BEHAVIORAL HEALTH MOVES TO MANAGED CARE: THE COALITION’S VIEW

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INTRODUCTION

“Medicaid managed care has the potential to significantly improve access to health care and health outcomes for the Medicaid population. It may also have the potential to reduce program costs. However, these goals can be achieved only if payment rates are set at appropriate, actuarially sound, and sustainable levels. Policymakers are understandably concerned that high payment rates might result in above-market profits for health insurers who participate in Medicaid MCO programs. However, an excessive desire to cut rates and limit profit may be counterproductive, as it may reduce quality and access and drive health insurers out of the MCO business.”

Robert Book, Forbes Magazine, October 18, 2012  

This counter-balance of savings and access to care are the driving objectives in New York State’s healthcare reform effort. As the transformation moves forward, The Coalition of Behavioral Health Agencies has a number of concerns that we will outline in this paper.

The Coalition is the foremost voice of the behavioral health community in the New York City metropolitan area. We represent over 130 non-profit behavioral health agencies, which together serve over 450,000 adults and children, and deliver the entire continuum of care throughout the diverse neighborhoods of the City and its surrounding counties.

The Coalition’s members have been practicing care in a bifurcated system for many years, where the medical care is organized under managed care while the behavioral health services have been “carved out” and remain in a fee-for-service mode. It is clearly time to integrate services under one single and uniform policy, and The Coalition is fully supportive in concept of this important change in public policy. We also understand that many persons with less complex behavioral health conditions have been served under managed care as part of the overall Medicaid benefits for mental health and substance use issues, and we expect that this would continue.

We should stress that The Coalition’s community network of providers remain committed to keeping every person in the appropriate level of care, avoiding where possible expensive high-end services and ensuring that all consumers achieve their full potential.

What follows are a series of considerations and recommendations designed to guide the development of the Request for Qualifications to be released to managed care organizations, and the points of accountability in the contracts between New York State and the managed care organizations selected by the State to proceed with Medicaid healthcare reform. The design and implementation of the Medicaid managed care approach has several elements that will play out in terms of the ability of the consumers to access care, the ability of agencies to provide needed
services, and the financial resources to support both the management and delivery of care. The focus of this White Paper is on consumers of mental health and substance use services (who are often high-cost Medicaid recipients) and the providers of services to this vulnerable population.

While the Medicaid Managed Care transformation (full carve-in; Fully-Integrated Duals Advantage programs (FIDA); Developmental Disabilities Individual Support and Care Coordination Organizations (DISCO)) is happening in a compressed timeframe (in a little over a year), other system transformations and dislocations resulting from the implementation of the Affordable Care Act (ACA) and New York State-initiated reforms are occurring simultaneously, affecting many of the same community-based providers. Furthermore, ACA will make even more consumers eligible for Medicaid at a time when the safety-net system is shrinking and off balance. Clinic rate transformations and the loss of Comprehensive Outpatient Services (COPS) reimbursements already have impacted negatively on the clinic programs and made many programs vulnerable. A significant number of them have closed and other closures seem imminent.

The two goals of savings and access to care were also the driving objectives of the implementation in New York State of Health Homes under the Affordable Care Act. The roll out of the Health Homes, even in this advanced phase, has been challenging and uneven, and provides us with a problematic test case that gives us even more reason for concern as we move toward a managed care carve-in.

The Coalition is fearful that the safety net system will be destabilized beyond repair and that needy consumers could be lost to care—counteracting the very premises of the transformation that would move people from inpatient and emergency services to community based-services.

At this time New York State has decided to go with a Medicaid “carve-in” model, meaning that all behavioral health benefits (mental health and substance use) will be part of the global benefit provided by the managed care organization (MCO). The Medicaid Institute at the United Hospital Fund issued a report in June 2009 (http://www.medicaidinstitute.org/assets/619) that argues (disquietingly to us) that there are very few successful and scalable examples of this model around the country. (“Providing Behavioral Health Services to Medicaid Managed Care Enrollees: Options for Improving the Organization and Delivery of Services,” United Hospital Fund Medicaid Institute, June 2009.)

We also know that some states have found ways to be creative in their approaches to meeting the needs of people enrolled in managed care, e.g., Ohio through its IMPROVE program, see Kaiser Family Foundation Report (http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8220.pdf, p.44. See Appendix I). Other states have similar pilots and small demonstrations that seem to have had some success, see Mailman School of Public Health Report, http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106. See Appendix I).

These observations and the facts that underlie them underscore the Coalition’s belief that the New York State Office of Alcoholism and Substance Abuse (OASAS) and the Office of Mental
Health (OMH), the agencies most knowledgeable and most experienced in the delivery of services to the high-needs behavioral health populations, must be given decisive roles in the development of oversight, regulation and monitoring of plan data, including rate setting, data analytics, licensing and regulation related to the behavioral health benefits.

