

MRT BEHAVIORAL HEALTH MANAGED CARE UPDATE

MRT Webinar

June 18, 2013

Guiding Principles of Redesign

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- Person centered care management
- Integration of physical and behavioral health services
- Recovery oriented services
- Patient/consumer choice
- Protection of continuity of care
- Ensure adequate and comprehensive networks
- Tie payment to outcomes
- Track physical and behavioral health spending separately
- Reinvest savings to improve services for behavioral health populations
- Address the unique needs of children, families and older adults

Vision for Behavioral Health Managed Care

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Fully integrated treatment where behavioral and physical health are valued equally and patients' recovery goals are supported through a comprehensive and accessible service system

Existing Managed Care Environment

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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

*HIV SNP is more inclusive of some behavioral health benefits for both SSI and Non SSI

**Unless otherwise excluded or exempted from enrolling

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Behavioral Health Phase II: Managed Care Program Design

NY's Design for Managed Behavioral Health

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- Behavioral Health will be managed by
 - ▣ Special needs Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs
 - ▣ Mainstream managed care plans
 - Plans may operate services directly only if they meet rigorous standards
 - Plans that do not meet rigorous standards must partner with a BHO which meets standards
 - Plans can partner with BHOs to meet the rigorous standards

Key Requirements for ALL Plans

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- Individual Plans of care and care coordination must be person-centered and be accountable for both in-plan benefits and non-plan services
 - ▣ e.g., housing, AOT requirements
- Plans must interface with social service systems to address homelessness, criminal justice, and employment related issues for their members
- Plans must interface with Local Governmental Units (LGU)
- Plans must interface with State psychiatric centers to coordinate care for members

Health and Recovery Plans (HARPs)

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- Distinctly qualified, specialized and integrated managed care product for individuals with significant behavioral health needs
 - ▣ Distinct product line
 - ▣ Specialized Plan administration and management appropriate to the populations/services
 - ▣ Enhanced benefit package with specialized medical and social necessity/utilization review approaches for expanded recovery-oriented benefits
 - Reflected in premium
 - ▣ Integrated health and behavioral health services
 - ▣ Additional quality metrics and incentives
 - ▣ Enhanced access and network standards
 - ▣ Enhanced care coordination expectations

Health and Recovery Plans (HARPs)

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- Participants must meet HARP eligibility criteria
 - ▣ Initial eligibility based on historical use
 - ▣ Future eligibility based on:
 - Functional/clinical assessment
 - (e.g., individuals with first episode psychosis)
 - Periodically updated historical utilization
- Open enrollment in HARPS for eligible populations
 - ▣ Other strategies to facilitate enrollment being explored

Health and Recovery Plans (HARPs)

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- Premiums include all Medicaid State Plan services
 - ▣ Physical Health
 - ▣ Behavioral Health
 - ▣ Pharmacy
 - ▣ Long Term Care
 - ▣ Health Home
- 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

Qualified BH Plan vs. Health and Recovery Plan (Under Development)

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Plan Qualified to Manage Behavioral Health

- Medicaid eligible
- Benefit includes all current services
- Benefit Management specific to public benefit population social needs
- Organized as benefit within MMC – Enhanced staffing for BH benefit management coordinated with PH benefit management
- Performance metrics specific to BH outcomes and plan management of Medicaid population and BH and social needs

Health and Recovery Plan (HARP)

- Eligible based on utilization pattern or functional impairment
- Benefits include all current and new 1915(i) like
- Benefit management built around expectations of higher need HARP Patients
- Organized as a separate product line with a separate medical direction and staff
- Performance metrics specific to specialized services, higher need population social and medical needs.

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Benefit Package

Behavioral Health Benefit Package

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Behavioral Health State Plan Services (for Adults)

- ❑ Inpatient - SUD and MH
- ❑ Clinic – SUD and MH
- ❑ PROS
- ❑ IPRT
- ❑ ACT
- ❑ CDT
- ❑ Partial Hospitalization
- ❑ CPEP
- ❑ TCM
- ❑ Opioid treatment
- ❑ Outpatient chemical dependence rehabilitation
- ❑ Rehabilitation supports for Community Residences

Enhanced Services for HARP

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Workgroup recommended 1915(i)-like waiver services* — Access based on functional/clinical assessment for targeted populations

- **Services in Support of Participant Direction**
 - Information and Assistance in Support of Participant Direction
 - Financial Management Services
- **Crisis**
 - Crisis Respite
- **Support Services**
 - Community Transition
 - Family Support
 - Advocacy/ Support
 - Training and Counseling for Unpaid Caregivers
- **Empowerment Services**
 - Peer Supports
- **Service Coordination**
- **Rehabilitation**
 - Pre-vocational
 - Transitional Employment
 - Assisted Competitive Employment
 - Supported Employment
 - Supported Education
 - Onsite Rehabilitation
 - Respite
 - Habilitation

* Draft service definitions can be found in appendix 2

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Quality and Performance

Raising Standards for Behavioral Health Care

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- Raise the bar on behavioral health management for all members:
 - Expertise and experience, network, access, service utilization/ penetration, care coordination
 - Quality Measures “beyond HEDIS”
 - Engaging the disengaged
 - Promoting consumer engagement
- Assure reinvestment of savings in services and supports for people with behavioral health needs
- Ongoing monitoring by the entire behavioral health community
- Incentive payments based on performance
- Minimum Medical Loss Ratio (MLR) requirements

Performance Expectations

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Limited metrics now in place to measure quality/outcomes for MH/SUD services and populations

- Expanded measures for addressing behavioral health in primary care
- Performance standards to be enhanced for MCOs and HARPs
- Measures to be developed for newly managed MH/SUD services. Examples:
 - Improving behavioral health care including increased access
 - Follow-up post inpatient/ER
 - Service engagement
 - Medication management
 - Improving physical health
- HARP measures additionally focus on coordination of behavioral health and primary care
 - Health Home Care Coordination/Engagement indicators
 - 1915(i)-like services and recovery metrics
 - For example: participation in employment; enrollment in vocational rehab services and education/training; housing status; community tenure; criminal justice involvement; peer service use and improving functional status
- New metrics require data beyond claims and encounters and may need to be phased in

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Plan Qualification

Plan Qualification Process

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- 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

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Next Steps

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- Continue to facilitate provider readiness
- Establish network requirements, selection criteria, evaluation/performance measures that meet Legislative requirements
- Set rates
- Federal approval
- Publish RFI/RFQ requirements and qualify Plans
- Implementation
- Continue development of children's design