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Medicaid Managed Care Oversight of Behavioral Health Care in New York

New York State Coalition on Children's Behavioral Health Policy Forum

Charlotte Carito, LMHC, BC-DMT

October 16, 2018

Agenda

- New York State Vision for the transition of Behavioral Health services to Managed Care
- Medicaid Managed Care Design and MCO Readiness
- Oversight of Medicaid Managed Care
- Lessons Learned

Shared Vision for Behavioral Health Transition of Children and Adults

Moving Towards Integrated Care

- ✓ Person-centered care planning and care management
- ✓ Integration of physical and behavioral health services
- ✓ Recovery-oriented services
- ✓ Patient/Consumer Choice
- ✓ Culturally and linguistically competent services and providers
- ✓ Ensure adequate and comprehensive networks
- ✓ Availability of evidence-based, evidence-informed, and promising practices
- ✓ Address the unique needs of children, families & older adults
- ✓ Tie payment to outcomes
- ✓ Track physical and behavioral health spending separately
- ✓ Reinvest savings to improve services for BH populations

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Children's System Transformation Vision

- Early identification and intervention
- **Family-Driven and youth-guided** care planning and care management
- Limit progression into high intensity and acute services
- Establish **trauma-informed care principles** across the entire service delivery system
- Maintaining children **at home** with support and services or in the least restrictive community-based settings
- Developing a delivery system that is free of silos that create barriers and result in disparate access to needed services
- Focus on **resilience for children** and **recovery for young adults** building resilience

Behavioral Health Medicaid Managed Care Design

Behavioral Health is managed by:

- Medicaid Managed Care Organizations (MCO) meeting rigorous standards (perhaps in partnership with a Behavioral Health Organization (BHO))
    - All MCOs MUST qualify to manage newly carved-in behavioral health services and populations
    - Plans can meet State standards internally or contract with a BHO to meet State standards
- Unlike the adult transition, which included a special needs plan (Health and Recovery Plans), **children will be in mainstream plans and services can be billed Fee-for-Service**
    - There will be parallel service systems in Medicaid Managed Care (MMC) and Fee-for-Service (FFS)

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Request for Qualification to Administer Children's Health and Behavioral Health Benefit

- Organization/Experience
- Personnel
- Member Services
- Network
- Cross Systems Collaboration
- Quality Management
- Data Reporting
- Utilization Management
- Clinical Management
- Claims Administration
- Financial Management

NOTE: The Children's Standards were developed to enhance standards already in place for Adults. MCOs are still required to meet all standards as outlined in the Adult RFQ as well as the additional requirements outlined in the Children's Standards.

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https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-07-31_mc_plan_rqmts.pdf

Children's Health and Behavioral Health Plan Readiness Review

NYS is implementing a phased approach to ensure MCOs are prepared to comply with the Children's Standards.

Phase 1: Ongoing Desk Reviews

- Document review of all Policies and Procedures, Medical Necessity Criteria, Recruitment and Training, Network Development. This is an iterative process leading up to and through implementation. This eventually rolls into the 2 year operational survey.
- This helps the State team focus on issues that need to be looked at during the onsite review.

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Children's Health and Behavioral Health Plan Readiness Review

Phase 2: December 2018

Claims/IT Readiness Review

- Confirm that MCOs are prepared to adjudicate claims for the three Children and Family Treatment and Support Services going live on January 1, 2019 including:
  - Other Licensed Practitioner (OLP)
  - Community Psychiatric Support and Treatment (CPST)
  - Psychosocial Rehabilitation Services (PSR)

- The State will conduct a review of the following areas:
  - Adequate systems configurations to pay claims as outlined in the NYS Children's Billing Manual
  - Provider testing of claims submissions
  - Providers are accurately loaded in the system
  - Review of provider portals

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Children's Health and Behavioral Health Plan Readiness Review

Phase 3: Early 2019

Comprehensive Program, Claims and IT Onsite Readiness Review

Confirm MCO ability to administer services moving into managed care according to the Children's Systems Transformation timeline. This includes:

- Interviews with Plan leadership, Utilization Management and Clinical Management staff, Member Services, Foster Care Liaison and Liaison for Medically Fragile Children
- Establishment of appropriate children's committees including the children's advisory committee
- Care Management and Authorization systems demonstrations
- IT and Billing Systems
  - Status of IT Systems Configurations
  - Claims system:
    - Submission of claims
    - Web portal demonstration
    - Network development

Provider and Consumer Protections

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Provider and Consumer Protections

Development of the following contractual requirements (Medicaid Managed Care Model Contract) relevant to providers who serve individuals in the behavioral health system as well as provide protection for consumers.

