New York State

Request for Information

Regarding the

Draft Request for Qualifications for

Behavioral Health Benefit Administration:

Managed Care Organizations and Health and Recovery Plans

12/5/2013

Responder Contact Information

Please provide the following information

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Background

New York seeks to create an environment where managed care plans, service providers, peers, families, and government partner to help members prevent chronic health conditions and recover from serious mental illness and substance use disorders and where all New Yorkers with behavioral health conditions – regardless of severity – receive appropriate, high-quality care. This partnership will be based on full community inclusion, person centered care, and a belief that with support, people can recover from the effect of mental illness and substance use to lead productive and rewarding lives.

While much progress has been made in this regard, achieving New York State's vision for behavioral health requires that public policy continue to be redesigned and resources reallocated. For many adults with serious mental illness and/or substance use disorders, the broad array of treatment options is difficult to navigate. One result is that twenty percent of people discharged from general hospital psychiatric units are readmitted within 30 days, indicating that discharge planning often lacks connectivity to outpatient aftercare.

In addition, the current service system does not always ensure priority access to individuals with the highest needs; services provided by different clinicians are not always well-coordinated; and payments for the delivery of services are not always structured to provide incentives that promote recovery. Medicaid's behavioral health services are currently paid through a fee-for-service model which lacks accountability for outcomes and leads to fragmentation of care. Weak accountability and lack of proactive engagement contributes to readmissions, overuse of emergency rooms, poor outcomes, and public safety concerns.

Governor Cuomo, recognizing these challenges, has called for "a fundamental restructuring of (the) Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure". The Governor appointed a broadly representative Medicaid Redesign Team (MRT) to review and provide recommendations to achieve these objectives.

An MRT Behavioral Health (BH) work group was created to guide the restructuring of Medicaid behavioral health services.

Responding to the MRT recommendations for behavioral health, the New York State Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse (OASAS), and the Department of Health (DOH) are working in collaboration to create a plan for a comprehensive service delivery system that focuses on person centered coordinated care, health outcomes, sustainable cost control, and a more efficient administrative structure. Details of this system are outlined in the attached draft Request for Qualification (RFQ).

To ensure that the transformation of the behavioral health system has a positive and lasting impact on the behavioral health population, New York seeks input from all stakeholders on the draft service design through this Request for Information (RFI).

The following RFI questions are designed to provide stakeholders the opportunity for input into the proposed behavioral health managed care design. Stakeholder feedback will also help inform the second generation RFQ as well as guide NYS in the provision of Plan and Provider readiness assistance in preparation for BH managed care transition. The criteria described in the RFQ are draft and subject to change based on stakeholder feedback through this RFI and negotiations with the federal government.

Please read the draft RFQ prior to responding. Responses will be kept confidential.

Draft RFI Questions

The following questions are structured to reflect the content of the draft RFQ.

Organization, Experience, and Performance

As recommended by the MRT, the RFQ (Section 3.2) requires Plans to have extensive experience managing care for individuals with complex BH conditions. Currently, Medicaid Managed Care Plans only manage a limited range of behavioral health services in New York State (NYS). Many Plans have limited experience serving and providing care management for populations with high behavioral health needs and their provider network may be inadequate or lack expertise to deliver specialty and recovery-oriented mental health and substance use disorder services.

NYS encourages Plans to contract with managed behavioral health organizations (BHOs) to obtain the required behavioral health expertise. NYS is considering accepting alternative demonstrations of experience. The draft RFQ provides examples of the kinds of experience that the State is considering. The State is seeking input on the following:

1. What other kinds of experience, beyond subcontracting with a BHO, should NYS consider acceptable for Plans to manage BH services (e.g., serving similar managed care products and populations such as Managed Long Term Care (MLTC), HIV SNP, Homeless, Home and Community Based Waiver services)?

2. If Plans are subcontracting with a BHO, are there any functions which should not be permitted to be subcontracted?

3. In addition to Plan contract experience, what kinds of experience should Plan Behavioral Health leadership have that would be acceptable for Plans proposing to manage behavioral health benefits internally?

4. How should the experience requirements be differentiated between Qualified Mainstream Plans-and Health and Recovery Plans (HARPs)?

    a. How should NYS evaluate this alternate experience?

