Behavioral Health Transition

- 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
Existing Managed Care Environment

Current Managed Care Benefit Package is Irrational for Behavioral Health

**TANF or Safety Net***
- Must join a health plan**
- Health plan covers most acute care services and some behavioral health services
- Health plan provides inpatient mental health, outpatient mental health, SUD inpatient rehabilitation, detox
- Continuing day treatment, partial day hospitalization and outpatient chemical dependency are provided through unmanaged fee for service

**SSI***
- Must join a health plan**
- Health plan covers most acute care services
- Health plan covers detox services
- All other behavioral health services are provided in unmanaged fee for service program

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***HIV SNP is more inclusive of some behavioral health benefits for both SSI and Non SSI
**Unless otherwise excluded or exempted from enrolling
Guiding Principles of Redesign

- Person-Centered Care management
- Integration of physical and behavioral health services
- Recovery oriented services
- 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
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 Submission to CMS

2014
- February: Post Final RFQ with Pending Rates
- 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 Adults in Rest-of-State (HARP & Non-HARP)

2016
- January: Implementation of Behavioral Health Children Statewide
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
Health and Recovery Plans (HARPs)

- Premiums include all Medicaid State Plan services
  - Physical Health
  - Behavioral Health
  - Pharmacy
- Manage new 1115 waiver benefits
  - Home and Community Based 1915(i) waiver-like services
    - Not currently in State Medicaid Plan
    - Eligibility based on functional needs assessment
Behavioral Health Benefit Package

Behavioral Health State Plan Services (for 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
  - 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
Plan Qualification Process

- Request for Qualifications (RFQ) for all Plans

- All Plans must demonstrate capacity to meet enhanced standards and manage currently carved-out services
  - Standards to be detailed in the RFQ
  - RFQ review will determine whether Plan can qualify (alone or in partnership with a BHO) or must partner with a qualified BHO

- Plans applying to develop HARPs must be qualified via RFQ
  - HARPs will have to meet some additional program and clinical requirements which will be reflected in the premium
  - A Plan’s HARP must cover all counties that their mainstream Plan operates in
RFI Objectives

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

RFI document will contain specific questions, the draft RFQ, and a databook

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

NYS will incorporate RFI feedback into the final RFQ
The final RFQ will establish BH experience and organizational requirements as recommended by the MRT.

Requirements intended to address specific concerns and design challenges identified by the MRT.
Request for Qualifications

- Plans must meet State qualifications in order to manage carved out BH services
- Plan qualifications will be determined through an RFQ
  - HARPS
  - Qualified mainstream plans
- Plans may partner with a Behavioral Health Organization to meet the experience requirements
- 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
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)
- Credential OMH and OASAS licensed or certified programs
- 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
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 Consortiums (RPCs) when possible
  - RPCs are comprised of each LGU in a region, representatives of mental health and substance abuse service providers, child welfare system, peers, families, health home leads, and Medicaid MCOs
  - RPCs work closely with State agencies to guide behavioral health policy in the region, problem solve regional service delivery challenges, and recommend provider training topics
  - RPCs to be created
FIDA/MLTC/BIP

- **FIDA** - integrate and provide care coordination for physical healthcare, behavioral healthcare, and long-term supports and services for a major segment of New York’s dual eligibles (Medicare and Medicaid).

- **MLTC** - help people who are chronically ill and who need health and long-term care services, such as home care or adult day care, stay in their homes and communities as long as possible.

- **BIP** - rebalance the delivery of long term services and supports (LTSS) and to promote enhanced consumer choice; streamlined eligibility processes, improved access and expanded LTSS for those in need; and provide essential services in the least restrictive setting.
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 Highlights

- Comprehensive service package
- Broad medical necessity definition applies to all services
- Interdisciplinary Team (IDT) authorizes virtually all services
- Integrated Grievance & Appeals (G&A) processes
Individuals receiving Community-Based LTSS (120 days standard)
- Voluntary Enrollment – Effective July 2014
- Passive Enrollment – Effective September 2014

Individuals receiving Facility-Based LTSS
- Voluntary Enrollment – Effective October 2014
- Passive Enrollment – Effective January 2015

Passive enrollment will occur over several months and will be phased based on how much time individuals have left on their eligibility authorizations.
Eligible Populations:

- Age 21 or older;
- Entitled to benefits under Medicare Part A and enrolled under Parts B and D, and receiving full Medicaid benefits; and
- Reside in a FIDA Demonstration County: Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk and Westchester Counties

Must also meet on the following three criteria:

- Are Nursing Facility Clinically Eligible (NFCE) and receiving facility-based long term support services (LTSS);
- Are eligible for the Nursing Home Transition and Diversion Waiver (NHTD); or
- Require community-based LTSS for more than 120 days.
January 2015- begin process of passive enrollment notification for dual eligible individuals residing in nursing homes.

This will be applicable to eligible individuals in the FIDA demonstration area.

Enrollment broker will provide enrollment counseling and assistance.
NYSDOH is proposing to use the NY Medicaid definition of medical necessity for all services.

Covered Services include services covered by the existing Medicare and Medicaid programs in New York in addition to some Home and Community-Based waiver services.

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.
Completed:

- Finalized initial HARP selection criteria
- 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
- Finalized draft 1115 Waiver amendment for public comment
Questions