1. Continuity of Care
2. Network requirements
3. Timely payment
4. Contract/Credentialing Requirements
5. Payment of government rates
6. All Products Clause
7. Continuity of Care
8. No Prior Authorization for the first 90 days that service is carved in to MC

Provider and Consumer Protections: Government Rate Mandate

Government Rate Mandate- Government rate is the minimum reimbursement rate a provider can be paid

- Requires MCOs to pay the Ambulatory Patient Group (APG) or Medicaid government rate for all OMH-licensed or OASAS-certified ambulatory behavioral health services, including behavioral health home and community based services (HCBS), to Medicaid eligible enrollees unless an alternative payment arrangement is approved by NYS.
- This mandate extends beyond clinic services paid at APGs, to include all other ambulatory behavioral health services paid at government rates.
- If a behavioral health provider bills MCO less than APG/Medicaid government rate, MCO must pay provider APG/Medicaid government rate.
- If a provider submits a claims with an APG/Medicaid government rate, the MCO cannot reimburse or pay less than the APG/Medicaid government rate.

Provider and Consumer Protections: Network Protections

- Contracting/Credentialing Protections-
    - State-designation of providers will suffice for the MCO's credentialing process.
    - MMCOs shall not separately credential individual practitioners of:
        - OMH licensed and OASAS certified program
        - Adult BH HCBS Designated Provider
    - MMCOs may still collect and accept program integrity related information
- For in-network integrated outpatient service providers, MCOs must contract for the full range of integrated outpatient services provided by such provider.
- Serving 5 or more for members (transitional requirement)- MMCOs must offer contracts to any OMH or OASAS provider with five or more active MCO members (active in Rest of State until 7/1/18)
- MCOs must meet minimum network standards as outlined in the Model Contract
- Under no circumstances is the MCO allowed to require that the provider participate in MCO's non-Medicaid lines of business
    - Also referred to as an All Products Clause

Provider and Consumer Protections: Service Access Protection

No Prior Authorization- The MCO shall not require prior authorization for either urgent or non-urgent ambulatory services delivered by:

1. OASAS certified Part 822 outpatient clinics (including intensive outpatient services),
2. Outpatient rehabilitation and opioid treatment programs,
3. OASAS certified Part 816 medically supervised outpatient withdrawal and stabilization programs,
4. OMH Part 599 licensed outpatient clinics (including community mental health services),
5. Integrated clinics

BH Pharmacy Access - Immediate access / no prior authorization for BH prescribed drugs for 72 hour supply; and 7 day supply for prescribed drug or medication associated with the management of opioid withdrawal and / or stabilization.

Link to prior authorization guidance: https://www.omh.ny.gov/omhweb/bho/docs/prior-concurrent-auth-ambulatory-bh.pdf

Provider and Consumer Protections: Service Access Protections

- **BH Self-referrals**- Enrollees may obtain unlimited self-referrals for Mental Health and Substance Use Disorder assessments from participating providers without requiring preauthorization or referral from the enrollee's Primary Care Provider.
- **Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)-** Use of the OASAS LOCATDR 3.0 for SUD is mandated for level of care determination.
  - https://www.oasas.ny.gov/treatment/health/locadtr/index.cfm

- **New law effective January 1, 2017** No prior authorization or concurrent review for 14 days.
  - **Must be medically necessary – determined by designated tool**
  - Inpatient includes – detox, IPR and Residential (Part 820).
  - In State and In-Network
  - Provider notification within 48 hours of admission and initial treatment plan
  - Provider must regularly assess the need for continued stay and move if clinically appropriate.
  - Periodic Consultation is required - Provider and MCO should communicate!
  - Retrospective Review Permitted
  - Not yet in contract, but will be included in next cycle.

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Enhanced Provider and Consumer Protections for Children's Carve-In: Utilization Management

For children transitioning to Medicaid Managed Care April 1, 2019:

- Services in POC for HCBS or LTSS, including provider, continue unchanged for at least 180 days
- No prior authorization/UM for new children's CFTSS services and newly aligned HCBS added to POC within first 180 days

For FFS Children in receipt of HCBS that move to MMC between April 1, 2019 and March 30, 2021:

- Services in POC for HCBS or LTSS, including provider, continue unchanged for at least 180 days

Enhanced Provider and Consumer Protections for Children's Carve-In : Network Adequacy

- MMCOs are required to offer contracts to:
  - OMH/OASAS providers with 5 or more enrollees who are under age 21
  - All licensed school-based mental health clinics in MCO's service area
  - All NYS-designated providers of Children's Specialty Services, within the MCO's service area, who were formerly a provider of services for the 1915(c)
  - Children's Health Homes
  - Out of Network Providers with members receiving services offering single case agreements
  - All VFCAs in the MCOs Service Area
  - All MCOs must have an adequate number of CFTSS and HCBS as outlined Children's Standards
- Continue with current provider for BH Episode of Care for 24 month period

