Office of
Mental Health

Preparing for Medicaid Managed Care and Value Based Payment in New York State

NYS Office of Mental Health
January 29th, 2019

What is the NYS Public Mental Health System?

- Approximately 4,500 State, voluntary, and county-operated mental health programs
  - i.e., Clinics, Personalized Recovery Oriented Services (PROS), Assertive Community Treatment (ACT) Teams, Comprehensive Psychiatric Emergency Programs (CPEP), Inpatient Programs, Home and Community Based Services (HCBS) providers
- Serves approximately 772,000 individuals
- $7 Billion in public mental health system expenditures
  - All funding sources such as Medicaid, Medicare, commercial insurance, SSI revenues for supporting housing and state aid
  - About $1.5 billion in State aid for mental health services

Mental Health Funding in NYS

- **Medicaid – largest payer**
- **Medicare**
  - Second largest payer for public mental health services
  - Significant payer for inpatient psychiatric care in Article 28 hospitals
- **State and local general fund dollars**
  - Fund a range of services such as supported education, peer support, drop in centers, clubhouses, vocational supports, crisis services, housing, housing supports
- **Third Party Health Insurance**

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Behavioral Health in Managed Care

- **Mainstream Managed Care Organizations (MCOs):**
  - Integrated benefits for adults 21 and over
  - MCOs qualified by NYS to administer the Behavioral Health benefit
- **Health and Recovery Plans (HARPs):**
  - For adults (21 and over) with serious mental illness and/or substance use disorders
  - Focused on integrated care for people with serious mental illness and substance use disorders
  - Specialized staff and enhanced benefits
    - Behavioral Health Home and Community Based Services
  - About 130,000 enrollees statewide

What is Value-Based Payment (VBP) through Medicaid Managed Care in NYS?

- Reimbursement focused on value
  - Fee-for-Service incentivizes volume, not outcomes
- Reduce total cost of care
  - Providers rewarded for achieving cross-system quality outcomes at or below expected total costs
- Focus is on quadruple aim
  - Improve Quality
  - Reduce Costs
  - Patient Experience
  - Care Team Well-being
- By April 1st, 2020, 80-90% of total MCO Medicaid expenditure (in terms of total dollars) must be captured in at least Level 1 VBPs
  - At least 35% of total payments contracted through Level 2 VBPs or higher for fully capitated plans
  - 15% contracted in Level 2 or higher for not fully capitated plans

Value Based Payment - Levels of Risk

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP
Activity Based Payments (ABP) with quality bonus and/or withhold based on quality scores	ABP with upside-only shared savings available when outcome scores are sufficient	ABP with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation bundle (with outcome-based component)
Activity Based Payments	Activity Based Payments	Activity Based Payments	Prospective total budget payments
No Risk Sharing	↑ **Upside Only**	↑ **Upside** & ↓ **Downside Risk**	↑ **Upside** & ↓ **Downside Risk**

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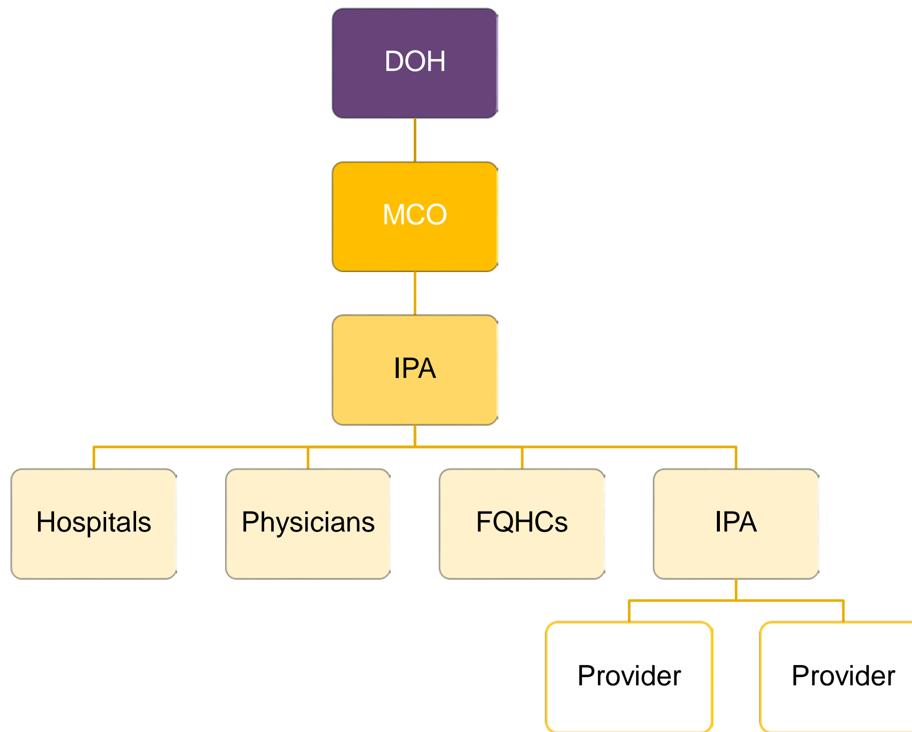
Total Care for the General Population: Flow of Funds