In addition, New York State’s design for managed behavioral health includes the introduction of Health and Recovery Plans (HARP), a distinct, comprehensive, integrated behavioral and primary care risk-bearing product line of the managed care plan. The covered benefits include physical and behavioral health, pharmacy, long-term care and health homes. HARPs will also include enhanced services. In fact, what distinguishes the HARPs from all other managed care plans is the enhanced 1915i “look-alike” services to be provided, which will cover home and community-based services targeted to specific eligible persons under Medicaid. HARPs are targeted for persons with serious mental illness and for those with serious substance use problems. (See Appendix II for the Short Summary of HARPs from the NYS OMH presentation of June 7, 2013.)

Especially with respect to HARPs, The Coalition also recommends that the New York City Department of Health and Mental Hygiene (and other appropriate local governmental units (LGUs) around the State) will continue their role in oversight, with performance reviews, communication facilitation, supporting a broad network of providers, and meaningfully facilitating “ground-up” enrollment into HARPs of consumers who are not identified by the formal criteria set for admission (e.g. homeless, jail populations, people with addictions related primary care conditions, etc.).

The Guiding Principles of Redesign by the Behavioral Health Reform Work Group of the Medicaid Redesign Team reflect the long-held values and operating principles of behavioral health providers and The Coalition. (See Appendix III for the MRT Work Group’s Final Recommendations.)

These include:

- Person-centered care management.
- Integration of physical and behavioral health services.
- Recovery oriented services.
- Patient/consumer choice.
- Protection of continuity of care.
- Ensuring adequate and comprehensive networks.
- Linking payment to outcomes.
- Tracking physical and behavioral spending separately.
- Reinvesting of savings to improve community based behavioral health services for behavioral health populations.
- Addressing the unique needs of children, families and older adults with a behavioral health diagnosis.
COALITION RECOMMENDATIONS AND GUIDING PRINCIPLES

The organization of behavioral health services under Medicaid managed care requires careful consideration. Consequently, The Coalition offers additional guiding principles and recommendations for this transition.

Based on a review by a think tank comprising some of our members on April 11, 2013, we offer the following key principles based on Coalition thinking for the implementation of managed care:

1. Patient and consumer choice must be preserved.
   a) Person-centered care should be at the core of the delivery system.
   b) A more holistic and comprehensive approach to care is required.
   c) Engagement of consumers and families within any system of care is not only an effective means to improve treatment outcomes but is also the right thing to do.
   d) Stabilization of patient enrollment should be a major goal for managed care.
   e) Ensured access for new demands and a growing population in need.

2. Article VII of the Laws of 2013 requires that managed care ensure “sufficient access” to care.
   a) There should be multiple access points for consumers.
   b) There should be outreach initiatives to engage consumers who are not currently involved with care, particularly on the local level. (See Appendix IV for details of Chapter 56 of Article VII of the Laws of 2013.)

3. Mental health and substance use and physical health should be addressed in an integrated manner. It is recognized that individuals with serious mental health and substance use have significant co-morbidities and they must be treated through an integrated system of care. (See “Prevalence and Severity of Behavioral Health Conditions. Understanding the prevalence and severity of behavioral health conditions among general hospital inpatients in New York State: Application of the use of new tools and analytics,” prepared by the ArthurWebbGroup and Welsh Analytics, January 2013. Also, see Bella, Somers and Llanos, “Providing Behavioral Health Services to Medicaid Managed Care Enrollees: Options for Improving the Organization and Delivery of Services,” United Hospital Fund Medicaid Institute, June 2009.)
   a) There is a growing body of research that indicates that integrated care models improve the outcomes of care.
   b) There is also a growing consensus on what constitutes a “gold” standard of care, and it is those services that are provided with fidelity to evidence-based practices to achieve positive clinical outcomes for the individual. New York State, in collaboration with the provider and consumer communities, should work to identify emerging interventions, best-practices, and key evidence-based practices that will be promoted and supported by the managed care organizations to achieve the desired clinical outcomes and reduce the cost of care.
   c) The goal should include a continuum of care options.
   d) Co-location of services should be one available model to promote integrated care.
   e) New York State should explicitly assert that integration is an expected outcome and the State should support expanded demonstrations of integration models with new funding.
f) Restrictive licensing and regulations and mandates need to be reviewed and revised to fit more effectively under managed care and HARPs.