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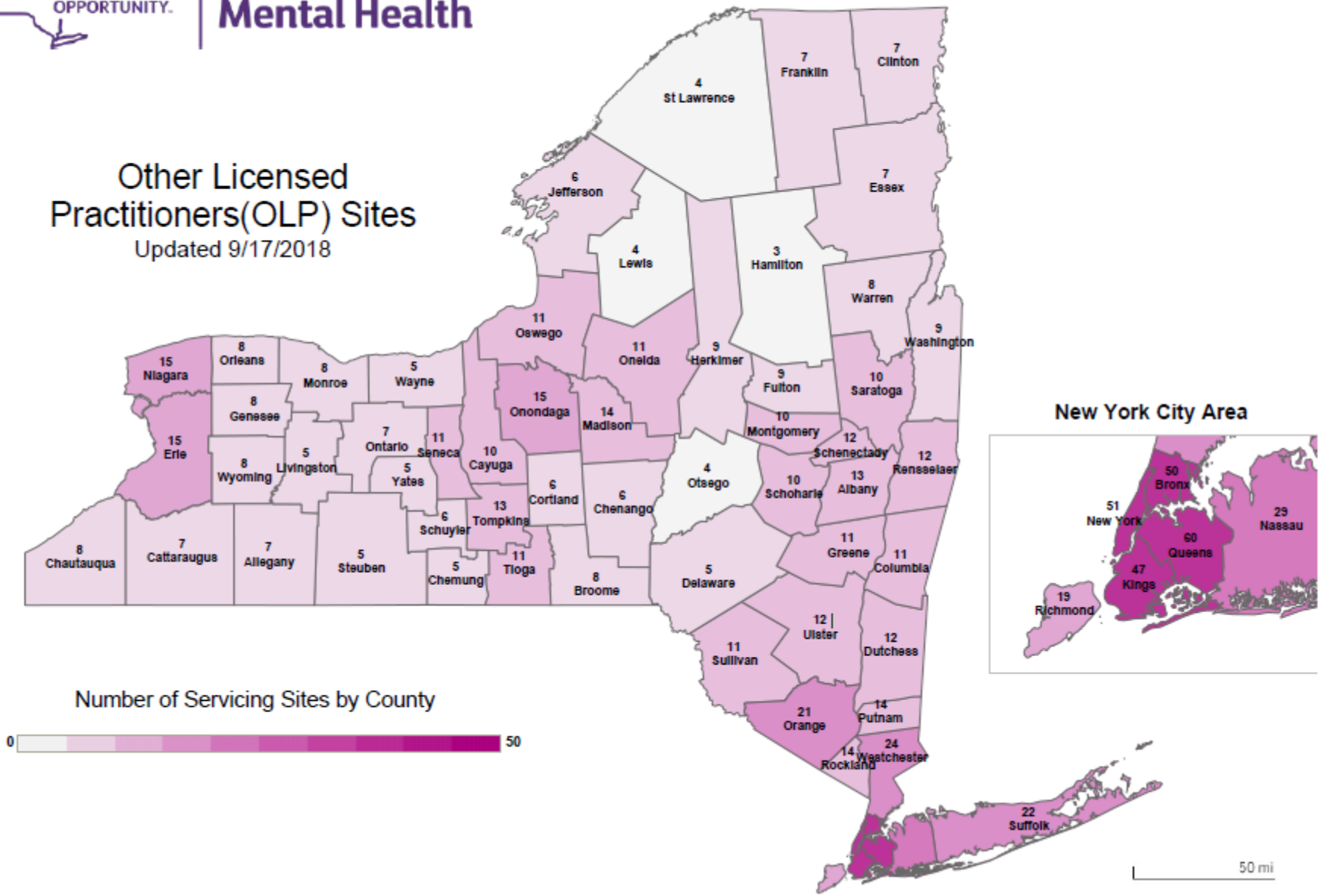
Other Licensed Practitioners(OLP) Sites

