Testimony of the New York Health Plan Association

to the

Assembly Standing Committee on Mental Health and Developmental Disabilities

on the subject of

Transition of Mental Health Supports and Services into Managed Care

October 21, 2015

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 28 health plans that provide comprehensive health care services to more than eight million New Yorkers, appreciates the opportunity to present its members' views on the transition of mental health supports and services into Managed Care. Our member health plans have long partnered with the state in achieving its health care goals, including improved affordable access to quality care in its government programs as well as providing access to care that exceeds national quality benchmarks for commercial enrollees. HPA's member plans include those that offer a full range of health insurance and managed care products (HMO, PPO, POS, etc.), prepaid health services plans (PHSPs) and managed long term care (MLTC) plans. The New Yorkers who rely on these plans are enrolled through employers, as individuals, or through government sponsored programs — Medicaid Managed Care, Child Health Plus and now, through New York's exchange, the NY State of Health (NYSOH).

We appreciate the opportunity to offer our view on the transition of mental health supports and services to managed care, which took effect in New York City on October 1st of this year. Moving the care and services for New Yorkers with behavioral health (BH) and substance use disorder (SUD) issues to managed care was a recommendation that came out of the Behavioral Health Workgroup of the Governor's Medicaid Redesign Team (MRT), which was created in 2011 to address underlying health care cost and quality issues in New York's Medicaid program. The workgroup, charged specifically with designing the restructure of BH Medicaid services, had 22 members including state officials, advocates, providers, insurers, and other stakeholders from the New York behavioral health community.

THE BASIS FOR TRANSITION

Discussion regarding the transition should begin with a reminder of the shortcomings of the current system it is tasked with replacing. The section below quotes directly from the state's Request for Qualification (RFQ) document for plans, released in March 2014:

"For many adults with serious mental illness and substance use disorder, the broad array of treatment options is difficult to navigate. The current service system does not always ensure priority access to individuals with the highest needs. Services provided by different clinicians are not always well-coordinated, and payments for services provided are not always structured to provide incentives that promote recovery. . . .

Noting that "Medicaid's behavioral health resources are still largely unmanaged and services are paid through a fee for service model which lacks accountability for outcomes and leads to fragmentation of care," the RFQ cited numerous problems with the existing system. Some of the most significant include:

- More than 20% of people discharged from general hospital psychiatric units are readmitted within 30 days. The majority of these readmissions are to a different hospital.

- Poor management of medication and pharmacy contributes to inappropriate polypharmacy, inadequate medication trials, inappropriate formulary rules, poor monitoring of metabolic and other side effects, and lack of a person centered approach to medication choices. In SUD treatment, patients often lack access to appropriate medications due to lack of management and inadequate number of certified physicians or programs that provide medication services.

- The lack of care coordination for people with serious SUD problems leads to poor linkage to care following a crisis or inpatient treatment.

The system the state seeks to improve through the transition to managed care, quite simply, does not provide the services the population needs—in part because of the almost complete lack of coordination of care.

PLAN PREPARATION FOR THE TRANSITION

To say that plans have been working diligently to be ready for the transition would be an understatement. Of ten health plans participating in the mainstream and HIV/SNP Medicaid managed care program in NYC, all qualified to provide carved-in BH and SUD services, and six of the eight mainstream plans chose to also offer a Health and Recovery Plan (HARP) product.

The RFQ and subsequent readiness review process plans went through has been rigorous. The RFQ outlined requirements related to plan organizational capacity—requirements for 24/7 toll free hotlines to provide information and service referrals and crisis referrals; requirements that plan staff be trained to handle BH network development, care management and provider relations activities related to BH; requirements for plans to provide training for their own staff and BH providers; requirements for plans to provide resources to assist with BH-specific quality management initiatives. The RFQ further outlined experience requirements for plan BH staff including requiring specific staff to be hired. Also among the long list of requirements and expectations of plans were network contracting and development requirements.

In short, plans have been working hard for the past two years to make sure the transition is successful and have invested significant dollars to prepare for the transition. Notably, they have made this investment before ever seeing a dollar in premium funding.

Plans have worked very collaboratively and cooperatively with the state and with providers to help them transition to managed care. Moreover, there are multiple layers of protection for providers built into the transition by the state; from rates to limits on utilization management, to reporting requirements on plans.

ISSUES AND ONGOING CONCERNS FOR PLANS

Plans are hopeful that they can help improve the delivery of care to this population. But, three weeks after the effective date in New York City, plans continue to have concerns about some elements of the transition design.

