to community and identifying community "hot spots" for service needs.

**Workforce Training and Retraining** would include the development of care management training/retraining programs that are focused on more comprehensive and multidisciplinary aspects of

the Health Home care management model; more specifically, leveraging and communicating best practices, including: successful outreach, engagement and care management strategies.

**Clinical Connectivity - Health Information Technology (HIT) Implementation** would address the uneven distribution of prior authorizations for HIT and HIE resources to Health Homes and their partners, including: smaller community based behavioral health and HIV programs that are key providers; efforts to establish linkages to other systems (e.g., criminal and juvenile justice, foster care and educational systems); and resources for the purchase of electronic care management software and the costs of buying RHIO connections, particularly for smaller community based care managers.

**Joint Governance Technical Assistance and Implementation Funds** to support technical assistance and start-up costs related to the formulation of joint governance models and the development of regional collaboration models for Health Homes. Waiver funds would be used to offset or reimburse some of the costs of developing joint governance organizations as well as offset or reimburse the necessity for capital contributions from partner organizations to support one-time implementation and readiness activities. Supporting the effective development of new governance structures is just one way Health Homes will shape a responsive health care delivery system based on the right care, at the right time, delivered by the right provider, with a single point of accountability. The development of this capacity will set the stage for more advanced Health Homes to evolve into Accountable Care Organizations.

Similar to the Vital Access Program, Health Home Development Funds will be distributed through a grant application process. The criteria and approach for monitoring the implementation and use of funds will be approved by CMS through the SPA process. Applications which address implementation challenges, leverage regional partnerships, link the care coordination network, and do not duplicate funds made available through other HIT investments (e.g., HEAL) or waiver resources will be prioritized for funding. HIT and HIE applications will be required to target technology to providers that have not had access to previous investments (e.g., behavioral health, smaller community based providers, non-hospital clinics). Successful applicants will receive a lump sum payment contingent upon providing details on how the funds will be used, including a description of how the applicant will address implementation or other challenges as well as providing a schedule for implementing those funds. Applicants will also be required to report on the actual disposition, use of the funds and the degree to which the funds addressed the intended challenges.

### **MANAGED CARE CONTRACTS:**

Several MRT Waiver Amendment reinvestment programs will be implemented through managed care contracts including **Primary Care Technical and Operational Assistance, Health Workforce Needs: Retraining, Recruitment and Retention, and 1915i Services**. New York recognizes that there are costs associated with implementing these programs. The funding for these programs would be provided through managed care capitation payments to plans. The programs will be benchmark-driven and New York will hold managed care plans accountable for achieving specific quality and performance outcomes.

#### **Primary Care Expansion: Technical and Operational Assistance**

Primary Care Expansion Technical and Operational Assistance will be implemented through expanded contractual agreements with Managed Care plans. The investment over five years would total \$305M. New York would require plans to provide technical and operational assistance that will enable providers in their network to expand access to primary and preventive care while maintaining high quality health care for Medicaid members. Plans will be required to meet established benchmarks in their new agreement though program development and provider network utilization. The State will evaluate the

implementation and outcomes of the program based upon agreed terms and conditions in their contract.

### **Health Workforce Needs: Retraining, Recruitment and Retention**

Health Workforce Needs: Retraining, Recruitment and Retention will be implemented through an increase in Managed Long Term Care (MLTC) capitation rates. The investment over five years would total \$245 M. MLTC plans would be required to invest in initiatives to attract, retrain, recruit and retain long term care professionals in the areas they serve. MLTC plans will also be required develop plans to address reductions in health disparities by focusing on the placement of long term care workers in medically underserved communities. Furthermore, MLTC plans will train needed workers to care for currently uninsured populations who will seek care under the Affordable Care Act expansion. Expanding home care and respite care enables those in need of long term care to remain in their homes and communities, while reducing New York's Medicaid costs associated with long term care. This will allow New York's Medicaid program to promote workforce flexibility, while lowering costs under managed care. The state would require MLTC plans to invest in workforce training for providers in their network that will prepare new long term care workers and build upon the skills of existing long term care workers to address the changes in the field.

Each MLTC plan would be required to submit to the state on an annual basis its retraining, recruitment and retention plan which the state would be required to approve. The state, in turn, would establish metrics for MLTC plans in terms of their ability to achieve the goals laid out in their workforce plan. After the workforce plan is implemented, the state would evaluate outcomes.

### **1915i Services**

New York will implement 1915i services through the development of a Managed Long Term Services and Supports (MLTSS) transition and Health System Transformation for Individuals with Serious Mental Illness (SMI) and Serious Substance Use Disorder Use. We propose that beginning January 1, 2014, FFP may be claimed for expenditures made for the MLTSS transition plan for individuals with SMI/SUD under 1115 amendment. The receipt of expenditure authority for the period of January 1, 2014 through implementation of the behavioral health MLTSS phase-in, is contingent upon the state development of a targeted pilot for assessment, network development, and person-centered planning for community based services for individuals with SMI /SUD. This pilot will test a process for assessment of individuals using the InterRAI and integration of the assessment results into a person-centered care planning approach for MLTSS. This pilot will also test strategies for the initial and ongoing development of a managed care provider network for the new 1915i-like services through the MCO delivery system, will develop tools to ensure compliance with all applicable rules, and will provide a strong basis of evidence of community capacity for MLTSS, providing basis for CMS' approval of major deliverables and ensuring a strong pathway for the behavioral health MLTSS transition.

