

# BEHAVIORAL HEALTH BENEFIT AND MANAGED CARE - DRAFT

9-11-2012

# MRT Recommendation

## Charge of Behavioral Health Workgroup:

- Consider the integration of substance abuse and mental health services, as well as the integration of these services with physical health care services, through the various payment and delivery models.
- Examine opportunities for the co-location of services and also explore peer and managed addiction treatment services and their potential integration with Behavioral Health Organizations (BHO).
- Provide guidance about health homes and propose other innovations that lead to improved coordination of care between physical and mental health services.

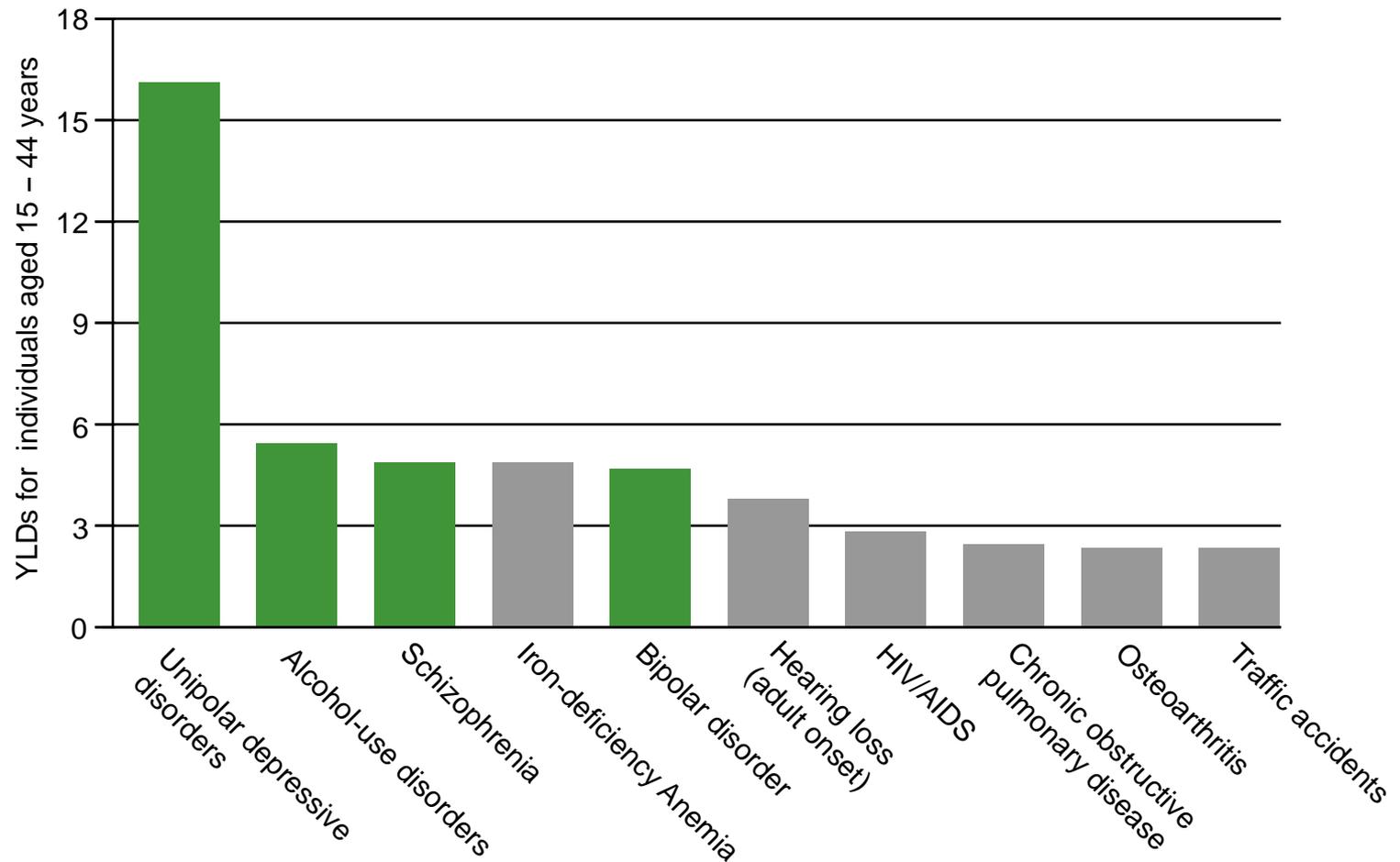
# Mental Health and Substance Abuse Population