4. The network of contracted providers should be adequate to meet physical and behavioral health needs of persons with behavioral health conditions.
   a) Geographic standards of access to inpatient care should be set on a practical basis.
   b) The network should include providers with expertise and demonstrated success with providing care to special needs populations.
   c) The State should ensure that sufficient housing be developed and that linkages be protected as managed care evolves. It is clearly demonstrated that safe and stable housing is one of the social determinants of effective mental health and substance abuse care. Adequacy (Article VII) also requires that providers have established linkages with other services fields including criminal justice, homeless services, children’s services, etc.
   d) The linkage with the criminal justice system is now more demanding than ever. Information and education should be provided to judges in determining effective clinical residential drug treatment orders.
   e) Consideration should be given to requirements for licensing, certification or the contracting with providers for any network. This consideration should be driven by the expectation that a provider network has a demonstrated track record of service and accountability.
   f) While the above seems essential, the State should also strive to reduce unnecessary regulatory burdens on providers and encourage flexible use of resources.
   g) Regulatory relief should be a high priority and be coincident with the implementation of “care management for all.”

5. The levels of care determinations should use evidence-based models (Article VII).
   a) Assessment tools and methods should be based on evidence and best practice.
   b) Plans of care should be comprehensive.
   c) Treatment options should be predicated on evidence-based assessments, consumer choice and cost-effective treatment models.
   d) Continuity of care for persons with court-ordered residential treatment should be part of the managed care standards.
   e) Individual needs should be differentiated and stratified so that care plans fit the needs of each consumer, using cost-effective methods.
   f) Identified needs for treatment and engagement must be ensured through metrics.
   g) Health Homes should be effectively integrated into the models of care.

6. Standards of care that encourage the use of services should be established (see Article VII).
   a) The Coalition recommends that standards and measures be applied separately for health and behavioral health as well as integrated health/behavioral health performance measures, so that costs of care, utilization and clinical outcomes can become part of an overarching quality improvement program to best meet the needs of consumers and health plan members.
   b) There should be sufficient time to achieve the new mandates for quality outcomes.
c) The recovery model of care should be an essential requirement for plans of care with an understanding that support for recovery is often a long-term prospect. Cost-effective supports like recovery centers should be included in the covered benefits.

d) Standards that utilize provider orders or prescriptions should be accepted and supported.

e) Quality care standards that have measurable outcomes should be based on best practices and evidence.

f) Consumer screening for mental illness and substance use disorders should be applied across specialty and primary care settings and should use proven assessment instruments that are approved by OMH and/or OASAS, as appropriate. Primary care screening of people living with mental illness and substance use disorders should be provided in behavioral health provider settings.

g) The State should monitor the sufficiency of care.

h) The State should have a continuous quality improvement process to develop the database to conduct evaluations, outcome assessments, and cost-effective studies. These studies will inform all stakeholders on how well the system of reform is performing.

7. The methods of payment should encourage cost-effective care and incentives to providers.

a) Based on the rapid pace of change and great uncertainty, The Coalition of Behavioral Health Agencies urges New York State policymakers to preserve the financial levels of behavioral health expenditures so that unmet needs can be addressed based on medical necessity for treatment at the lowest levels of care (community-based).

b) Innovative payment reform should be pursued that supports integrated services.

c) Sustainable medical-loss ratios and reasonable levels of reinvestment should be established.

d) Prompt reimbursement to providers must be made to ensure appropriate capacity.

e) Appropriate provider payments to incentivize treatment of the harder to serve.

f) Payments that promote the delivery and use of the appropriate level of care that is medically necessary should be required.

g) We support the Article VII requirements that certain services should remain outside of managed care until the rates and program features are approved by the Commissioner of Health in consultation with Commissioners of Mental Health and Alcohol and Substance Abuse Services.

h) There should be flexible methods of payment that balance risk-management with appropriate care services.

i) *Money follows the person* should form the basis of the payment reform. As people’s needs change, managed care payments should follow and be appropriate. One of the features should be payment for transitions of care.

j) The Coalition supports the integration of Medicaid and Medicare funding. Given the high percentage of individuals with behavioral health disabilities who are dually eligible for Medicaid and Medicare, we support the use of FIDAs. However, Medicare savings also should be reinvested in service integration and care coordination.

k) Initial premium levels for managed care entities should be based on prior service spending or actuarially sound methods that are designed to encourage plan investment.
in prevention, early interventions, timely access to treatment and development of capacity for cost-effective and evidence-based services.

8. A system of empowered care coordination should be established, and be stratified by risk/need of consumer. Payment models should incentivize coordination among physical and behavioral health providers.

a) Since Health Home is a required service for MCOs, we recommend that the current Health Home model be reformed to be more cost-efficient and responsive to the reality of care delivery.

b) Health Homes, in their current configuration, are not equivalent to the requirement of care coordination. For persons with complicated care needs, a Health Home has to be more intensive and should have care determinations as part of its requirements and be consistent with provider orders and prescriptions.

c) Care coordination requires a robust Information Technology (IT) platform and the State should invest in developing and applying an effective care management tool. Little to no money, Federal or State, has been available for these purposes for the behavioral health sector.