Updated 9/17/2018



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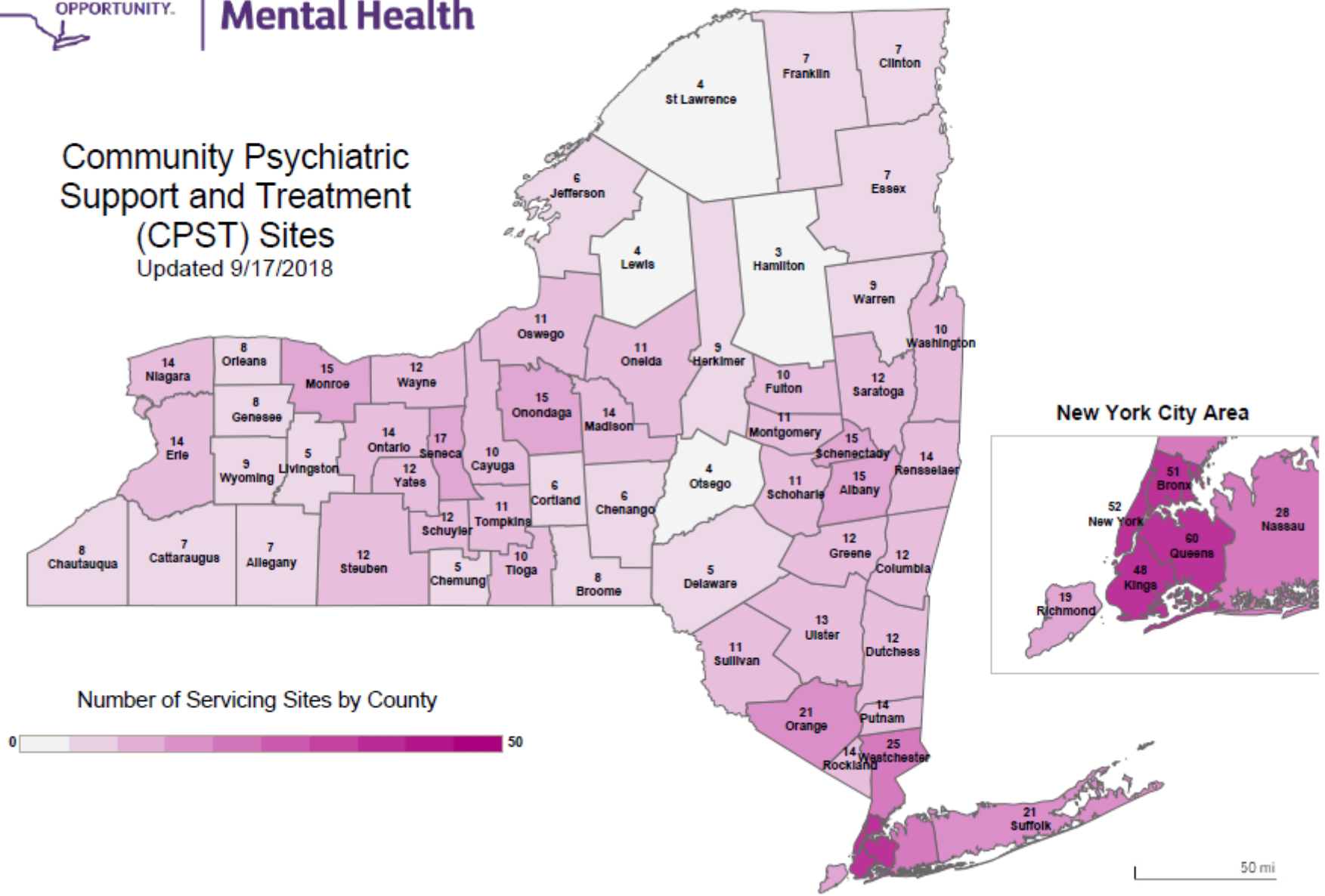
Community Psychiatric Support and Treatment (CPST) Sites

Updated 9/17/2018



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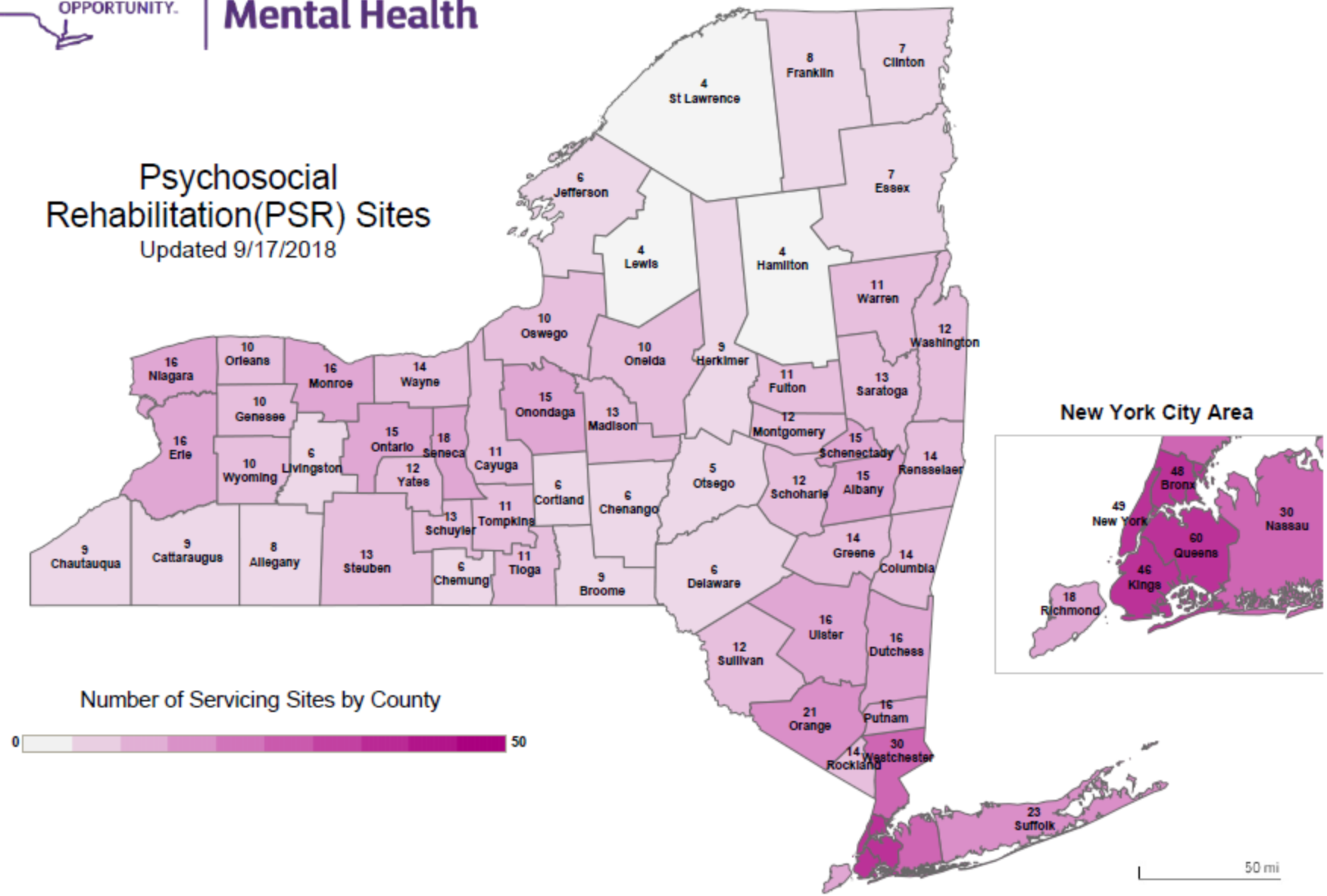
Psychosocial Rehabilitation(PSR) Sites

