

# Behavioral Health Organizations

NYS Office of Mental Health

NYS Office of Alcoholism and Substance Abuse Services



# Governor Cuomo's Medicaid Redesign Team and Behavioral Health

- **Managed Care expansion**
  - Inclusion of all individuals with SPMI in mandatory Medicaid managed care enrollment
    - Individuals with SSI still carved out for behavioral health
  - Within 3 years, all Medicaid recipients will be in some form of managed care
  - BHOs/SNPs/IDS's are the mechanism to do this for people with SMI/SUD

# Phase 1 BHOs

- **Not risk-bearing**
- **Not authorizing or paying for services**
- **Goals for Phase 1:**
  - Get ready for Phase 2!
  - Get ready for Phase 2!
  - Advise providers and the Offices regarding inpatient behavioral health service use
  - Monitor inpatient discharge planning
  - Learn about child/adolescent SED population

# Phase 1 Population Focus

- **Adult and child Medicaid fee-for-service inpatients:**
  - Admissions to OMH-licensed psychiatric units (all ages) in general hospitals (Article 28 hospitals);
  - Children and youth admitted to OMH-licensed psychiatric hospitals (Article 31 hospitals);
  - Children and youth direct admissions (i.e., not transfers) to OMH State-operated children's psychiatric centers or children's units of psychiatric centers;
  - Children with a serious emotional disturbance (SED) diagnosis covered by Medicaid and receiving care in and OMH-designated specialty clinic.

# Phase 1 Population Focus (cont.)

- ❑ OASAS-certified hospital (Art 28/32) or freestanding (Article 32 only) Part 818 Chemical Dependence Inpatient Rehabilitation Services; and
- ❑ OASAS-certified Part 816 Inpatient Detoxification Services (Article 28/32).
- ❑ Excludes dual eligible (Medicare/Medicaid) individuals in year 1.

# Phase 1 BHO Tasks

- **Task 1: Monitor, review and assess the use of behavioral health inpatient care**
  - Concurrent review of inpatient behavioral health services
  - Provide information from Medicaid data to inpatient clinical staff
  - Monitor hospital discharge planning
- **Task 2: Monitor and track children's outpatient SED**
- **Task 3: Profile providers (in collaboration with Offices)**
  - Minimum of 4 quarterly meetings with stakeholders
- **Task 4: Facilitate cross-system linkage**
  - Improve engagement, re-engagement, continuity of care, accountability, service integration – across behavioral and physical health care

# Discharge Planning

- **BHO will monitor key aspects including:**
  - Contact/coordination with community providers
  - Contact/coordination with Health Homes
  - Assessment of need for case management
  - Assessment of physical health needs
  - Participation of individual/family members
- **Enhanced engagement efforts will be used for:**
  - Readmissions within 30 (mental health) or 45 (substance use) days
  - Individuals with 3 or more detox admissions in prior 12 months
  - High Need Ineffectively Engaged population defined by the Offices

# Performance Monitoring/Evaluation

- **BHO will profile regarding:**
  - Interactions between provider and BHO
  - Concurrent review statistics
  - Characteristics, timeliness, and completion of discharge plans
- **The Offices will profile regarding:**
  - Inpatient length of stay
  - Readmission rates
  - Engagement with post-discharge services
  - Psychotropic medication fills post-discharge

# BHOs and Health Homes

- Health Homes (HHs) will provide care coordination and care management for individuals with SPMI or multiple chronic health conditions
- HHs are approved by Department of Health with input from OMH and OASAS
- BHOs provide concurrent review of services and (in Phase 2) will authorize and pay for care
- BHO care managers and HH care coordinators will work together to develop and monitor care coordination efforts

# Health Homes Authorization

- Health Homes for Medicaid enrollees with chronic conditions was recommended by the Governor Cuomo's Medicaid Redesign Team.
- Authorizes the Commissioner of Health, in collaboration with the Commissioners of the Office of Mental Health, Office of Alcohol and Substance Abuse Services, and the Office of People with Developmental Disabilities, to establish health homes for NYS Medicaid enrollees with chronic conditions.

# State Plan Amendment

- NYSDOH submitted a draft SPA that has been approved by CMS and establishes health homes in phase 1 Counties to begin on January 1, 2012 focusing on the chronic medical/behavioral health population.
- Available on the NYSDOH Health Home Website at:  
[http://nyhealth.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/index.htm](http://nyhealth.gov/health_care/medicaid/program/medicaid_health_homes/index.htm)

# Health Homes for Medicaid

## Enrollees with Chronic Conditions

- **Phase I - 10 counties:**
  - Implementation began January 1, 2012.
  - Awaiting rate approval from DOB. (actual implementation has been delayed)
  - (Nassau, Kings, Bronx, Schenectady, Warren, Washington, Essex, Clinton, Franklin and Hamilton Counties)
- **Phase II:**
  - SPA has not yet been approved.
  - The designation of phase II HHs were announced on 4/9. (except for Manhattan (Suffolk, Richmond, Queens, Manhattan, Westchester, Rockland, Putnam, Sullivan, Orange, Dutchess, Ulster, Monroe and Erie Counties)
- **Phase III:**
  - SPA has not yet been approved.
  - Health Home preliminary application due date for those who submitted a Letter of Intent in September 2011 for **Phase III counties only is May 1, 2012**
  - Health Homes final application due date for **Phase III counties only is June 1, 2012**

# Why Health Homes?

- Navigating the current health care system can be difficult for enrollees who have high-cost and complex chronic conditions that drive a high volume of high cost inpatient episodes.
- A significant percentage of Medicaid expenditures are utilized by this subset of the Medicaid population.
- Appropriately accessing and managing these services, through improved care coordination and service integration, is essential in controlling future health care costs and improving health outcomes for this population.