9. Savings from better managed behavioral and physical health care should be reinvested to the extent possible to further improve outcomes and reduce health costs.

a) New York State must assure that the financial underwriting for the managing entity is adequate and that the behavioral health portion of that underwriting is segregated and transparent to assure that some of the savings from the behavioral health spending can be tracked and is reinvested in critical community services.

b) The Coalition urges New York State policymakers to assure consumer access to care and expand the availability of medically necessary services in a manner that assures the stability of the provider safety network.

c) Reinvestment should prioritize non-clinical support services, such as housing, peer, employment, and family services. These should be funded by Medicaid under Federal waivers.

d) Investment in preventive services that avoid the need for tertiary care should be incentivized.

e) Savings might be shared with consumers to incentivize engagement.

OUTCOMES AND QUALITY OF CARE

In “Medicaid Managed Care: Costs, Access, and Quality of Care,” Research Synthesis Report No. 23 September 2012, Michael Sparer, The Mailman School of Public Health, Columbia University (http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106), the following points were made regarding quality measures:

"States collect data in response to: … Federal rules that require them to set forth their criteria for measuring the quality of care provided by Medicaid managed care organizations. Most states comply with this federal mandate by requiring participating health plans to submit data on a range of quality performance measures developed by the National Commission on Quality Assurance (NCQA). More than half of the states go even further, requiring participating health
plans to be accredited by the NCQA, thereby imposing a quality assurance stamp of approval lacking in Medicaid fee-for-service programs. Other states have developed their own set of quality performance indicators and rank health plans based on the results. New York officials, for example, have created the Quality Assurance Reporting Requirements (QARR) initiative, and not only rank each participating plan based on its performance, but also provide a fiscal bonus to high-scoring plans. Other state strategies include beneficiary satisfaction surveys, provider network adequacy requirements, and contracts with External Quality Review Organizations, many of which conduct studies focused on particular clinical outcomes.” (See Appendix I for an additional citation from this report.)

Additionally, states have a long history of requiring MCOs to produce quality studies according to measures that are important to that state. In a September 2011 report from the Kaiser Commission on Medicaid and written by Kathleen Gifford, Vernon K. Smith, Dyke Snipes and Julia Paradise, “Quality improvement activities in the states with MCOs reveal a breadth of state priorities. MCOs must conduct “performance improvement projects,” and all states must contract with External Quality Review Organizations (EQRO) to provide an independent assessment of the quality of care provided by Medicaid MCOs. States reported wide-ranging quality improvement activities, including, for example, projects focused on improving birth outcomes, increasing access to pediatric subspecialists, identifying high-risk individuals for case management, and increasing coordination between behavioral health and medical providers.”

(See Appendix I for an additional citation from this report.)

In developing standards to be used in the MCO procurement and contract process, The Coalition recommends that quality measures be applied separately for health and behavioral health as well as for integrated health/behavioral health performance measures so that costs of care, utilization and clinical outcomes can become part of an overarching quality improvement program to best meet the needs of consumers and health plan members.

- Outcomes of care should have broad social benefits and support wellness at all levels of care.
- Outcomes should be developed by a collaborative process involving all key stakeholders.
- Some of the possible benchmarks of success are the following:
  - Evidenced-based clinical outcomes for key chronic medical and behavioral conditions be agreed upon.
  - Improved integration of medical and behavioral care.
  - Reductions of unnecessary hospital admissions; preventable or avoidable emergency room use, and re-admissions.
  - Reductions of repeat detoxifications.
  - Reductions in use of court-ordered outpatient treatment for mental health and substance abuse.
  - Improved care transitions among all levels of care.
  - Cost-effective metrics reflected in positive clinical outcomes.
  - Increase in the stability of living arrangements.
Integration of primary or specialty care for physical health (and vice-versa) as measured by a consumer's satisfaction that their care providers are knowledgeable about their whole health and that providers report a meaningful exchange of clinical information, as allowed under HIPPA.
Ambulatory care following discharge from emergency department or hospital as evidenced by an appointment with an appropriate aftercare provider of discharge, depending on the severity of the need.
Appropriateness of drug regimen; and adherence to drug regimen as evidenced by timely filling of prescriptions and regular refills, as prescribed.

There are additional benchmarks of success that New York State and/or the LGU should track:
- Reunification with families.
- Achievement of employment.
- Reductions of mortality and health disparities associated with mental illness and substance use.
- Preventions of criminal and juvenile justice involvement.

PAYMENT REFORM

According to a 2012 report from the Kaiser Family Foundation, “States pay MCOs a fixed, monthly “capitation” rate for each Medicaid enrollee. Federal law requires states to pay actuarially sound rates. Most states set rates administratively using actuaries, but others negotiate rates, set them by competitive bid, or combine approaches. Most states risk-adjust rates based on beneficiary age, sex, eligibility category, geographic location, and health status. About half also have risk-sharing arrangements with plans, such as reinsurance.”

The Coalition urges New York State to be transparent about the portion of the capitation rate created for behavioral health care. The Coalition further asks that the State require the MCO to track expenditures for behavioral health from year to year and to report this to the public, so that the public may have input on strategic reinvestment with dollars saved.