## NYS Medicaid Top Diagnosis Groups and Spending

Diagnosis Grouping	Sum of MH/SA Spending	Sum of MH/SA Recips
<b>TOTAL</b>	<b>\$ 7,270,312,543</b>	<b>411,980</b>
Schizophrenia	\$ 1,064,324,943	71,796
Schizophrenia and Other Moderate Chronic Disease	\$ 987,483,578	51,021
HIV Disease	\$ 896,305,908	22,252
Dementing Disease and Other Dominant Chronic Disease	\$ 323,686,677	11,961
Diabetes - Hypertension - Other Dominant Chronic Disease	\$ 237,735,446	11,303
Diabetes and Other Dominant Chronic Disease	\$ 160,873,540	7,826
Psychiatric Disease (Except Schizophrenia) and Other Moderate Chronic Disease	\$ 156,625,537	15,842
Schizophrenia and Other Dominant Chronic Disease	\$ 140,336,943	5,809
Diabetes and Other Moderate Chronic Disease	\$ 139,516,879	11,583
Asthma and Other Moderate Chronic Disease	\$ 138,597,650	11,757
Diabetes - 2 or More Other Dominant Chronic Diseases	\$ 137,828,720	4,185
Depressive and Other Psychoses	\$ 136,096,859	13,809

Diagnosis Grouping	Sum of MH/SA Spending	Sum of MH/SA Recips
Two Other Moderate Chronic Diseases	\$133,721,190	16,691
Moderate Chronic Substance Abuse and Other Moderate Chronic Disease	\$130,702,804	10,031
One Other Moderate Chronic Disease and Other Chronic Disease	\$128,258,771	16,832
Bi-Polar Disorder	\$104,845,381	7,233
One Other Dominant Chronic Disease and One or More Moderate Chronic Disease	\$97,316,553	6,436
Diabetes - Advanced Coronary Artery Disease - Other Dominant Chronic Disease	\$90,245,930	3,303
Schizophrenia and Other Chronic Disease	\$89,393,330	5,494
Chronic Obstructive Pulmonary Disease and Other Dominant Chronic Disease	\$85,555,831	4,328
Diabetes and Hypertension	\$83,038,235	9,638
Diabetes and Asthma	\$79,170,754	5,484
Diabetes and Advanced Coronary Artery Disease	\$57,899,075	3,577
Dialysis without Diabetes	\$55,750,739	904

# Neuropsychiatric diseases are among the top 10 causes of disability worldwide (ages 15-44)



# Starting At The Beginning: Patterns of Mental Illness and Mental Health Care

50% of the population: no lifetime mental illness

50%--some MI in lifetime

20-25%--some MI within any year

NYS Medicaid: 6-7% specialty care rate/year

10-15%--mild impairment

5-7%--moderate impairment

5% (Kids)  
3-5% (Adults)  
Severe Impairment

## Patterns of Illness and Treatment:

--Anxiety, Mild depression/ADHD-----Most get no care; if treatment received, self help or meds-only in primary care is dominant modality--often with moderate relief. Most care is with PCP's. **Adequate "dose" of (brief) therapy indicated**

--Moderate depression, ADHD, well controlled bipolar and schizophrenia. Many in plans. About half get any care—**Combined therapy generally indicated.**

--Schizophrenia, bipolar illness, serious PTSD, OCD, Multiple trauma. **Good care requires continuous integrated mobile treatment with engagement and rehabilitation, meds, peer support. Most treatment in public system.**

# Behavioral Health

## Service Fragmentation Documented in MRT Report

- 600K people in public mental health system with \$7B in spending
- 250K people in substance abuse treatment system at \$1.7B in spending

*“Despite the significant spending on behavioral health care, the system offers little comprehensive care coordination even to the highest-need individuals, and there is little accountability for the provision of quality care and for improved outcomes for patients/consumers.”*

# Behavioral Health

## Service Fragmentation Documented in MRT Report

- “Behavioral health also is not well integrated or effectively coordinated with physical health care at the clinical level or at the regulatory and financing levels.”
- “The behavioral health system is currently funded primarily through fee-for-service Medicaid, while a substantial portion of physical health care for people with mental illness or substance use disorders is financed and arranged through Medicaid managed care plans. This also contributes to fragmentation and lack of accountability.”

# Specific Deficits to Address in Current Care

- Most care is discontinuous
- Most care is not integrated
  - ▣ Mental health care itself fragmented: meds, therapies, rehabilitation, addiction treatment may be in different locations by different providers, with HIT that does not communicate
  - ▣ Education, employment, housing supports available to only a minority
  - ▣ Medical care is often casual, not connected
- Orientation to symptom management not wellness management (changing significantly)
- Potential of Health Homes

# *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, 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 benefit is more inclusive of some behavioral health benefits for both SSI and Non SSI

\*\* Unless otherwise excluded or exempted from enrolling

# Behavioral Health – Substance Use Disorders (SUD)

Annual spending for all SUD treatment modalities in 2011-2012 is estimated to be \$1.5 billion

- What are the funding sources?
  - ▣ \$ 83.2 million from the Federal SAPT Block Grant
  - ▣ \$297.6 million from the New York State General Fund
  - ▣ \$32.9 million from Local Government maintenance of effort
  - ▣ \$89.4 million from Public Assistance: congregate care II, food stamps, SSI & SSA
  - ▣ \$2.7 million from Medicare
  - ▣ **\$883.4 million from Medicaid (50% is Federal match)**
  - ▣ \$76.2 million from other revenues that include additional federal and state grants, voluntary local government contributions and other third party revenues.
  