- ***Three State Agencies:*** The BH/SUD transition effort has involved three separate agencies; Department of Health (DOH), Office of Mental Health (OMH) and the Office of Alcohol and Substance Abuse Services (OASAS). This overlap of authority has impacted the design and financing structure of the program, and created implementation difficulties.

- ***Rates and Rate Adequacy:*** HARP premiums were finally approved in late September. However, plans have still not seen final draft premiums related to the carve-in of BH and SUD services—notwithstanding that these services were transitioned on October 1st and are now the plans responsibility to pay for. In addition to the fact that it will be several months between the time plans see the proposed rates—yet to be approved by CMS—and before funds begin flowing to plans, plans remain unsure of whether administrative funding will be adequate to

reflect the additional responsibilities of managing the BH benefit or whether the rate is supported by utilization management rules and restrictions.

Both the HARP and mainstream carve-in require certain levels of spending on BH services by plans. These are designed to protect the providers' revenue stream without regard to whether current service utilization patterns are appropriate.

It is noteworthy that the HARP premium is reduced to reflect anticipated savings plans will achieve from inpatient hospitalizations, but the state has restricted the tools plans can use to manage the program—i.e., they cannot negotiate reimbursement rates; they are limited in performance of utilization management. It remains to be seen whether the HARP rate built in sufficient funding to cover the cost of serving the population and meeting the state's administrative requirements, while providing the care management services the population needs.

The state cannot build in traditional managed care savings, if the program doesn't allow the application of traditional managed care tools. HPA respects the desire of the state to place some additional parameters around the program structure, but the endeavor is doomed to fail if, on the one hand, plans are expected to generate efficiencies and improve care, but on the other hand are expected to maintain the status quo among the BH provider community.

- ***Provider Readiness***: Plans have worked collaboratively and cooperatively with the state and providers to help them transition to managed care. HPA created a workgroup including all member plans that has worked closely with the state's Managed Care Technical Assistance Center (MC TAC) to standardized claiming and billing processes to the greatest extent possible and develop a training program for

the providers. However, provider compliance with billing/claiming training has been erratic.

A recent state survey of providers inquiring about participation in the claims testing process revealed only 25% of the city's behavioral health providers responded to the survey and, disturbingly, some respondents were unfamiliar with the upcoming rollout. Moreover, plan efforts to engage in actual claims testing have revealed a low percentage of provider compliance, dismissal of the need to test and confusion about the need to bill for claims in the new ICD-10 format. HPA has expressed serious concern that the lack of attention to this critical testing process will create cash flow problems for providers, thus endangering the viability of many, which, in turn, will jeopardize the success of the transition, and ultimately impact the ability of plan members to get the services they need.

To be clear, plans do not want providers to have claiming issues or cash flow problems, but it will be difficult to resolve issues on such a broad scale if providers are as unprepared as we fear. Plans will continue to participate in an ongoing BH provider training workgroup along with MC TAC, in addition to each plan having a process in place to attempt to address claiming issues with providers as they arise to avoid reimbursement delays to providers.

- ***Health Homes:*** Health Homes have been promoted as the solution to Medicaid's care coordination challenges for the chronically ill—including the HARP population. Almost four years after they were launched, and after a recent intensive effort by the state to increase enrollment, only approximately 20 percent of the HARP-eligible population is enrolled in a Health Home. For more than a year, plans have advocated for a rational strategy to assure that HARP members receive the care

coordination they so desperately need—specifically in instances where either a member declines to enroll in a Health Home or where the Health Home has insufficient capacity to manage the member. A bridge solution is needed to ensure both HARP and serious BH members receive care coordination services.

- ***Accountability for Outcomes:*** One final concern, currently, there are not any outcome measures applied to BH and SUD providers, and reimbursement is not tied to outcomes. The process for developing and implementing real process and outcome measures must begin in earnest, particularly as the state moves toward value based payment (VBP) in Medicaid. The Delivery System Reform Incentive Payment (DSRIP) program goal of 90% of medical payments tied to outcomes cannot be achieved in the timeframes required by DSRIP without metrics and performance benchmarks.

CONCLUSION

HPA and its member plans are proud of the role they continue to play in helping New York improve access to needed health care services and quality of care for its residents, and plans remain committed to working with you and your colleagues on initiatives that keep New York moving forward on this course. We thank you for the opportunity to share our views today and look forward to an ongoing discussion to assure that the behavioral health transition is a success for a segment of the Medicaid population that desperately needs—and deserves—a redesign of its care delivery.