CONCLUSION

The Coalition of Behavioral Health Agencies (The Coalition) is committed to achieving the highest level of effective and efficient delivery of system of care. (See the following Mission Statement.) The Coalition is also committed to working with New York State and other stakeholders including consumers, families, and MCOs to effectuate the most viable transition to managing risk under managed care.

Because of the concerns with the compressed time frame for implementation, with the limited evidence that managed care for special populations actually improves quality and effectiveness, and with limited information on what the level of funding will be to support behavioral health services, The Coalition is calling for an immediate meeting with State officials to review our recommendations and to arrive at a consensus on guidelines for implementation.
We understand the State policy is moving to “care management for all” but we also know that our provider community has long-established relations with their consumers and have years of experience that need to be integrated into the policy considerations by the State. This should be respected and considered as an essential building block as we integrate behavioral health with general health services.

To reinforce our recommendations stated above, the broad areas for immediate attention are:

- Consumer choice and access should be protected.
- Ensure the capitation levels are at a sufficient level to support serving complex needs.
- Establish quality standards for all stakeholders that are driven by best practices and evidence that are relevant and related to behavioral health.

The Coalition urges policymakers to reserve a “seat at the table” for The Coalition; there are many uncertainties as we approach the transition to risk-bearing models, and The Coalition is prepared to help its constituents live and thrive in an unknown and uncertain environment, as well as to help the State negotiate its approach to the providers of services and those constituents.

Many states are moving towards managed care for some people with serious mental health and substance use disorders who have the most complex and complicated needs, and we should learn from their experience. The pace of change requires a partnership with New York State and providers (as well as consumers and families) to make this transition as understandable as possible to the consumers who are most directly affected. The last thing we would want to see is consumers lose access to care and “fall between the cracks.”

In the transition to managed care, State funding for behavioral health and substance use disorders under Medicaid cannot fall below current levels. What the delicate balance is between cost, quality and assured access is a matter of good practical thinking, combined with experience. Now more than ever, there is a place for common sense. There is also a place where consumers, families, providers and payers can share space. This is the common ground we seek to achieve.
Mission Statement of
The Coalition of Behavioral Health Agencies, Inc.

As the umbrella association and voice of behavioral health agencies in the five boroughs of New York City, Westchester County, Long Island and environs, the Coalition’s mission is to advocate for, inform, and provide training and technical assistance for these agencies so that they may provide the best possible services with sufficient funding in a favorable regulatory environment. Taken together, these agencies serve more than 450,000 adults and children and deliver the entire continuum of behavioral health care.

The Coalition fulfills this mission by:

- Coordinating the efforts of government and the private sector toward efficient delivery of quality behavioral health services to children, adults and families who depend upon them;

- Promoting the development and provision of services to all New Yorkers, including persons with HIV, struggling families, the fragile elderly, people living with co-morbid health conditions, people discharged from psychiatric hospitals and detoxification units, prison discharges and troubled children;

- Advocating with government, business and philanthropy to seek ample resources for its members;

- Serving as a liaison and sector representative with government officials;

- Analyzing, proposing and supporting appropriate public policies that affect the behavioral health provider community and the other stakeholder constituencies;

- Furnishing information and linkages, by means of print and technology, to enable the public and sector representatives to more actively participate in the public debate about behavioral health policy;

- Acting as an information clearing house, informing and involving member agencies in issues and policies that affect the community;

- Promoting best practices in the delivery of services and offering high value technical assistance and training to our members that will help them offer quality, and cost effective services and help them to compete in an evidence-informed and market driven health care environment with changing and complex laws, regulations and oversight requirements;

- Fighting the stigma associated with mental illness and substance dependence and promoting public and community acceptance of people who live with mental illness and substance dependence and the programs that treat and serve them.
Appendix I

Citation from pages 2 and 8

Although not specific to behavioral healthcare a recent study published by the Robert Wood Johnson Foundation sheds some light on the unknowns related to Medicaid managed care. (“Medicaid Managed Care: Costs, Access, and Quality of Care”, Research Synthesis Report No. 23 September 2012, Michael Sparer, The Mailman School of Public Health, Columbia University (http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106.)

