Implementing Medicaid Behavioral Health Reform in New York

December 17th 2013
Agenda

- Goals
- Status and Project Timeline
- BH Benefit Design
- Overview of RFI/RFQ
- Next Steps
Key MRT initiative to move fee-for-service populations and services into managed care

Care Management for all

The MRT plan drives significant Medicaid reform and restructuring

Triple Aim:
- Improve the quality of care
- Improve health outcomes
- Reduce cost and right size the system
Draft RFI/RFQ released (Adults)

- Comments due 1/10/14

1115 BH Waiver Amendment (Adults)

- Draft with Centers for Medicare and Medicaid Services (CMS)
- Final amendment scheduled to be submitted to CMS December 30, 2013

Final RFQ scheduled for release February 2013 (Adults)
Project Status

- **Public Outreach**
  - Meet with MRT BH Workgroup early 2014
  - Provider/plan readiness meetings begin
    - January/February in NYC
    - March ROS

- **Implementation**
  - Adults in NYC - January 2015
  - Adults in Rest of State - July 2015
  - Children - January 2016
NYS MEDICAID BEHAVIORAL HEALTH TRANSFORMATION IMPLEMENTATION TIMELINE

2013
- September: Behavioral Health Databook (HARP & Non-HARP Spend Population)
- October: Distribute Draft RFI for Comments
- November: Post HARP & Non-HARP Rate Ranges
- December: 1115 Waiver & SPA Submission to CMS

2014
- February: Post Final RFQ with Pending Rates
- February - April: RFQ TA Conferences Plan
- February - April: Anticipated CMS Approval of 1115 Waiver
- May: NYC Plan Submission of RFQ
- May - August: NYC Plan Designations
- September - November: NYC Plan Readiness Reviews

2015
- January: Implementation of Behavioral Health Adults in NYC (HARP & Non-HARP)
- July: Implementation of Behavioral Health Children Statewide

2016
- January: Implementation of Behavioral Health Adults in Rest-of-State (HARP & Non-HARP)

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

AUGUST 2013
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
Behavioral Health will be Managed by:

- Medicaid MCOs (Qualified Health Plans) that qualify to provide the full array of BH/SUD services including those formerly carved out through:
  - Organizational Experience
  - Partnership with BHO or Experienced Vendors
- Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs
Qualified Plan vs. HARP

Qualified Managed Care Plan

- Organized as Benefit within MCO
- Medicaid Eligible age 21 and over
- Benefit includes Medicaid State Plan covered services
- BH benefit management coordinated with physical health benefit management
- Performance metrics specific to BH
- Plan Case/Care Management
- BH medical loss ratio

Health and Recovery Plan

- Specialized integrated product line for people with significant behavioral health needs
- Medicaid Eligible 21+ who meet targeting criteria and risk factors
- Benefits includes Medicaid State Plan covered services plus access to Home and Community Based (1915i) Services
- Benefit management built around higher need HARP patients - specialized medical and social necessity criteria/ utilization review
- Enhanced care coordination - All in Health Homes
- Performance metrics specific to higher need population and 1915i
- Integrated medical loss ratio
Behavioral Health Benefit Package

- Behavioral Health State Plan Services - Adults
  - Inpatient - SUD and MH
  - Clinic – SUD and MH
  - PROS
  - IPRT
  - ACT
  - CDT
  - Partial Hospitalization
  - CPEP
  - Opioid treatment
  - Outpatient chemical dependence rehabilitation
  - Rehabilitation supports for Community Residences
Proposed Menu of 1915i-like Home and Community Based Services - HARPs

- **Rehabilitation**
  - Psychosocial Rehabilitation
    - Rehab counseling, support & skills building to restore and develop skills to improve self management and functioning in community
  - Community Psychiatric Support and Treatment
    - Goal-directed supports, strength based planning/treatment and solution-focused interventions to assist individual, family, collaterals