Updated 9/17/2018



Oversight of Behavioral Health Services in Medicaid Managed Care

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Key Components to Monitor Integrated Person-Centered Care in Medicaid Managed Care

1. Collaboration
2. Stakeholder Feedback
3. Data, Data and more Data
4. Leveraging and Changing Existing Oversight processes (Ex. Medicaid Model Contract and Operational Surveys)

Oversight of Medicaid Managed Care: Collaboration

Everyone working together to change the system. Roles are changing and flexibility is needed to continue to move towards system transformation.

- ✓ With sister agencies (OMH, DOH, OASAS, OCFS, OPWDD)
- ✓ With local government
- ✓ With a variety of stakeholders

Oversight of Medicaid Managed Care: Stakeholder Feedback

NYS is absorbing feedback on an ongoing basis from stakeholders through the following channels

- Regional Planning Consortiums
- Plan/Provider Roundtables (NYC and Rest of State)
- Consumer and provider complaints
- Managed Care Technical Assistance Center Forums
- Monthly Meetings with MCOs and Advocates
- Formal and Informal Workgroups
- Monthly Meetings with MCO BH Medical Director

Oversight of Medicaid Managed Care: Stakeholder Feedback – Complaints and Inquiries

Medicaid Managed Care Mailboxes

- OMH: OMH-Managed-Care@omh.ny.gov
- OASAS: Practice Innovation and Care Management (PICM) Mailbox: PICM@oasas.ny.gov
- DOH: Behavioral.Health.Complaints@health.ny.gov

OMH Managed Care Mailbox

OMH developed the OMH Managed Care (OMH-Managed-Care@omh.ny.gov) mailbox to receive and respond to questions related to :

- Managed Care transition
- Billing and Claiming concerns
- Service questions

- Mailbox inquiries are given an initial response within 1-3 business days
- Any issues rising to the level of a complaint are sent to DOH for further investigation
- Day 1 of Implementation
  - Conduct daily calls with State agencies to address implementation concerns

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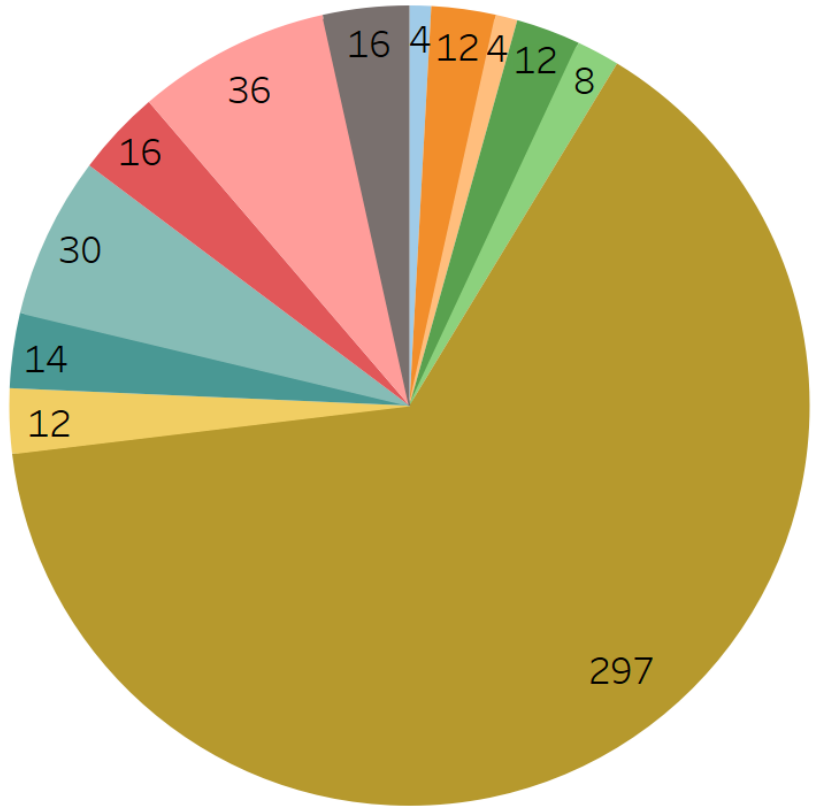
Sample Complaints Analysis from 1/19/2017 to 10/3/2018