- “…most studies that examine the ways in which Medicaid managed care impacts costs, quality and access focus either on a single state (or even a single county or region within a state) or on a small subset of states (comparing outcomes among the different states). ….. There also seems to be a disconnect between the criteria states themselves use to assess programmatic success, and the methodologies used by academics that publish evaluations in peer-reviewed journals. p.10
- In Illinois, for example, much of the traditional safety-net provider community is boycotting the state’s current managed care initiative, arguing that the payment rates are too low and the bureaucratic micromanagement is too high. (2012), p.3
- After a somewhat rocky start, the Arizona program became a national model, and it remains today (with Tennessee) one of only two states that requires all services (including long-term care) be provided through managed care organizations. p.5)

Citation from pages 2 and 8

“Through its statewide collaborative, “Implement Medicaid Programs for the Reduction of Avoidable Visits to the Emergency Department (IMPROVE),” Ohio coordinated key stakeholders in five regions with high ED utilization. Regional participants include hospitals, community providers, managed care plans, advocacy organizations and their respective associations, and Medicaid consumers. The IMPROVE Collaborative adopted a rapid-cycle quality improvement approach, developed by the Institute for Healthcare Improvement, that is population-based and patient-centered. Five regional groups, including executive/clinical leaders of health care systems, partner with Ohio Medicaid and managed care plans to identify priority populations for the reduction of avoidable ED visits.”
http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8220.pdf,  p. 44
Appendix II

New York State Office of Mental Health
Presentation to Mental Health Services Council
June 7, 2013

Short Summary of HARPs

NY’s Design for Managed Behavioral Health
- Design will enhance the array and quality of services available in all Plans.
  - Existing 1115 Managed Care Partnership Plan waiver will be amended.
- All Plans MUST meet rigorous standards for managing behavioral health benefits.
- All Plans MUST qualify to manage currently carved out behavioral health services and populations.
- Plans can meet State standards internally or contract with a BHO to meet State standards.
- Plans may also choose to apply to be a Health and Recovery Plan (HARP) with expanded benefits.

Health and Recovery Plans (HARPs)
- A 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)
- 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) and periodically updated historical utilization.
- Open enrollment in HARPS for eligible populations
  - Other strategies to facilitate enrollment being explored

Health and Recovery Plans (HARPs) Premiums include all Medicaid State Plan services.
- Physical Health
- Behavioral Health
- Pharmacy
- Long-Term Care
- Health Home
Behavioral Health Benefit Package
- Inpatient - SUD and MH
- Clinic – SUD and MH
- PROS
- IPRT
- ACT
- CDT
- Partial Hospitalization
- CPEP
- TCM
- Opioid treatment
- Outpatient chemical dependence rehabilitation

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.

Enhanced Services for HARP under 1915 (i)
- 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

Initial HARP Eligible Population – Mental Health
- Minimum Qualifications
  - Medicaid Enrolled
o Initially, over 20 years of age as of 2011 (Qualifying service use prior to 21st birthday is considered in qualification.) Could add individuals 18-21 based on functional assessment and diagnosis e.g., first episode psychosis
o Non Medicare enrolled ("dual enrollee") in the 2009-2011 period
o Not eligible for OPWDD managed care
o SMI diagnosis

Other Criteria for Eligibility
• SSI or SSI/MA only and at least one "organized" mental health Medicaid fee-for-service or Medicaid managed care service in 2011.
• SSI individuals who did not meet the qualifications and non-SSI individuals who met the “Minimum HARP Qualifications” if they met one of the following qualifications:
  o Received three or more claims for ACT, TCM, PROS, or PMHP services in any of the 2009-2011 years.
  o Received more than 30 days of psych inpatient services in any of the last 3 years.
  o Had three or more psychiatric inpatient admissions in the three years 2009 through 2011 with at least one admission in 2011.
  o Were discharged from an OMH PC after an inpatient stay greater than 60 days in last year.
  o Had a current or expired AOT ("Assisted Outpatient Treatment") order in 2008-2011.
  o Were discharged from NYS Department of Corrections with a history of inpatient or outpatient treatment through OMH's Central NY Psych Center in 2008-2011.
  o Were residents in OMH funded Housing for persons with serious mental illness in any of the 2009-2011 years.

HARP Eligible Population – Substance Use
• 2 or more detoxification admissions (inpatient/outpatient) within 12 months (CY 2011).
• 1 inpatient rehabilitation admission within 12 months (CY 2011).
• 2 or more inpatient hospital admissions with primary substance use diagnosis or with SUD related DRG and a secondary substance use diagnosis within 12 months (CY 2011).
• 2 or more emergency department visits with primary substance use diagnosis or primary non-substance use/related secondary substance use diagnosis within 12 months (CY 2011).
Appendix III

MRT Behavioral Health Reform Work Group
Final Recommendations
October 2013
Appendix A
Behavioral Health Organizations

One of the many MRT recommendations enacted into law is the creation of BHOs. When fully implemented, all currently unmanaged Medicaid behavioral health services will be managed through some combination of regional Special Needs Plans (SNPs), Integrated Delivery Systems (IDSs), or Behavioral Health Organizations (BHOs).

Implementation of the BHOs is divided into two phases with Commissioners of OMH and OASAS having the authority to determine readiness for Phase II (Chapter 59 of the laws of 2011, Part H Section 42.d).