Independent Practice Association (IPA) to IPA Contract



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Behavioral Health Care Collaboratives

Without a focus on Behavioral Health (BH), value based outcome and spending reductions will be hard to achieve

- In NYS, Medicaid members with a BH diagnosis account for:
  - 21% of the population but 60% of Medicaid expenditures
  - 53.5% of hospital admissions
  - 45% of Emergency Department visits
  - 82% of all readmissions within 30 days of the original admission
    - 59% of those readmissions were for a medical condition
- The average length of stay per admission for BH Medicaid recipients is 30% longer than for the overall Medicaid population
- People with BH conditions experience poor inpatient to outpatient connection

Source: Measuring Physical and Behavioral Health Integration in the Context of Value-Based Purchasing. Greg Allen, December 7, 2016.
http://www.nashp.org/wp-content/uploads/2016/12/Allen-Slides.pdf
based on 2014 Medicaid claims data

Behavioral Health Care Collaboratives (BHCCs)

- New York State is investing $60 million over three years to support BH providers transitioning to VBP
  - Funds reinvested from Medicaid managed care savings
  - **The final BHCC deliverable is participation in a VBP arrangement**
- BHCCs must
  - Provide the full spectrum of BH services available in a region
  - Promote social determinants of health (SDH), physical health, and prevention through community partnerships
- BHCCs may take on a variety of forms ranging from loosely structured to incorporated entities

BHCCs MUST include, as available:

- A full spectrum of regionally available BH service types
- Peer-run agencies
- Certified Community Behavioral Health Clinics (CCBHCs)
- Community rehabilitation providers
- Primary care providers
- Community-based programs addressing SDH
- Hospitals or Article 28 licensed providers including hospital operated Article 31/32
- Health Homes (HH)
- Performing Provider System (PPS)

Behavioral Health Care Collaboratives

- **19 BHCCs funded and under contract**
  - Seven in NYC/LI
    - Cover 75% of Medicaid Managed Care covered lives
  - Twelve in rest of the state
    - Cover 90% Medicaid Managed Care covered lives

NYS Medicaid Behavioral Health Value-Based Payment Readiness Program: BHCC County Coverage of Network Provider

Updated Dec. 2017

BHCC(ROS)

- Capital Behavioral Health Network
- CBHS IPA
- Central New York BHCC
- Coordinated Care Network (CCN)
- Finger Lakes and Southern Tier BHCC (FLST)
- Hillside Catholic Charities BHCC
- Integrity Partners for Behavioral Health
- Mohawk Valley BHCC
- North Country BHCC
- South Central BHCC
- Tug Hill Seaway BHCC, Inc.
- Value Network BHCC

North Country
Tug Hill Seaway
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Vermont
New Hampshire
Central New York
Mohawk Valley
Captial BH Network
Hillside Catholic Charities
Mohawk Valley
FLST
Central New York
Integrity Partners
New York
Mohawk Valley
FLST
Value Network
Hillside Catholic Charities
Captial BH Network
Mohawk Valley
FLST
South Central
Mohawk Valley
Integrity Partners
Captial BH Network
Integrity Partners
Mohawk Valley
Integrity Partners
FLST
CBHS
CBHS
Coordinated Care Network
Coordinated Care Network
Massachusetts

BHCC(NYC&LI)

- AHN
- AsOne BHCC
- Behavioral Health NYC IPA
- CBC IPA
- IDUHA IPA
- Lower East Side Service Center BHCC (LESC)
- Recovery Health Solutions IPA

New York City and Long Island

Recovery Health Solutions
CBC
LESC
AHN
Behavioral Health NYC
AsOne
IDUHA
Recovery Health Solutions

Percentage of individuals in Medicaid Managed Care who received any Behavioral Health service:
New York City and Long Island - BHCCs covered 75%
Rest of State - BHCCs covered 90%

BHCC Goals

- Enable providers to measure and achieve clinical quality outcomes for BH populations
- Promote and develop provider capacity to show value and track quality
- Develop infrastructure to support data collection, reporting, and analytics
- Enhance BH provider readiness to participate in VBP arrangements
- Demonstrate value of rehabilitation and recovery

BHCC Funding

Supports four Readiness Areas upon which the BHCCs are evaluated bi-yearly:

1. Governance
2. Data Analytics
3. Quality Oversight
4. Clinical Integration

Managed Care Technical Assistance Center (MCTAC): BHCC Learning Collaborative

- MCTAC
  - Was created by NYS to prepare providers for the transition to Medicaid Managed Care
  - Provides training on quality improvement strategies, management, organizational and clinical practices
  - Operated by New York University's McSilver Institute in partnership with the National Center on Addiction and several community organizations
- Learning Collaborative designed to assist providers in transitioning to Value Based Payment
  - The first learning collaborative module focused on information management and data sharing, analytics, and reporting

Early Success

With New York State support, the BHCC initiative has already seen substantive results in increased

- communication
- education
- collaboration

among BHCC providers AND the local system of care

Communication

- Providers are meeting regularly, engaging in conversations about how to manage shared populations with entities that may have been competitors or not on their radar

- Conversations and partnerships have opened up with PPS, Federally Qualified Health Centers (FQHCs), private physician and hospital groups

Education

BHCC participants are becoming familiar with VBP and the New York State VBP Roadmap, including

- Clinical Advisory Group measures
- VBP arrangement types
- VBP levels of risk
- Participation in a VBP arrangement

Builds on the training provided by the NYS Managed Care Technical Assistance Center

Collaboration

Examples

- Creation of referral resources that catalogue the services provider/hours open/contact information of BHCC partners.
- Environmental scans across the BHCC network to determine
  - Technology in use
  - Measures already being collected
  - Gaps in the above

Collaboration

- Some BHCCs are determining the cost of delivering services; a necessary pre-requisite for engaging in VBP
- Some BHCCs across the state are working together on various aspects of infrastructure
- Partnering with data platforms, such as
  - Regional Health Information Organizations (RHIOs): real time alerts
  - PSYCKES: building BHCC views for population health management*
  - DSRIP Performing Provider Systems

*The Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES-Medicaid) is a NYS MH/SUD web-based tool to support quality improvement and clinical decision-making. Providers are able to access quality indicator and service use reports at the state, region, county, agency, site, program, and client level.

Early VBP Partnerships

- Partnerships already exist between some BHCCs' providers and contracting partners (FQHCs, ACOs, MCOs)
  - Behavioral Health and disability services provider and an FQHC
    - Joint IPA
  - Large multi services agency addressing complex needs and FQHC
    - Partnership to address complex family needs in Brooklyn
  - Substance Use Disorder specialty BHCC and Special Needs Plan
    - HIV Total Cost of Care
  - Substance Use and Opioid Treatment specialty BHCC and large metropolitan hospital
    - DSRIP project 3.a.i
  - Substance Use specialty BHCC and two Delivery System Reform Incentive Payment Program (DSRIP) funded partners
    - A large metropolitan hospital – addressing Opiates in the Emergency Room
    - PPS in Long Island– Health Home outreach

Challenges

- Achieving clinical integration
  - Within/across behavioral health providers
  - With physical health
- Developing/implementing standardized outcome measurement
  - Limited array of Behavioral Health HEDIS measures
  - No common recovery measures
  - Challenge of sharing substance use information
- Difficult to engage Primary Care and ACOs
  - Limited understanding of behavioral health
  - Challenging to demonstrate value to payers

Impressions

Visited and reviewed all 19 BHCCs

- Leadership matters
- Infrastructure investment essential for VBP participation
- Education takes time and multiple exposures
- Getting actionable data is a challenge
- Strong focus on clinical integration seems to support successful BHCC progress
- Ongoing tension between payers/providers regarding data, contracting and shared savings
- Two high-level challenges
  - Obtaining/using relevant data: real-time, total cost of care, performance
  - BHCC/ IPA sustainability
- Organized and clear communication with state officials matters.
  - Medicaid is a big program and many people don't understand the complexities of behavioral health

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Thank you for participating!

For questions, please email:
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For more information please visit:
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Appendix: FQHCs Pursuing APMs

Learn more about FQHC APM:

- NACHC Primer on Multi-layer model: http://www.nachc.org/wp-content/uploads/2015/11/Health-Centers-and-Payment-Reform.pdf
- Oregon APM Case Study: http://www.nachc.org/wp-content/uploads/2016/12/Oregon-FQHC-APM-December-2017.pdf
- CA APM Case Study: http://www.nachc.org/wp-content/uploads/2016/06/NACHC_Navigating-Payment-Reform.pdf
- NACHC APM Toolkit: http://www.nachc.org/wp-content/uploads/2017/08/NACHC_APMToolkit-1.pdf
- WA APM Case Study and Overview of WA APM by HMA: http://www.nachc.org/wp-content/uploads/2018/05/NACHC-WA-APM-Case-Study-2018.pdf https://www.healthmanagement.com/wp-content/uploads/072518-HMA-Roundup.pdf
- NASHP APM Toolkit (more focused on state officials): https://nashp.org/toolkit-state-strategies-to-develop-value-based-alternative-payment-methodologies-for-fqhcs/