Navigating New York State’s Transition to Managed Care

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Agenda

• Introduction of the Managed Care Technical Assistance Center (MCTAC) and its resources

• Review key areas of readiness that all providers need to consider ahead of the transition to Managed Care

• Discussion of what changes front line providers can expect and how they can prepare

• How the transition to managed care fits in with other initiatives and the broader changing health care landscape
The goal of MCTAC is to provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.

NYS has partnered with MCTAC as a training, consultation, and educational resource center that offers resources to ALL mental health and substance use disorder providers in New York State.
# MCTAC SCOPE

<table>
<thead>
<tr>
<th>Licensing Office</th>
<th>Number of Agencies</th>
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<tr>
<td>OASAS</td>
<td>444</td>
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<tr>
<td>OMH</td>
<td>545</td>
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<tr>
<td>OASAS and OMH</td>
<td>107</td>
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<tr>
<td><strong>UNIQUE ORGANIZATIONS</strong></td>
<td><strong>887</strong></td>
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MCTAC is partnering with OASAS and OMH to provide:

- Foundational information to prepare providers for Managed Care
- Support and capacity building for providers
  - tools
  - group consultation
  - informational training
  - assessment measures
- Information on the critical domain areas necessary for Managed Care readiness
- Aggregate feedback to providers and state authorities
- MCTAC will serve as a clearing house for other Managed Care technical assistance efforts
Setting the Stage for Managed Care
GOVERNOR’S VISION FOR MEDICAID REFORM

It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure.”

Governor Andrew Cuomo, January 5, 2011

EXPECTED OUTCOMES:

- Improved health status
- Improved quality of care
- Reduced costs

Care Management for All.....
Medicaid Expenditures: 2013

$49.1 billion
Managed Care 101...
Managed Care: Definition

- An integrated system that manages health services for an enrolled population rather than simply providing or paying for the services.
- Services are usually delivered by providers who are under contract to or employed by the plan.
Managed Care: Key Ingredients

- Care “management”
  - Utilization management
  - Disease management
- Vertical service integration and coordination
- Financial risk sharing with providers
Managed Care: Goals

- Control costs
  - Health care costs growing faster than GDP
  - Reduce inappropriate use of services
  - Increase completion: focus on value
- Improve service quality
- Improve population health
- Increase preventive services: promote health (not just treat illness)
Managed Care: Key Components

- Network of providers created via contracting
- Medical home created with primary care provider functioning as a gatekeeper
- Prior approval required for inpatient admissions, specialty visits, elective procedures, etc.
- Benefits package defined set of covered services
- Contained list of covered pharmaceuticals (Formulary)
- Utilization review practices to manage inpatient admissions and length of stay
Managed Care Organization receives a fixed payment each month for each member: Per Member Per Month (PMPM)
- Fixed fee is for a specific time period (typically a month)
  - Covers defined set of services (these are the benefits)
- Provider accepts risk for delivering services:
  - Agrees to comply with prior authorization and utilization management practices
  - May enter into pay for performance arrangement
How Providers May Be Paid

- Capitation Rate: MD groups, hospitals or Accountable Care Organizations (ACOs) may enter into such agreements.
  - May include shared risk/savings arrangement
- Negotiated fee for service: some MDs, ancillary services, labs, etc..
- Per diem/ fixed daily payment: hospitals, SNF
- Payment based upon the episode of care:
  - Diagnostically Related Groups (DRGs)- Today
  - Acute /post acute bundled payments- Future
Determining Service Provision and Payment

- Is the person a member?
- Is the service included in the member’s benefit plan?
- Is the service medically necessary?
- If authorization is required, has the service been authorized?
- Is the provider that will deliver the service a part of the MCO network?

The answers to all of the above questions must be “YES” if the service is to be paid for by the MCO.
How Might Physicians Be Organized?

- **Medical Group**: MDs are employees of the group.
- **Independent Practice Association (IPA)**
  - MDs own and operate private practices.
  - MDs and other service providers may also choose to become a part of an IPA. Why?
    - Functions as a contracting vehicle with the MCOs: Provides critical mass of providers and covers a broad enough geography to be interest.
    - Functions as a management vehicle: offers business processes (such as capitation reconciliation) as well as clinical functions (UM and prior-authorization, etc.)
What Does the NYS Medicaid Managed Care Program Look Like Today?
The Publicly Funded Behavioral Health System Today.....