<Managed Care Complaints + Inquiries>



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Program Type
- 21 Century Cures Act
- ACT
- CDT
- Children's Provider
- CPEP
- HCBS
- Inpatient
- OASAS
- OMH Clinic
- Other
- PROS
- SDE

Sum of Number of Records. Color shows details about Program Type. Size shows sum of Number of Records. The marks are labeled by sum of Number of Records. Details are shown for Program Type. The data is filtered on MCO, Date Received, Status (Closed/ Open) and Submission Category. The MCO filter keeps 19 of 19 members. The Date Received filter ranges from 1/19/2017 to 10/3/2018. The Status (Closed/ Open) filter keeps Closed and Open. The Submission Category filter keeps Null, Complaint, Other, Question and Question & Complaint. The view is filtered on Program Type, which excludes Null.

Oversight of Medicaid Managed Care: Data – Monitoring Reports

1. Staffing
2. Network Adequacy
3. Claims
    1. Service Utilization and Access
    2. Claims and Encounter Payment
4. Medical Necessity Denials (Inpatient and Ambulatory)
5. Adult BH HCBS Workflow Data
6. Ad Hoc Reports

Many of these reports will be carried over to monitor the Children's Transition. NYS continues to research other reports as applicable.

Managed Care Monitoring Reports: Staffing

NYS developed specific staffing requirements for managing the Adult and Children's population to ensure that the Managed Care companies possessed the appropriate staff and experience to address the needs to individuals in receipt of behavioral health services.

- MCOs are required to:
  - ✓ Notify the state when there is a change in Key Staffing
  - ✓ Submit a Staffing report monthly
    - MCO Key Staff for Children
      - BH Medical Director for Children
      - BH Clinical Director for Children
      - Medical Director Designated for Medically Fragile Children
      - Foster Care Liaison
      - Liaison for Medically Fragile Children

Managed Care Monitoring Reports-Network

- There are minimum contracting requirements for each program that is brought into Managed Care for Adults and Children
- The State tracks on a monthly basis (for Children) MCO network adequacy

Managed Care Monitoring Reports-Minimum Network Standards

Service	Urban Counties	Rural Counties
• Outpatient Clinic — licensed to serve children and adolescents as well as adults (mental health) • Outpatient Clinic — licensed to only serve children and adolescents under 21 years old (mental health) • Outpatient Clinic (SUD)	The higher of 50% of all licensed clinics or minimum of 2 per county	The higher of 50% of all licensed clinics or minimum of 2 per county
• Outpatient Clinic — with 0–5 specificity reflected on Operating Certificate • State Operated Outpatient Programs • Article 28 Hospitals — licensed for children only • Detoxification (including Inpatient Hospital Detoxification, Inpatient Medically Supervised Detoxification, and Medically Supervised Outpatient Withdrawal	All in county	All in region
Partial Hospitalization serving children	2 per county where available	All in region where available
Comprehensive Psychiatric Emergency Program & 9.39 ERs — child specific	All per county	All per region
OASAS opioid treatment program (OTP) services	All per county and for NYC — all in the City	All per region
Inpatient Treatment (SUD)	Minimum of 2 in county where available	Minimum of 2 in region where available
Buprenorphine prescribers	All licensed prescribers serving Medicaid patients	All licensed prescribers serving Medicaid patients

Managed Care Monitoring Reports-Minimum Network Standards

Service	Urban Counties	Rural Counties
• Community Psychiatric Supports and Treatment (CPST) • Other Licensed Practitioner (OLP) • Family Peer Support Services • Youth Peer Support and Training • Psychosocial Rehabilitation Services (PSR) • Caregiver/Family Supports and Services • Habilitation • Respite (Crisis/Planned) • Prevocational Services • Supported Employment • Community Self-Advocacy Training and Support	The higher of 50% of all programs designated or minimum of 2 per county designated where available	The higher of 50% of all programs designated or minimum of 2 per region designated where available
OCFS Licensed VFCAs	TBD	TBD
Children's Crisis Intervention	All within Plan's service area	All within Plan's service area
Adaptive and Assistive Equipment	One entity experienced in arranging for assessments and gathering documentation to support provision of adaptive and assistive equipment for Medicaid eligible children	One entity experienced in arranging for assessments and gathering documentation to support provision of adaptive and assistive equipment for Medicaid eligible children
Accessibility Modifications	One entity experienced in arranging for assessments and gathering documentation to support provision of accessibility modifications for Medicaid eligible children	One entity experienced in arranging for assessments and gathering documentation to support provision of accessibility modifications for Medicaid eligible children
Palliative Care	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available

