Agenda

- Goals
- Timeline
- BH Benefit Design
- Overview of RFI/RFQ
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
Behavioral Health Managed Care Transition Timeline

NYC implementation 1/1/15

- POST RFQ EARLY TO MID MARCH
- PLAN RESPONSES DUE
- BEGIN MEMBER NOTIFICATION OF HARP PASSIVE ENROLLMENT*
- NYC IMPLEMENTATION

*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

1 Feb 1 Mar 1 Apr 1 May 1 Jun 1 Jul 1 Aug 1 Sep 1 Oct 1 Nov 1 Dec 1 Jan 1 Feb 1 Mar
State review/designation and revision as needed--NYC RFQ responses 6/1/14-10/1/14
NYC Plan Readiness Review 8/29/14-11/1/14
Building statewide capacity for 1915(i)-like services begins 10/1/14** ($30M)
BH Benefit Design
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:

- 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 - All current PLUS access to 1915i-like services
- Specialized medical and social necessity/utilization review for expanded recovery-oriented benefits
- Benefit management built around higher need HARP patients
- 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
  - Community Psychiatric Support and Treatment (CPST)
- Habilitation
- Crisis Intervention
  - Short-Term Crisis Respite
  - Intensive Crisis Intervention
  - Mobile Crisis Intervention
- Educational Support Services

- Support Services
  - 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
Overview of RFI/RFQ
RFI Update

- Processed RFI comments
  - Received RFI comments received from 48 entities: Plans, Providers, Advocacy Groups, Local Governments, and other Stakeholders
  - All comments logged and sorted into three categories
    - Possible change to RFQ; No change; Update guidance documents
  - Common themes were identified across submissions
Common RFI Themes

- Plan experience/Staffing Flexibility
- Health Homes/Plan Care Management Roles and Responsibilities
- 1915(i) Home and Community Based Services
- Accommodating BH Services in Managed Care
- Utilization Management
- Network Services
- Information Technology Requirements
- Provider Reimbursement/Claims Administration
- Performance Management
- Regulatory Flexibility
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
Member Services

- Service centers with several capabilities such as:
  - Provider relations and contracting
  - UM
  - BH care management
  - 24/7 day capacity to provide information and referral on BH benefits and crisis referral

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

There must be a sufficient number of providers in the network to assure accessibility to benefit package.

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.
- State open to modifying payment requirements based on Plan/Provider agreement.
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 Consortia (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
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
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

Additional HARP requirements include oversight and monitoring of:

- Health Home services and 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)
Next Steps

- Health Home/Plan care management roles and responsibilities (beyond that which is already in the existing HH/Plan agreement)
- Determine the care management model for HARP members and HARP eligibles that are not enrolled in HHs
- Building Health Home capacity for HARP enrollees
- 1915i program development
  - Pilot test an interRAI assessment tool to develop scoring and to project cost of utilization
  - Develop guidance for 1915i services
  - Conduct a survey to identify potential 1915(i) providers
  - Designating 1915i qualified providers
Next Steps (continued)

- Develop Mainstream BH and HARP MLR percentage
- Final Rates available in April
- Provide ongoing technical assistance for Plans and providers
- Implement Start-Up Activities (with funding in 2014-15 Executive Budget)
- Facilitate creation of Regional Planning Consortiums (RPCs)
Discussion and Feedback