- Operating expenses for voluntary funded providers are paid through state aid (Mental Hygiene Law Article 26) to cover the balance left after monies are received by providers from other sources.

# Behavioral Health – Substance Use Disorders (SUD)

- SUD services were provided to 159,429 unique Medicaid recipients in 2010 (FFS claims only). Many recipients received services at multiple modalities.
  - The greatest number of recipients were served in outpatient programs (115,104), followed by Opioid Treatment (36,115), Crisis/Detox (25,102), inpatient (18,440) and Residential Rehab Services for youth (1,373)
  - **Over 1.75 billion dollars were spent to provide non-SUD services to recipients of SUD services in SFY 2010**
  
- Of the approximate 2.5 million people in NYS age 18 and over eligible for Medicaid, 5.5% received SUD services in SFY 2008
  
- Statewide trends indicate the number of individuals served and Medicaid dollars spent on Crisis/Detox, Inpatient and Opioid treatment services has been steadily declining; while the units of service and Medicaid dollars spent on non-SUD services for the SUD population has increased.

# Draft BH Benefit Redesign Proposal

- SNPs:
  - In NYC (and other areas of the State where viable) full benefit Special Needs Plans (SNP) are the preferred managed care vehicle **for members with “Significant” Behavioral Health Conditions**
  - SNP eligibility criteria and specialized benefits will be developed by DOH, OASAS, OMH and NYC with stakeholder input.
  - SNPs will manage all behavioral health services for all their members. Includes existing and specific carved out Behavioral Health services.
  - SNPs must have fully integrated care delivery and care management networks.
  - SNPs must be a licensed risk bearing entity in NYS.
  - A limited number of SNPs will be selected and preference will be given to mainstream plans (or freestanding SNPs) with robust specialty behavioral health expertise including active partnerships with BHOs and HHs.
  - Existing plans that are designated as SNPs must demonstrate intent and ability to reach out to SNP eligible enrollees to enroll as many eligible enrollees as possible in SNPs.
  - Specialized enrollment strategies will be considered and employed to maximize the enrollment of the higher need eligible population into SNPs.

# Draft BH Benefit Redesign Proposal

- Stakeholder/Plan input:
  - ▣ Care coordination and access
  - ▣ Quality Measures beyond HEDIS
  - ▣ Engaging the disengaged
  - ▣ Pay for performance
  - ▣ Promoting patient engagement throughout a long term episode of care

# Draft BH Benefit Redesign Proposal

- Mainstream Plans/BHOs
  - Mainstream plans will be responsible for all behavioral health services for all their members. Includes existing and specific carved out Behavioral Health services.
  - Plans will be required to either contract with a state certified BHO *OR* demonstrate capacity to meet carefully constructed State requirements for clinical management of behavioral health benefits.
  - Plan requirements will be jointly developed and monitored by OMH, OASAS and DOH with significant stakeholder input.
  - In communities *with* approved SNPs - this model will apply to the behavioral health population without “significant” behavioral health issues or those opting not to enroll in SNPs.
  - In communities *without* SNPs - this model will apply to all members.
  - This may be the predominate model in most areas outside of NYC.

# Draft BH Benefit Redesign Proposal - Timeline

## BHO/SNP Draft Implementation Timeline

Date	Task
Spring 2013	Finalize BHO/SNP program design
Summer 2013	Finalize BHO/SNP managed care contract requirements and financing
	Publish procurement documents for minimum 30 days
Fall/Winter 2013	Select SNPs/BHOs
Spring 2014	Fully operational

# Draft BH Benefit Redesign Proposal – Stakeholder Input

- Considerable Stakeholder input has already been received through the MRT process and through the behavioral health workgroup.
- This draft plan will be vetted one more time with key stakeholders to make any needed regional and population adjustments (e.g., children) necessary.
- Rate setting conversations will begin immediately.

# Abbreviations

- ADHD: Attention Deficit Hyperactivity Disorder
- B: Billion
- BH: Behavioral Health
- BHO: Behavioral Health Organization
- DOH: Department of Health
- FFS: Fee-for-service
- HEDIS: Healthcare Effectiveness Data and Information Set
- HH: Health Homes
- HIT: Health Information Technology
- HIV: Human Immunodeficiency Virus
- K: Thousand
- MH: Mental Health
- MI: Mental Illness
- MRT: Medicaid Redesign Team
- NYC: New York City

# Abbreviations Continued

- NYS: New York State
- OASAS: Office of Alcohol and Substance Abuse Services
- OCD: Obsessive-Compulsive Disorder
- OMH: Office of Mental Health
- PTSD: Post Traumatic Stress Disorder
- Recips: Recipients
- SA: Substance Abuse
- SAPT: Substance Abuse Prevention and Treatment
- SFY: State Fiscal Year
- SNP: Special Needs Plan
- SSA: Social Security Administration
- SSI: Supplemental Security Income
- TANF: Temporary Assistance for Needy Families
- YLDs: Years Lived with Disability