Medicaid Recipient

Services Not Covered by Medicaid Managed Care

Recipients Not Covered by Medicaid Managed Care

Medicaid Carve Out Services – Fee For Service

High Risk/High Need Medicaid Recipients

Non-Medicaid Funded Services

Who is accountable for the whole person?
Remaining System Challenges

- 20% of people discharged from general hospital psychiatric units are readmitted within 30 days.
  - A majority of these admissions are to a different hospital.
- Discharge planning often lacks strong connectivity to outpatient aftercare.
  - Lack of assertive engagement and accountability in ambulatory care.
  - Contributes to: readmissions, overuse of ER, poor outcomes and public safety concerns.
- Lack of care coordination for people with serious SUD problems leading to poor linkage to care following a crisis or inpatient treatment.
- A significant percentage of homeless singles populations has serious mental illness and/or substance use disorder.
Remaining System Challenges

- People with mental illness and/or substance use disorders are over represented in jails.
- Unemployment rate for people with serious mental illness is 85%.
- 33% of people entering detox were homeless and 66% were unemployed in 2011.
- People with serious mental illness die about 25 years sooner than the general population, mainly from preventable chronic health conditions.
- 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 person centered approach to medication choices.
What We Know about the Changes Anticipated....
RFQ BH Benefit Administration: MCO & HARP

• What will Change?
  – All Medicaid recipients will be members of a Managed Care Plan
  – More services (including recovery services) covered by Managed Care Plans
  – Individuals w/significant needs can become a part of a Health and Recovery Plan (HARP) - receive services not available through the standard BH plan
  – Imbeds process / resource changes within a specific philosophical model:
    • Person centered, recovery focused practices
    • Reliance on care management for high need individuals
    • Greater reliance on community services rather than inpatient services
    • Service integration
    • Greater accountability for achieving outcomes
Services To Be Covered by MCO as of July 1, 2015 *(Not paid for by MCOs today)*

- Continuing Day Treatment
- Partial hospitalization
- PROS
- ACT
- Rehabilitation services for residential SUD treatment supports
- Inpatient Psychiatric services (currently FFS for all SSI Medicaid recipients)
- Rehabilitation services for residents of community residences (beginning in year 2)
Who is eligible?

- Must either meet the target risk criteria and risk factors or be identified by service system or service provider identification.

**Target Criteria:**

- Medicaid enrolled 21 and older
- SMI/SUD diagnoses
- Eligible for Mainstream enrollment
- Not dually eligible
- Not participating in OPWDD program

140,000 individuals are estimated to be eligible (60,000 in Upstate NY).

All will be expected to have a Health Home Care Manager.
Let’s not forget:
Other initiatives underway.....

- Health Home Care Management
- Delivery System Reform Incentive Payment (DSRIP) Plan
Health Home Care Management
What is a Health Home?

• Outgrowth of the **Affordable Care Act**

• Designed to expand on the traditional medical home model to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care for individuals with multiple chronic illnesses
What is a Health Home?

• A program that provides **Care Management to High Need Medicaid Recipients**

• All of the professionals involved in a member’s care communicate with one another so that all needs are addressed in a comprehensive manner.

• **Medical, behavioral health and social service needs** are to be addressed
What are the Desired Health Home Outcomes?

- Improve health care and health outcomes
- Lower Medicaid costs
- Reduce preventable hospitalizations and ER visits
- Avoid unnecessary care for Medicaid members
Delivery System Reform Incentive (DSRIP) Plan....
Delivery System Reform Incentive Payment (DSRIP) Plan

$7.567 Billion over 5 years

**Goal:** Reduce avoidable hospitalizations by 25% over five years.

**Theme:** Communities of providers encouraged to work together to develop DSRIP project proposals

- Focus on reducing inappropriate hospitalizations
- Open to a wide array of safety net providers
- Payments are performance based
- Must choose from a menu of 25 CMS-approved programs
NYS DSRIP: Key Components

- Key focus on reducing avoidable hospitalizations by 25% over five years.
- Statewide initiative open to large public hospital systems and a wide array of safety-net providers.
- Payments are based on performance on process and outcome milestones.
- Providers must develop projects based upon a selection of CMS approved projects from each of three domains.
- Key theme is collaboration! Communities of eligible providers will be required to work together to develop DSRIP project proposals.
PERFORMING PROVIDER SYSTEMS (PPS): LOCAL PARTNERSHIPS TO TRANSFORM THE DELIVERY SYSTEM

Partners should include:

- Hospitals
- Health Homes
- Skilled Nursing Facilities
- Clinics & FQHCs
- Behavioral Health Providers
- Home Care Agencies
- Other Key Stakeholders

Responsibilities must include:

- Community health care needs assessment based on multi-stakeholder input and objective data.
- Building and implementing a DSRIP Project Plan based upon the needs assessment in alignment with DSRIP strategies.
- Meeting and reporting on DSRIP Project Plan process and outcome milestones.
DSRIP FINANCE FRAMEWORK