Personnel

The draft RFQ (Section 3.3) requires that Plans have sufficient staff to meet all contract requirements and performance standards and requires that all staff have the training, education, experience, orientation, and credentials to perform assigned job duties. In order to assure that Plans meet these requirements, the RFQ requires a range of BH professional staff (See Attachment D of the draft RFQ).

Under certain circumstances, NYS would consider providing staffing flexibility to Plans. The State is seeking input on the following:

1. How, if at all, should NYS scale HARP staffing requirements and standards for:
    a. Plans with small total enrollment?
    b. Plans with small BH populations?
    c. Plans with small HARP populations?
2. What factors should be considered when evaluating staffing flexibility requests from Plans that wish to share resources between their Qualified Mainstream Plans and HARPs to maximize efficiency? How does the State ensure the protection of the high-needs behavioral health focus of the HARP while ensuring high-quality behavioral health services generally via the Qualified Mainstream Plans?

Customer/Member Services

In section 3.4, the RFQ requires the creation of BH service centers with several capabilities such as provider relations; contracting; UM; BH care management; and 7 day capacity to provide information and referral on BH benefits and crisis referral.

1. What adaptations at the Plan level need to be made to accommodate the addition of these behavioral health services?
    a. Staffing expertise and volume?

b. Member to customer representative ratios?

c. Connections to community crisis responders and crisis respite centers?

Network Management

1. How can Plans ensure that their network of services is adequate to meet the needs of the Medicaid BH populations?
2. What guidelines should Plans use in their network selection process to identify and contract with providers that deliver 1915(i)-like services?
3. A key goal for NYS during the transition to Medicaid managed care is to ensure continuity of care and avoid rapid system destabilization. For at least the first 24 months of operation, this RFQ reflects a requirement that Qualified Mainstream Plans and HARPS offer contracts to behavioral health providers licensed or certified by OMH or OASAS who currently serve five or more Medicaid managed care enrolled beneficiaries.
    a. Do you agree with this approach? If so why and if not why?
    b. What additional/alternative approaches do you recommend and why?
4. How can NYS and Plans facilitate/expand the use of tele-medicine for behavioral health to improve access to network services?
5. A major goal of NYS is to ensure access to services when needed and divert individuals from emergency settings.
    a. How will Plans assure availability of ambulatory after-hours, weekend, and same day behavioral health services when necessary?
6. How can Plans assure that members are educated about the full range of services being added to their benefits?
7. How should capacity for 1915(i)-like services be developed?

8. How should NYS evaluate cost effective alternative services in rural areas if there is limited access to certain Plan services?

Utilization Management

1. NYS is requesting feedback regarding minimum standards for Plan behavioral health utilization management:

    a. If you are a Plan, are your utilization management standards proprietary?

    b. How should Plans inform members and network providers of their utilization criteria?

    c. How should Plans ensure that members and network providers understand their utilization management criteria?

    d. What, if any, behavioral health services should be provided without prior authorization? How should utilization be managed in these cases?

    e. How should current Plan utilization management practices be changed in response to the newly added behavioral health services and State and federal parity rules?

2. New York is adding a range of "non-traditional" Medicaid services to managed care (i.e., Home and Community Based "1915(i)-like" Services).

    a. What types of utilization criteria should be utilized for "non-traditional" Medicaid services?

    b. What patient specific Home and Community Based Service utilization service limits do you recommend? Upon what clinical/social criteria should this be based?

3. If you are a Provider, what issues have you had previously working with Plan utilization management procedures; and, what alternatives do you propose?

Clinical Management

1. Please describe strategies that should be used by Plans to manage and coordinate care for individuals with complex and high-cost co-occurring behavioral health and medical conditions? Please address at least the following elements:

    a. Strategies for stratifying members according to risk, severity, co-morbidity, and level of need in order to target outreach, engagement and case management;

    b. Strategies for ensuring individualized, person-centered care plans.

2. How can Plans ensure that their networks provide coordination among network providers in order to integrate BH and PH care?

3. What standards should be established for Plans, Providers, and Health Homes to monitor, locate, re-establish contact, outreach and re-engage individuals who are lost to contact with the behavioral health system?

4. What specific training and monitoring requirements would be necessary to implement programs to manage complex and high-cost, co-occurring behavioral health and medical conditions?

    a. If you currently manage behavioral health and physical health separately, how will you manage the integration of care?

5. For Plans, please describe how you would use administrative and other data to identify, predict, and manage high risk or high cost members.