In Phase I, regional BHOs will perform the following functions:
- Monitor behavioral health inpatient length of stay.
- Reduce unnecessary behavioral health inpatient hospital days.
- Reduce behavioral health inpatient readmission rates.
- Improve rates of engagement in outpatient treatment post discharge.
- Improve understanding of the clinical conditions of children diagnosed as having a Serious Emotional Disturbance (SED).
- Profile provider performance.
- Test metrics of system performance.

In addition to reducing the incidence and length of unnecessary inpatient behavioral health care and increasing the rate of engagement in outpatient care, Phase I is designed to assist stakeholders in transitioning from the current unmanaged, fee-for-service environment to an environment in which the delivery and financing of behavioral health services is managed.

Implementation of Phase I is scheduled to begin on Nov. 1, with the BHOs fully operational by Jan. 1, 2012. Additional information is available at: http://www.omh.state.ny.us/omhweb/rfp/2011/bho/

For Phase II of BHOs, OMH, OASAS, and DOH will implement one or more risk bearing care management options. These include:
- Special Needs Plans (SNPs). These are specialty managed care networks that manage physical and behavioral health services for a defined behavioral health population;
- Integrated Delivery Systems (IDS). These are provider operated risk bearing entities that take on financial risk and manage the physical and behavioral health services for a defined behavioral health population;
• Carve-out BHOs. These are risk bearing managed care entities with a specialization in behavioral health. They only manage behavioral health services. The mechanism for care management may be different in different regions of the State, but payment will be risk-based for all of them. In New York City, full-benefit SNPs or IDSs should be implemented by April 1, 2013.
Appendix IV

Chapter 56 of the laws of 2013, Article VII as amended and enacted.

§ 36. Paragraphs (c), (m) and (p) of subdivision 1 of section 364-j of the social services law, paragraph (c) as amended by section 12 of part C of chapter 58 of the laws of 2004, paragraph (m) as amended by section 42-b of part H of chapter 59 of the laws of 2011, and paragraph (p) as amended by chapter 649 of the laws of 1996, are amended and a new paragraph (z) is added to read as follows:

(c) "Managed care program," A statewide program in which medical assistance recipients enroll on a voluntary or mandatory basis to receive medical assistance services, including case management, directly and indirectly (including by referral) from a managed care provider, [and including as applicable, a [mental health and substance abuse special needs plan] special needs managed care plan or a comprehensive HIV special needs plan, under this section.

(m) "Special needs managed care plan" [and "specialized managed care plan"] shall have the same meaning as in section forty-four hundred one of the public health law.

(p) "Grievance". Any complaint presented by a participant or a participant's representative for resolution through the grievance process of a managed care provider, [comprehensive HIV special needs plan or a mental health special needs plan].

(z) "Credentialed alcoholism and substance abuse counselor (CASAC)". An individual credentialed by the office of alcoholism and substance abuse services in accordance with applicable regulations of the commissioner of alcoholism and substance abuse services.

§ 37. Paragraph (c) of subdivision 2 of section 364-j of the social services law, as added by section 42-c of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(c) The commissioner of health, jointly with the commissioner of mental health and the commissioner of alcoholism and substance abuse services shall be authorized to establish special needs managed care [and specialized managed care] plans, under the medical assistance program, in accordance with applicable federal law and regulations. The commissioner of health, in cooperation with such commissioners, is authorized, subject to the approval of the director of the division of the budget, to apply for federal waivers when such action would be necessary to assist in promoting the objectives of this section. With regard to such special needs managed care plans, in addition to the applicable requirements established in this section, such commissioners shall jointly establish standards and requirements to:

(i) ensure that any special needs managed care plan shall have an adequate network of providers to meet the behavioral health and health
needs of enrollees, and shall review the adequacy prior to approval of any special needs managed care plan, and upon contract renewal or expansion. To the extent that the network has been determined to meet standards set forth in subdivision five of section four thousand four hundred three of the public health law, such network shall be deemed adequate;

(ii) ensure that any special needs managed care plan shall make level of care and coverage determinations utilizing evidence-based tools or guidelines designed to address the behavioral health needs of enrollees;

(iii) ensure sufficient access to behavioral health and health services for eligible enrollees by establishing and monitoring penetration rates of special needs managed care plans; and

(iv) establish standards to encourage the use of services, products and care recommended, ordered or prescribed by a provider to sufficiently address the behavioral health and health services needs of enrollees;

and monitor the application of such standards to ensure that they sufficiently address the behavioral health and health services needs of enrollees.

§ 37-a. Paragraphs (b) and (c) of subdivision 3 of section 364-j of the social services law are REPEALED.