Outcome Metrics & Avoidable Hospitalizations

Process Metrics

Population Health Measures

Time
Rather than think about these transformational initiatives (BH Carve In, Health Homes and DSRIP) as disparate initiatives, let's consider the alignment that exists.
Transforming the Children’s System
Visual Framework for social emotional development and learning in New York State (0-18yrs population 4.5 million 2006 US census estimate)

- 4.5 million children
- 540,000 children
- 225,000 children

- Directing vulnerable individuals to optimistic paths
  Emotional Disturbance with intensive need for specialty services (~59%)

- Intervene early when developmental barriers or concerns arise
  Early identification and intervention with at-risk behavior (~12%)

- Strengthen all children's emotional and social development and learning
  Youth development builds protective factors for all children
– Intervening early in the progression of behavioral health disorders is effective and reduces cost.

– Accountability for outcomes across all payers is needed for children’s behavioral health.

– Solutions should address unique needs of children in a unified, integrated approach.

– The current behavioral healthcare system for children and their families is underfunded.

– Children in other public or private health plans should have access to a reasonable range of behavioral health benefits.
Proposed 2016 Children’s Medicaid Managed Care Model

For all children 0-21 years old

Mainstream Medicaid Managed Care Organization: Benefit Package

| All Health & Pharmacy Expanded Benefits | Behavioral Health State Plan Services and New State Plan Services | Aligned HCBS Services for children meeting LON and LOC criteria (transition of existing children’s 1915c Waivers - OMH, B2H & CAH /II) |

Care Management for All

Care Management will be provided by a range of models that are consistent with a child’s needs (e.g., Managed Care Plans, Patient Centered Medical Homes and Health Homes). Most children’s care and services will be coordinated through Health Homes.

*MCOs may opt to contract with other entities (e.g., BHOs) to manage behavioral health benefits

Service Provider Network

- Children’s Care at Home III Providers
- Children’s Behavioral Health Providers
- Foster Care Providers
- School Districts & CSEs
- Community Services & Supports (non-Medicaid)
- Juvenile Justice/Criminal Justice System
- Regional Planning Consortiums
- Local Government (LDSS, LGU, SPOA, Probation)

Required to contract

Required to have MOUs and/or working relationships
Existing Medicaid Services will Transition into Managed Care

- HCBS
- Clinic
- Day Treatment
- Community Residence
- Residential Treatment Facility
- Inpatient
Proposed New State Plan Services

- Mobile Crisis Intervention
- Community Psychiatric Supports and Treatment (CPST)
- Other Licensed Practitioner
- Psychosocial Rehabilitation Services
- Family Peer Support Services
- Youth Peer Advocacy and Training
Proposed HCBS Array

- Care Coordination (only for those ineligible for, or opt out of, Health Home)
- Skill Building
- Family/Caregiver Support Services
- Crisis & Planned Respite
- Prevocational Services
- Supported Employment Services
- Community Advocacy and Support
- Non-Medical Transportation
- Day Habilitation
- Adaptive and Assistive Equipment
- Accessibility Modifications
- Palliative Care
• CANS-NY (Child and Adolescent Needs and Strengths) undergoing revision to increase sensitivity in appropriate assessing all populations under the 1115

• CANS-NY Algorithm under revision to account for differentiation between LON and LOC, in addition to use in assigning Health Home acuity levels and subsequent rate payments
Current Continuum of Care

Intensity of Need

- Family Support
- Primary Care
- Clinic
- Day Treatment
- HCBS Waiver
- CR/RTF
- Hospital
Some Things to Consider Now

**Understanding your population:**

- Develop an agency-wide profile of the client population served and their needs
- Determine which insurance plans your clients are currently enrolled in for physical health, or behavioral health as applicable
- Map out the services you provide now and who provides them (e.g., which types of services and for whom)
- Identify any Home and Community Based Services you provide or that are available in your community
Importance of Cross-System Collaboration

- Community Supports
- Child Welfare
- Probation
- Developmental Disabilities
- Juvenile Justice
- Pre-K or After-School
- Mental Health
- Pediatricians
- School