6. How can health information technology be used collaboratively by Plans and Health Homes to improve care coordination, improve outcomes, coordinate benefits, and reduce costs?

    a. How should plans promote/support HIT/HIE development in their networks?

7. How should Plans incentivize the use of integrated models such as collaborative care models in primary care settings?

8. How do Plans educate and train providers on evidence-based practices (RFQ section 3.8)?

    a. How, if at all, do Plans monitor provider fidelity to these practices?

9. Outpatient Opioid Treatment services (including methadone programs) are currently out of the benefit package but will be included in the Qualified Mainstream and HARP Plans. Many plans do not currently manage these benefits. Please describe how these benefits should be managed.

10. OASAS is considering a plan that would bring clinical services provided in a residential setting into the benefit plan. Please describe how a plan should approach management of these services.

11. What mechanisms should Plans that do not establish a HARP line of business put in place to identify high risk or high need members and refer them for a HARP eligibility assessment?

Cross System Coordination

1. How should Plans delineate the services provided by Health Homes from the care management responsibility at the Plan level?

2. How should Plans coordinate care with non-Medicaid services, (providers, and systems i.e., jails, prison, family & specialty courts, probation, parole, Institutions for Mental Disease, housing, homeless shelters, social services)?

    a. Please differentiate your response between Qualified Managed Care Plans and HARPs?

    b. Please differentiate your response for cases where a person is enrolled in a Health Home and cases where the person is not enrolled in a Health Home (due to choice or ineligibility).

Quality Management and Performance

New York State is committed to measuring Plan and provider performance on behavioral health and related outcomes beyond the current requirements in the State's Quality Assurance Reporting Requirements (QARR). Year one performance measures will be released for comment subsequent to the RFI, but prior to the distribution of the final RFQ. The State will use a combination of administrative and member survey data to measure performance for MCOs. HCBS required reporting shown in attachment B of the RFQ will also apply to HARPs. Additional information from the evaluation for 1915(i)-like eligibility and the interRAI assessment will be used to measure HARP performance. New York State is interested in recommendations regarding behavioral health performance measures. Please provide input on the following:

1. What other measures of performance should be considered beyond those listed in the QARR, RFQ Section 3.12 Quality Management, RFQ Section 3.13 Reporting, and Section 18.2 of the MCO Model Contract?

    a. Please indicate why and how they should be used and specify data sources the measures would be derived from.

    b. Please differentiate between the HARP and Qualified Mainstream MCO.

Reporting and Data Exchange

1. What IT and information connection standards should be required of Plans and behavioral health Providers and why?

2. How, if at all, are Plans and behavioral health Providers currently exchanging clinical and financial information?

    a. What various capabilities (e.g., EMR, other) do Plans have to exchange clinical/reporting information with providers?

3. Should NYS require Plans to connect to RHIOs? Please explain the advantages or disadvantages of your recommended approach.

4. If you are a Plan, what is your current process for exchanging data with the Health Homes? What changes will be needed to ensure data coordination between Health Homes and the Plans related to care management and, delivery of the behavioral health benefit package including HCBS 1915(i)-like services?

Claims Administration

New York State wishes to streamline managed care claiming processes as much as possible across Plans.

1. What claims submission rules are currently placed on Providers? Please differentiate between those that are part of submitting a HIPAA compliant claim and those that are Plan specific.

2. For Plans: Does your Plan have the ability to receive web based claim submittals from Providers that do not have their own electronic billing system? If yes, please provide the web link.

3. If you are Plan, what initial and ongoing training and support will you give Providers to promote their ability to successfully submit claims?

    a. How will this training and support be enhanced beyond current claims training and support?

Performance Guarantees and Incentives

1. The Quality Strategy for the NYS Medicaid Managed Care Program currently includes a quality incentive program. Should NYS consider other pay-for-performance approaches?

2. Besides provider subcapitation, do Plans use other provider payment models beyond fee-for-service? If so, please describe.

Regulatory Flexibility:

1. Managed Care offers some flexibility not otherwise available under Medicaid fee-for-service. (e,g, OMH clinic regulations, Part 599, does not

apply all FFS standards to patients enrolled in Medicaid Managed Care.) If you had the opportunity to amend state regulation, which specific regulatory mandates would you change? Please identify the specific regulation, how you would like it changed, and why?