- **Habilitation**

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

- **Education Support Services**

- **Peer Supports**

- **Support Services**
  - Family Support and Training
  - Training and Counseling for Unpaid Caregivers
  - Non-Medical Transportation

- **Employment Support Services**
  - Prevocational
  - Transitional Employment Support
  - Intensive Supported Employment
  - On-going Supported Employment

- **Self Directed Services**
Overview of RFI/RFQ
Request for Information

- **RFI Objectives**
  - Improve the RFQ content
  - Ensure a transparent, fair and inclusive qualification process

- RFI document contains specific questions, the draft RFQ, and a databook. Draft rates will be released before the final RFQ.

- RFI provides an opportunity to provide feedback on the proposed managed care design

- NYS will incorporate RFI feedback into the final RFQ
RFQ: Addressing BH Needs

- Establishes BH experience and organizational requirements as recommended by the MRT BH Workgroup
- Designed to address concerns and design challenges identified by the MRT BH Workgroup
Plan Qualifications

- Plans must meet State qualifications in order to manage BH services
  - Qualified mainstream plans
  - HARPS

- Plans may qualify by
  - Meeting experience requirements
  - Partnering with a Behavioral Health Organization or experienced vendor

- NYS will consider alternative demonstrations of experience and staffing qualifications for Qualified Plans and HARPS
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
The RFQ requires the creation of BH service centers with several capabilities such as

- Provider relations and contracting
- Utilization Management
- BH care management
- 7 day capacity to provide information and referral on BH benefits and crisis referral, prior authorization, and concurrent review if required

These should be co-located with existing service centers when possible
Plan’s network service area consists of the counties described in its current Medicaid contract

Proposed transitional requirements include:

- Contracts with OMH or OASAS licensed or certified providers serving 5 or more members
- 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

State open to modifying payment requirements based on Plan/Provider agreement
Preliminary Network Service Requirements

- 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 implement a comprehensive BH provider training and support program. Topics include:
  - Billing, coding and documentation
  - Data interface
  - UM requirements
  - Evidence-based practices
- HARPs must train providers on HCBS requirements
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
Clinical Management

- Additional HARP requirements include oversight and monitoring of:
  - Health Home services
  - 1915(i) assessments
  - Access to 1915(i)-like services
  - Compliance with conflict free case management rules (federal requirement)
  - Compliance with HCBS assurances and sub-assurances (federal requirement)
In order to manage new services Plans must:

- Meet CMS performance and quality requirements
- Understand how these services support community based living and avoid hospitalizations and ED visits
- Articulate their vision for network development, utilization management, access, and overall philosophy of services supportive of recovery
Plan Quality Management

- Plans will 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

- HARP tracks:
  - 1915(i)-like HCBS service utilization
  - Rates of engagement of individuals with First Episode Psychosis (FEP) services
Claims Processing

- The Plan’s system must capture and adjudicate all BH claims and encounters
- Plan must be able to support BH services
- Plans must meet timely payment requirements
Regional Planning Consortiums

- Cross system collaboration will be facilitated through Regional Planning Consortiums (RPCs)

- RPCs will be comprised of
  - LGUs in region
  - Provider representatives (mental health, substance abuse, child welfare system)
  - Consumer and family representatives
  - Health home leads, and
  - Medicaid MCOs
Regional Planning Consortiums

- RPCs will work closely with State agencies to
  - Guide behavioral health policy in the region
  - Problem solve regional service delivery challenges, and
  - Recommend provider training topics
    - When possible, Plan training for providers is coordinated through RPCs

- 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 quarterly with NYS and RPCs
Next Steps

- RFI comments due January 10, 2014
- Performance Metrics are in development and will be shared with stakeholders in future
- Final RFQ scheduled for release February 2013 (Adults)
- Implementation
  - Adults in NYC - January 2015
  - Adults in Rest of State - July 2015
  - Children - January 2016
Questions?