Kids & Families
## Transformational Alignment

<table>
<thead>
<tr>
<th>Common Themes</th>
<th>Behavioral Health Carve-In</th>
<th>Health Homes</th>
<th>DSRIP</th>
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<tr>
<td><strong>SHARED GOAL:</strong></td>
<td>Reduce avoidable ED and Inpatient admissions</td>
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<td><strong>SHARED THEMES:</strong></td>
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<tr>
<td><strong>Collaboration</strong></td>
<td>New relationship expectation for MCOs and Providers</td>
<td>Cross-systems Care Team required</td>
<td>Essence of Performing Provider Systems; mutual accountability across NYS</td>
</tr>
<tr>
<td><strong>Integration</strong></td>
<td>Goal for QHP’s Required for HARPS</td>
<td>Required for Health Homes (Unfunded)</td>
<td>Required and potential dollars</td>
</tr>
<tr>
<td><strong>Care Management</strong></td>
<td>Available through QHP Required for HARP</td>
<td>New dollars to expand care management availability</td>
<td>Tool for achieving DSRIP goals</td>
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<tr>
<td><strong>New Solutions</strong></td>
<td>Flexible supply of Medicaid payable 1915i Services</td>
<td>Required focus on social determinants of health</td>
<td>Key to success</td>
</tr>
<tr>
<td><strong>Focus on Outcomes</strong></td>
<td>Core MCO value</td>
<td>Core Health Home value</td>
<td>Core DSRIP value</td>
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What should providers be doing to prepare?

Ready, Get Set, Go!
Change Management Leadership:
Guiding an organization through rapid and uncharted waters
So basically we need to:
Understanding the Impact of Change on the Workforce

• It is not unusual for an organization’s leadership to believe that it is engaged in promoting *strategic* change and for its workforce to experience *shock* change.

Leadership and staff members will need to work together to support these initiatives in ways that create synergy within the organization....
Getting Ready…

- **Innovate / Adapt:** Consider how your work might need to change in order to support the outcomes required in the transformed system.

- **Training:** Think about the training you will need in order to be successful in this new model – and share your thoughts with your supervisor.

- **Stay Informed:** Read articles and other materials given you to better understand how these changes will impact your work.

- **Get Involved:** Participate in relevant trainings / agency planning sessions.
Managed Care Readiness Assessment

Content Areas

• Understanding MCO Priorities
• MCO Contracting
• Communication /Reporting
• IT System Requirements
• Credentialing Process
• Level of Care (LOC) Criteria / Utilization Management Practices
• Member Services/Grievance Procedures
• Medical Management
• Quality Management/Quality Studies/Incentive Opportunities
• Finance and Billing
• Access Requirements
• Demonstrating Impact/Value (Data Management & Evaluation Capacity)
AREAS OF READINESS FOR MANAGED CARE
Understanding Managed Care

• Shifting from a volume based to an outcome based organization
• Clinical and Business Implications
• Transitioning from Utilization Review to Utilization Management
• Understanding HARP and HCBS
• Role and functions of physicians in a managed care environment
Understanding Your Population

- What insurance plans are your clients currently enrolled in for physical health, or behavioral health as applicable.
- Developing an agency wide profile of your population served and needs including HARP and HCBS.
- Understanding your internal service patterns.
- Have all your HARP eligible clients been enrolled?
Contracting

• Understanding current contracts with MCO’s
• Have you met with the MCO’s in your region?
• What is your plan for developing contracts with all MCO’s in your region?
• How do insurance plans in your region differ across factors such as authorization, billing, and utilization management?
• Reporting Requirements for each MCO
• Access Requirements
Business Operations

• Billing
• Cash Flow Management
• Revenue Cycle Management
• IT
Utilization Management

- Medical necessity
- Length of stay
- Clinical outcomes
- Level of Care
- Medical Management
- OASAS LOCADTR
"This really is an innovative approach, but I'm afraid we can't consider it. It's never been done before."
Data-Driven Decision Making

42.7 percent of all statistics are made up on the spot.
Data-Driven Decision Making

Making decisions based on available data
Professional experience – Colleagues – Available data

• What do we already track? What is required and necessary?

• What do we need to track? Requires thinking in advance how data may best inform what we need to know

• How should we track our progress? Implement standard performance-monitoring protocol

• What changes do we need to make? Be willing to adjust measurements intermittently – feedback loop
Data-Driven Decision Making

Utilizing Data

• **All levels of staff** will use the best available data to make informed-decisions
  
  • *Clinical staff* will collect, monitor, and review clinical outcome data to make treatment decisions
  
  • *Program directors* will use outcome data, clinical, claims and payment data for each service and program to understand profitability (e.g., cost management, staff management, reimbursement optimization, and service line profitability)
  
  • *Leadership* will use data to make decisions about staffing, and contracting and negotiating leverage
Thank you very much for your participation!

Contact us: MCTAC.info@nyu.edu

Visit MCTAC’s website for more information and access to past webinars and trainings:
http://www.CTACNY.com/ManagedCare