Transition activities performed through the pilot eligible for FFP for the movement to behavioral health MLTSS will include the following:

- person-centered planning training for health plans, care managers and providers,
- network development and initial delivery of HCBS services included in the 1915i program,
- beginning the pilot on the resource allocation methodology outlined in the 1115 amendment,
- health plan readiness review results, and
- implementation of the necessary quality monitoring structures for the 1915i-like services.

Each quarter, New York will report the new capacity for home and community-based services for individuals with SMI /SUD to be supported in home and community-based settings as the system prepares to implement behavioral health MLTSS in January 1, 2015. Specifically, this will include the training of providers, care managers and State and MCO staff and development of a behavioral health assessment utilizing the InterRAI, a person-centered planning approach to develop a Recovery Plan to meet the beneficiary's needs in the least restrictive manner possible, and network development and initial delivery of such priority services as crisis intervention, mobile crisis teams, peer supports, and expanding over time to additional service capacity in such HCBS as supported employment, residential supports in community settings and through such means such as Permanent Supported Housing and Assertive Community Treatment. New York's' MLTSS transition for individuals with SMI /SUD represents a major system transformation consistent with the goals of Olmstead.

The investment over five years for this MLTSS transition would total \$1.357B. NYS has been engaged with a broad stakeholder group in designing a much more robust care management, treatment and social support system for addressing those with behavioral health disorders. The centerpiece of this effort is moving our currently carved out fee for service behavioral health services into an integrated managed care environment. Key to this will be the establishment of a special needs product called Health and Recovery Plans (HARPs) to bring additional focused care management, better service integration and new community support services through MLTSS and 1915i-like authorities. While it is the state's intention to build these community based recovery support services at the same time that the behavioral health benefits transition into managed care beginning in January of 2015, we see the opportunity to jump start some select critical 1915i-like capacities with IGT funding to support key services to help keep members from unnecessary hospitalizations. As discussed above these "quick start" services include, Intensive crisis intervention, mobile crisis intervention and peer supports. These services may be delivered on a fee for service basis (transitionally to bring up capacity for managed care), as part of managed care or both depending on the timing of the development and approval of these services.

Including 1915i-like services as part of an MLTSS pilot will provide a broader range of home and community based services (HCBS) to individuals living in the community to support member's recovery and to avoid hospitalization. In keeping with the MRT Action Plan and the "Triple Aim", obtaining authority to provide these critical 1915i services will enable individuals to access services tailored to their needs.

Three higher priority 1915i services; intensive crisis intervention, mobile crisis intervention and peer supports are proposed to be developed statewide to assist members struggling with starting or maintaining recovery in the community. The need for these services was continually raised throughout stakeholder session including MRT Public forums. Stakeholder engagement sessions, including our Medicaid member focus groups, generated a significant number of comments about the need to help patients (all patients not just those with behavioral health) with managing the complexities associated with all the change and transition in Medicaid and health care in general. Specifically, some suggested that peer community health workers should be utilized to assist complex patients' transition to managed care and health homes. Individuals living in supportive, community based settings will be able to access peer support services as well as crisis intervention as appropriate. The description for each service is provided below:

**Peer Support (PS)** services will be consumer-delivered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of

recovery-oriented principles such as hope and self-efficacy, and community living skills. Activities included must help achieve the identified goals or objectives set forth in the consumer's individualized care plan. The individualized care plan delineates specific goals that are flexibly tailored to the consumer, while attempting to utilize community and natural supports. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

Certified Peer Specialists are appropriately supervised treatment team members who will play an integral role in care planning, including: the Wellness Recovery Action Plan (WRAP), treatment planning and the development of psychiatric advance directives (PAD). Training for Peer Specialists will be provided/contracted by OMH and OASAS and will focus on the principles and concepts of recovery, coping skills, and advocacy. Peer services programming will extend beyond behavioral health and will include peer run wellness coaching, bridging and crisis services. The goal of these pilots is to launch and demonstrate the effectiveness of fidelity-level peer innovations for all 'high needs' Medicaid beneficiaries in areas of the state where they currently don't exist.

**Mobile and Intensive Crisis Intervention** - this service will interrupt and/or ameliorate the crisis experience and will include a preliminary assessment, immediate crisis resolution and de-escalation. The goals of Crisis Interventions are engagement, symptom reduction and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis. Crisis intervention is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, or on a mobile basis to other community locations where the person lives, works, attends school, and/or socializes.