Managed Care Monitoring Reports-Network

Sample Adult Network Report Summary

	Nassau		Suffolk		Orange		Rockland	
	Contracted	Available	Contracted	Available	Contracted	Available	Contracted	Available
Clinic	11	12	20	22	5	5	3	4
State Operated Clinic	0	0	4	4	2	2	2	2
PROS, CDT, IPRT	4	5	15	15	2	2	2	2
ACT	5	5	7	7	1	1	1	1
Partial Hospital	2	2	1	2	0	0	0	0
CPEP	0	0	0	1	0	0	0	0
Inpatient 28	6	6	3	6	2	2	1	1
OASAS Outpatient	30	34	33	40	12	13	6	6
OASAS Opioid Treatment	3	3	5	5	1	1	1	1
TOTAL	61	67	88	102	25	26	16	17

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Managed Care Monitoring Reports: SAMPLE HCBS Workflow Data

For MCOs that offer a Health and Recovery Plan and have members accessing Home and Community Based Services (specialty services in addition to Mental Health and Substance Use services), the State tracks completion of the assessment and access to the service.

See below for sample report:

Progress in Unique Recipients Count	HARP Enrolled	Health Home Enrolled	HCBS Assessed	HCBS Eligible	LOSD Requested	HCBS Auth Rev'd	HCBS Claimed
9/20/2018	132,286	38,985	21,430	20,322	8,687	3,432	2,838
Compare with previous month report	-1,378	-653	+995	+2,014	+595	+213	+230
Compare with previous month report (by %)	-1%	-2%	+5%	+11%	+7%	+7%	+9%

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Managed Care Monitoring Reports: Medical Necessity Denials

Inpatient Medical Necessity Denial Report: Each month, MCOs are required to electronically submit a report to the State on all denials of inpatient behavioral health services based on medical necessity.

- The report includes aggregated provider level data for service authorization, requests and denials
- Whether the denial was Pre-Service, Concurrent, or Retrospective, and the reason for the denial.
- Total number of inpatient clinical denials across all MCOs from 2016 to present is **1.4%**

Outpatient Medical Necessity Denial Report: MCOs are required to submit on a quarterly basis a report to the State on ambulatory service authorization requests and denials for each behavioral health service.

- Total number of outpatient clinical denials across all MCOs from 2016 to present is **.4%**
- Total number of HCBS denials across all MCOs from 2016 to present is **.4%**

Managed Care Monitoring Reports: Claims

Service Utilization and Access

- Comparative analysis is done between MCO and FFS baseline data to identify problem areas

Claims and Encounter Payment

- On a monthly basis MCOs submit the following claims information:
  - ✓ Total paid
  - ✓ Total pended
  - ✓ Total denied (administrative denials)
  - ✓ Top ten reasons denied claims

Managed Care Monitoring Reports: Sample Claims and Encounters Payment

NYC MH & SUD Claims Stats			
Plan name	Total Received Claims	Total Paid Claims	Total Denied Claims
Plan 1	35,510	93%	26%
Plan 2	41,558	89%	15%
Plan 3	17,743	91%	31%
Plan 4	17,838	84%	19%
Plan 5	67,259	91%	8%
Plan 6	125,388	92%	8%
Plan 7	192,857	83%	24%
Plan 8	19,349	60%	7%
Plan 9	3,005	76%	12%
Plan 10	368	55%	50%
Total (08/01/2018-08/31/2018)	520,875	86.8%	16.6%
Last report (07/01/2018-07/31/2018)	521,309	78.1%	16.0%

Note: The total received, paid and denied claims volumes are monthly snapshot, hence it is possible that the sum of paid and denied volumes exceeds the total received volume for one certain reporting month.