Supplemental Questions

1. If you are a Plan operating in NYS, do you plan to create a HARP in your service area? If not, why not?
2. If you are a Plan operating in NYS, do you intend on subcontracting with a behavioral health management company? If so, which functions do you plan to outsource and why?
3. Describe the challenges and issues anticipated with moving the new behavioral health benefits into manage care? How can NYS help mitigate these challenges?
4. If you are a plan that intends to establish a HARP, describe the challenges and issues anticipated with providing 1915i HCBS services. How can the State help mitigate these challenges?
5. What other considerations or recommendations do you have any aspect of the draft RFQ?
6. What other considerations or recommendations do you have regarding the movement of behavioral health services into managed care?

Scenarios: *The purpose of this section is to provide Plans, Providers and others with an opportunity to describe how various scenarios could/should be addressed in light of the goals, objectives and requirements identified in the draft Behavioral Health RFQ. Answers provided will help guide NYS in the provision of technical assistance to Providers and Plans.*

1. Developing Home and Community Based Care Models for Behavioral Health

One of New York's main goals in redesigning the behavioral health system is to enable Plans and Providers to incorporate innovative, cost-effective

and evidence-based models of care into service delivery. One way New York is doing this is through the provision of new 1915(i)-like home and community based services in the HARP benefit package. These services are intended to provide diversion from and alternatives to hospitalization to members eligible for the HARP benefit package.

a. How should Plans use these services to support:

    a. Inpatient diversion?

    b. Crisis response?

    c. Community Integration and Employment?

b. What specifically is required to make these suggestions a reality?

c. Members with SUD only will access 1915(i) like services. What can plans and providers do to develop services specific to the needs of these members?

Addressing behavioral health issues is not only about managing symptoms and preventing hospitalizations. Important outcomes are social: stable housing, employment, avoidance of incarceration, economic self-sufficiency. Recovery management approaches place emphasis on supports within the family and the community that can be leveraged to enhance recovery initiation and maintenance.

a. What considerations around interaction with local services systems does NYS need to be thinking about?

2. Promoting Best Practices in Behavioral Health Care

There are evidence-based practices for serious mental illnesses focusing on: antipsychotic medications; Assertive Community Treatment (i.e., team-based care, high frequency contacts, community-based contact, low caseloads); treatment of co-occurring substance use disorders, cognitive-behavioral therapy, supported employment, skills training, family-based services, and weight management interventions.

a. How will Plans and Providers ensure that all patients who can benefit from these evidence-based practices actually receive them?

b. What requirements should be put into managed care contracts to promote these best practices?

Approximately 20% of the HARP eligible spend is for pharmacy. Poor management of medication and pharmacy contributes to inappropriate poly-pharmacy, inadequate medication trials, inappropriate formulary rules, poor monitoring of metabolic and other side effects, and lack of a person centered approach to medication choices.

a. What approaches should HARPs take to address these issues?

NYS is in the midst of a growing epidemic of prescription opioid misuse and associated opioid dependence. In addition, NYS has a preexisting unmet need for medication treatment of opioid dependence. Methadone is one evidence-based treatment, and primary-care based prescribing of buprenorphine is another. Buprenorphine is available as part of the Medicaid pharmacy benefit, but there are an insufficient number of providers who are certified (waivered) to prescribe it.

a. How can Plans promote the use of evidence-based treatment for opioid dependence?

b. How can Plans influence the supply of buprenorphine prescribers?

c. If you are Plan, what actions are currently being taken to address these issues?

d. How should NYS establish network requirements for buprenorphine prescribers? Performance metrics? Incentives?

3. Collaborative Care

Much of the RFQ focuses on the seriously ill population, but NYS reform also aims to better address behavioral health in the broader population – those with moderately severe conditions. For depression, scientific

consensus is emerged around a general model called “collaborative care” that is designed to work best in a “patient-centered medical home” approach: screening, use of a registry, care managers embedded in the primary care practice, and psychiatrist consultation and referral. There needs to be a more robust activity in primary care practice to effectively identify and manage conditions like depression and substance use disorders.

a. How can NYS work with Plans and Providers to promote collaborative care in a managed care environment?

b. How should Plans approach care management and utilization management for a patient with significant chronic health conditions as well as behavioral health conditions?

c. How should care management and utilization management for these conditions be coordinated and integrated across a Plan’s physical health and behavioral health department?

d. How should these functions be integrated at the network and provider levels?