# What is a Health Home?

- A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner.
- This is done primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital.
- Health records are shared (either electronically or paper) among providers so that services are not duplicated or neglected.
- The health home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual“ Health Home.”

# From the Health Home State Plan Amendment (Sounds similar to BHO)

Under New York State's approach to health home implementation, a health home provider is the **central point for directing patient-centered care and is accountable** for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

•

•

# Eligibility for Health Home Participation

- (1) Two chronic conditions,
- (2) One chronic condition and are at risk for a second chronic condition, or
- (3) One serious persistent mental health condition to qualify for health home services.

# Health Home Services Include

- Comprehensive care management,
- Health promotion,
- Transitional care including appropriate follow-up from inpatient to other settings,
- Patient and family support,
- Referral to community and social support services,
- Use of health information technology to link services.

# What Will Health Homes Do?

- Approved health homes will directly provide, or contract for, health home services to the identified eligible beneficiaries.
- To meet this goal, it is expected that health home providers will develop health home networks with primary, medical, specialty and mental health providers, substance abuse service providers, community based organizations, managed care plans and others to provide enrollees access to needed services.

# Health Information Technology

- Providers must meet initial HIT standards to implement a health home. Furthermore, applicants must provide a plan to achieve the final standards within eighteen months of program initiation in order to be approved as a health home provider.
- To the extent possible health home providers will be encouraged to utilize regional health information organizations or qualified entities to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs).
- Health home providers will be encouraged to utilize HIT as feasible to create, document, execute and update a plan of care that is accessible to the interdisciplinary team of providers for every patient.
- Health home providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, community based services and provider referrals.



# Single Care Management Record

- A single care management record will be agreed to and shared by all team professionals and case reviews will be conducted on a regular basis.
- The care manager will be responsible for overall management and coordination of the enrollee's care plan which will include both medical, behavioral health and social service needs and goals.

# Recipient-Centered

- The care manager will be required to make sure that the individual (or their guardian) plays a central and active part in the development and execution of their plan of care, and that they are in agreement with the goals, interventions and time frames contained in the plan.
- Family members and other supports involved in the patient's care should be identified and included in the plan and execution of care as requested by the individual.
- The care plan must also include outreach and engagement activities which will support engaging the patient in their own care and promote continuity of care.

# Care Coordination

- The health home provider will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's plan of care.
- The enrollee's health home care manager will be clearly identified in the patient record and will have overall responsibility and accountability for coordinating all aspects of the individual's care.
- The health home provider will be responsible to assure that communication will be fostered between the dedicated care manager and treating clinicians to discuss as needed enrollee's care needs, conflicting treatments, change in condition, etc. which may necessitate treatment change (i.e., written orders and/or prescriptions).

# Comprehensive Transitional Care

- The health home provider will also have policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to ensure coordinated, and safe transition in care for its patients who require transfer to/from sites of care.
- The health home provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge.
- The health home care manager will be an active participant in all phases of care transition, including: discharge planning and follow-up to assure that enrollees received follow up care and services and re-engagement of patients who have become lost to care.

# Peer Supports

Peer supports, support groups, and self-care programs will be utilized by the health home provider to increase patients' and caregivers knowledge about the individual's disease(s), promote the enrollee's engagement and self management capabilities, and help the enrollee improve adherence to their prescribed treatment.

# Referral to Community and Social Support Services

The health home provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services.

To accomplish this, the health home provider will develop policies, procedures and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants.

The plan of care will include community-based and other social support services, appropriate and ancillary healthcare services that address and respond to the patient's needs and preferences, and contribute to achieving the recipient's goals.

# OMH Web Site

[http://www.omh.ny.gov/omhweb/adults/health\\_homes/](http://www.omh.ny.gov/omhweb/adults/health_homes/)

- Transition of TCM to HH CM Interim Instructions and email link to submit questions on OMH.
- TCM transition to HH Power Point.
- FAQ's Coming Soon!
- Link to DOH Health Home website.

OMH will add information as it becomes available.

# Population to be Served in HHs

- This HH SPA is target to serve people who are 18 years old or older.
- No individuals served in C&Y TCM programs will have their names forwarded to DOH for enrollment (no matter what age their individual is).
- No individual under 22 years old will have their names added to the lists provided to HHs by MMC plans and DOH.
- We are delaying attachment of adult home SCM resources.
- We are delaying attachment of State PC ICM until MOUs with HHs are promulgated.

# State Plan Services

## (e.g., clinics, PROS, PCP)

- Many referrals will come from within HH networks.
- Services will continue to be reimbursed via Medicaid Managed Care or Fee-For-Service Medicaid.
- The HH does NOT limit its enrollees freedom of choice to access providers outside the network. The Medicaid card will continue to reimburse for all FFS services.

# Managed Care

## BHO II Special Needs Plans

- **Goal: All Medicaid Recipients in Care Management within 3 Years**
- **Approaches for Behavioral Health**
  - Special Needs Plans – Comprehensive Health/Behavioral Health Long Term Care, Pharmacy
  - Behavioral Health Organizations – Manage the Behavioral Health Benefit in Coordination with Mainstream Managed Care Plan
- **Status**
  - Plan to Develop Procurement Document and Begin in a Part of NYS by late 2013
  - Engage Consultant
  - Discussions with DOH and NYC
  - Define Target Population
  - Benefit Package
  - Actuarial Work
  - Incentives and Performance Metrics