§ 38. Paragraphs (a), (d) and (e) of subdivision 3 of section 364-j of the social services law, paragraph (a) as amended by section 13 of part C of chapter 58 of the laws of 2004, paragraph (d) as relettered by section 77 and paragraph (e) as amended by section 77-a of part H of chapter 59 of the laws of 2011, and paragraph (d) as amended by chapter 648 of the laws of 1999, are amended and a new paragraph (d-1) is added to read as follows:

(a) Every person eligible for or receiving medical assistance under this article, who resides in a social services district providing medical assistance, which has implemented the state's managed care program shall participate in the program authorized by this section. Provided, however, that participation in a comprehensive HIV special needs plan also shall be in accordance with article forty-four of the public health law and participation in a mental health and substance abuse special needs managed care plan shall also be in accordance with article thirty-one of the mental hygiene law.

(d) Until such time as program features and reimbursement rates are approved by the commissioner of health, in consultation with the commissioners of the office of mental health and substance abuse, the office for people with developmental disabilities, the office of children and family services, and the office of alcoholism and substance abuse services, as appropriate, the following services shall not be provided to medical assistance recipients through managed care programs established pursuant to this section, and shall continue to be provided outside of managed care programs and in accordance with applicable reimbursement methodologies;

provided, however, that no medical assistance recipient shall be
required to obtain services that are certified, funded, authorized or
approved by the commissioner of the office for people with developmental
disabilities through a managed care program until the program features
approved by the commissioner of health, in consultation with the commis-
ioner of the office for people with developmental disabilities, include
features for habilitation services as defined in paragraph c of subdivi-
sion one of section forty-four hundred three-g of the public health law:
(i) day treatment services provided to individuals with developmental
disabilities;
(ii) comprehensive medicaid case management services provided to indi-
viduals with developmental disabilities;
(iii) services provided pursuant to title two-a of article twenty-
five of the public health law;
(iv) services provided pursuant to article eighty-nine of the educa-
tion law;
(v) mental health and substance abuse services provided by a certified voluntary
free-standing day treatment program where such services are provided in
conjunction with educational services authorized in an individualized
education program in accordance with regulations promulgated pursuant to
article eighty-nine of the education law;
(vi) long term services as determined by the commissioner of
[mental retardation and the office for people with] developmental disa-
bilities, provided to individuals with developmental disabilities at
facilities licensed pursuant to article sixteen of the mental hygiene
law or clinics serving individuals with developmental disabilities at
facilities licensed pursuant to article twenty-eight of the public
health law;
(vii) TB directly observed therapy;
(viii) AIDS adult day health care;
(ix) HIV COBRA case management; and
(x) other services as determined by the commissioner of health.
(d-1) Services provided pursuant to title two-A of article twenty-five
of the public health law shall not be provided to medical assistance
recipients through managed care programs established pursuant to this
section, and shall continue to be provided outside of managed care
programs and in accordance with applicable reimbursement methodologies.
(e) The following categories of individuals may be required to enroll
with a managed care program when program features and reimbursement
rates are approved by the commissioner of health and, as appropriate,
the commissioners of the [department] office of mental health, the
office for [persons] people with developmental disabilities, the office
of children and family services, and the office of [alcohol] alcoholism
and substance abuse services:
(i) an individual dually eligible for medical assistance and benefits
under the federal Medicare program [and enrolled in a Medicare managed
care plan offered by an entity that is also a managed care provider];
provided that (notwithstanding paragraph (g) of subdivision four of this section):

(a) if the individual changes his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, and enrolls in another Medicare managed care plan that is also a managed care provider, the individual shall be (if required by the commissioner under this paragraph) enrolled in that managed care provider;

(b) if the individual changes his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, but enrolls in another Medicare managed care plan that is not also a managed care provider, the individual shall be disenrolled from the managed care provider in which he or she was enrolled and withdraw from the managed care program;

(c) if the individual disenrolls from his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, and does not enroll in another Medicare managed care plan, the individual shall be disenrolled from the managed care provider in which he or she was enrolled and withdraw from the managed care program;

(d) nothing herein shall require an individual enrolled in a managed long term care plan, pursuant to section forty-four hundred three-f of the public health law, to disenroll from such program; provided, however, nothing herein shall: (a) require an individual enrolled in a managed long term care plan, pursuant to section forty-four hundred three-f of the public health law, to disenroll from such program; or (b) make enrollment in a Medicare managed care plan a condition of the individual's participation in the managed care program pursuant to this section, or affect the individual's entitlement to payment of applicable Medicare managed care or fee for service coinsurance and deductibles by the individual's managed care provider.

(ii) an individual eligible for supplemental security income;

(iii) HIV positive individuals;

(iv) persons with serious mental illness and children and adolescents with serious emotional disturbances, as defined in section forty-four hundred one of the public health law;

(v) a person receiving services provided by a residential alcohol or substance abuse program or facility for a mentally retarded developmentally disabled;

(vi) a person receiving services provided by an intermediate care facility for the mentally retarded developmentally disabled or who has characteristics and needs similar to such persons;

(vii) a person with a developmental or physical disability who receives home and community-based services or care-at-home services through existing waivers under section nineteen hundred fifteen (c) of the federal social security act or who has characteristics and needs similar to such persons;