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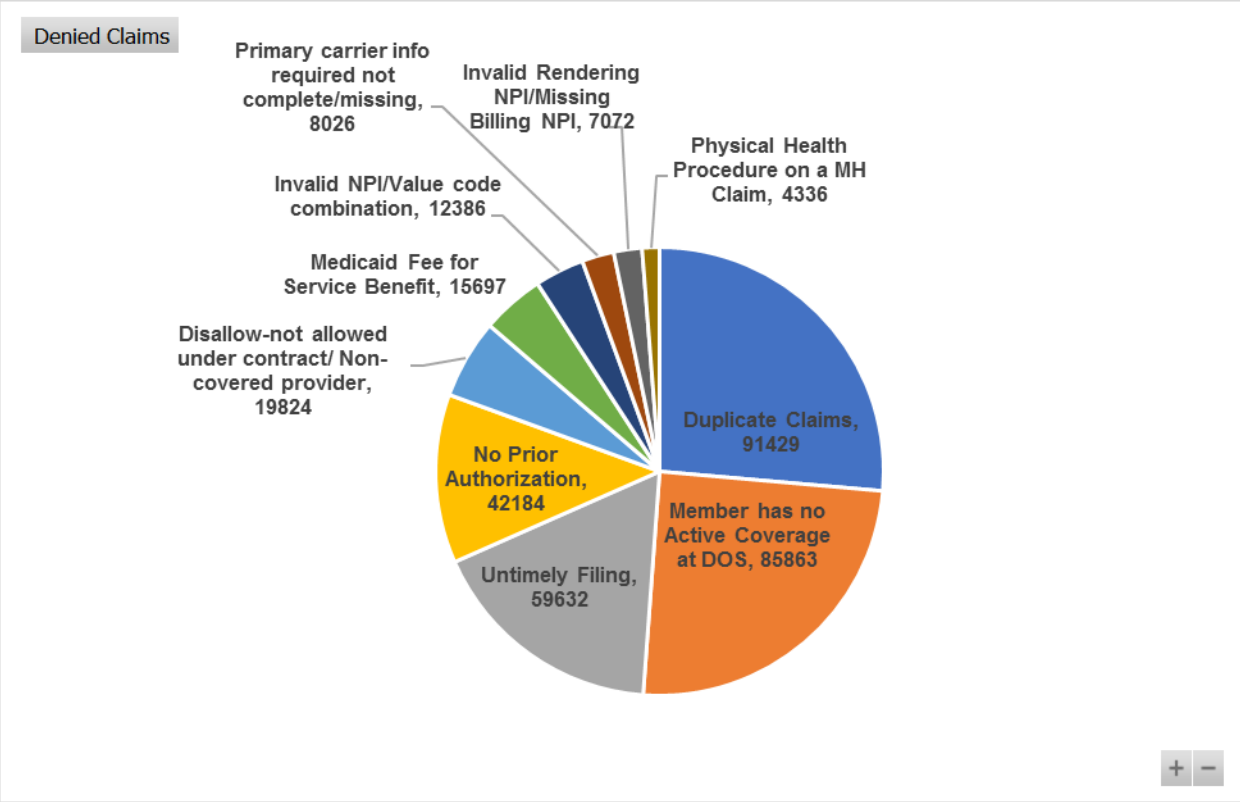
Managed Care Monitoring Reports: Sample Claims Denials Dec 2017-May 2018



Top 10 Pended Reasons	Count of Claims
Duplicate Claims	91,429
Member has no Active Coverage at DOS	85,863
Untimely Filing	59,632
No Prior Authorization	42,184
Disallow-not allowed under contract/ Non-covered provider	19,824
Medicaid Fee for Service Benefit	15,697
Invalid NPI/Value code combination	12,386
Primary carrier info required not complete/missing	8,026
Invalid Rendering NPI/Missing Billing NPI	7,072
Physical Health Procedure on a MH Claim	4,336

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Oversight of Medicaid Managed Care: Leveraging and Changing Existing Oversight Processes – Medicaid Managed Care Operational Surveys

- The goal is to complete an Operational Survey for each Medicaid Managed Care Organization every year.
  - A Full Operational Survey is a review of all survey tasks and involves all survey partners, Aids Institute, Office of Patient Quality and Safety, and Office of the Medicaid Inspector General. (Soon to include Behavioral Health partners, too).
- OMH and partner agencies have worked to incorporate the **Behavioral Health Medicaid Managed Care Standards** into the DOH Operational Survey to ensure that MCOs are continuing to meet all requirements.

Oversight of Medicaid Managed Care: Leveraging and Changing Existing Oversight Processes – Medicaid Managed Care Model Contract

New York State (NYS) has provided Medicaid Managed Care Organizations (MMCO aka MCO aka Health Plans aka Insurance Company) with specific legal requirements, the Medicaid Managed Care Model Contract, and accompanying guidance regarding the process of entering into agreements with providers of these services that address the following:

1. Promoting financial stability through payment and claiming requirements;
2. Ensuring Medicaid Managed Care plans establish adequate behavioral health provider networks; and
3. Supporting access to and removing barriers to behavioral health treatment and recovery services.

Providers can access the approved Medicaid Managed Care Model Contract (including behavioral health provisions as amended October 1, 2015) on the NYS Department of Health website:

https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

BH Medicaid Managed Care: Lessons Learned

- Billing and Claims systems and needed edits for Behavioral Health transitions
  - Unlicensed providers issue (https://www.omh.ny.gov/omhweb/bho/claiming-guidance-for-clinics.pdf)
  - EMR Billing System
  - Role of the clearinghouse in getting a claim to the MCO
    - Understand your relationship with 3rd party billing vendors and clearinghouses
- Understand the differences between Notification, Prior Authorization and Concurrent Review
- Pay close attention to contracting and credentialing
- Build a robust communication process with Providers, MCOs and State
- Gathering "point person" at each MCO for specialty children's services (https://matrix.ctacny.org/)
- Ensure your agency is connected to larger networks in preparation for VBP

Next Steps for January 1 Launch

- Claims testing
  - Timely submission of claims
  - Coordination of billing and clinical staff

  Note: This is a requirement within the Children's Start-up Funds
- Educate horizontally and vertically in your agency on all aspects of system transformation through staff meetings, agency memos, supervision, etc.
- NYS will be forming short-term workgroups to encourage MCO and provider generated solutions as needs are identified.

Thank you!