

DRAFT

Behavioral Health and Managed Care Agency Agreement

Mainstream Plans/ Behavioral Health Organizations in New York State (NYS) Other Than New York City (NYC)

- Mainstream plans will become responsible for managing all behavioral health services for their members. This will include both the existing behavioral health benefit as well as those mental health and substance abuse services currently “carved-out” of mainstream managed care contracts.
- Mainstream plans will be required to work with a State-certified behavioral health organization (BHO) for management of behavioral health benefits. State-certified BHOs (one or more per region) must demonstrate previous experience managing/coordinating care for individuals with significant behavioral health needs. Specific, rigorous requirements for the clinical management of behavioral health benefits will be developed and monitored by the Office of Mental Health (OMH), Office of Alcohol and Substance Abuse Services (OASAS), and Department of Health (DOH). The State will monitor compliance with laws and regulations governing the administration of the benefit, and apply sanctions for non-compliance. Mainstream plans that can demonstrate that they have the capacity to meet the same requirements could manage the behavioral health benefits with appropriate monitoring by OMH, OASAS, and DOH.
- In addition to new requirements, OMH, OASAS, and DOH will develop and implement new behavioral health quality measures that will track the performance of BHOs and plans in managing behavioral health benefits and will be incorporated into existing or new performance incentive programs.
- The total behavioral health premium, including all existing behavioral health fee-for-service (FFS) and behavioral health service and administration dollars currently managed by the plan, will be separately identified from the health premium and will be separately tracked. Behavioral health service savings will be identified and will be available for reinvestment (under a State approved reinvestment plan) into the behavioral health system to promote crisis response, recovery outcomes, employment support and housing.
- With appropriate Centers for Medicare and Medicaid Services (CMS) approvals, plans will be given responsibility to pay for inpatient care at State psychiatric hospitals and coordinate discharge planning. As State psychiatric centers are freed up through downsizing and admission diversion, these funds will be reinvested to fund community-based support services. The State will pursue CMS approval of “in lieu of” services,

including for OASAS and OMH community-based and State-operated inpatient rehabilitation services.

- Management of the behavioral health benefit will be closely monitored by DOH, OMH, and OASAS, and specific requirements for how the benefit is managed will be developed and, as appropriate, include such standards/requirements in the overall model contracts. DOH, OMH, and OASAS will closely monitor network capacity, service access and behavioral health quality outcomes.

Special Need Plans Outside of NYC


In areas outside of NYC, it is expected that a mainstream plan/behavioral health organization (BHO) model will be the predominant approach. The viability of full benefit (behavioral and physical health) Special Needs Plans (SNPs) for regions of the State outside of NYC will be considered. SNPs, outside of NYC, will need to meet the criteria outlined below. If a SNP is not viable in a given area, the mainstream BHO model will be the only model in that area.

SNP REQUIREMENTS:

- SNPs must function as an integrated network with an ability to share information electronically among network providers and provide intensive care coordination services. SNPs must also demonstrate ability to effectively communicate/engage with non-network providers when such services are necessary.
- SNPs must include qualified Health Homes as a vital part of their networks.
- SNPs will be expected to be fully integrated plans which will manage the entire Medicaid benefit for patients including: physical health, behavioral health, acute care, long term care and pharmacy.
- SNP leadership must demonstrate to the State experience and expertise with regard to behavioral health services and populations.
- SNPs must be appropriately licensed by the State as risk-bearing entities.
- SNPs will be subject to robust performance metrics and incentives on behavioral health, as well as physical health issues relevant to a high need behavioral health population.
- A qualification and designation process will be used to select a limited number of SNPs. Mainstream plans, including those that partner with specialty behavioral health plans or health home networks with robust specialty behavioral health expertise and capacity, will be given preference. Free standing SNP applications will also be considered. . A free standing SNP must be an appropriately certified risk bearing entity.
- SNPs will include reinvestment of savings.
- The development from savings of a member-specific self-directed spending account available only through SNPs to purchase needed services or materials which will facilitate recovery outcomes.
- Existing plans that are designated to operate a SNP must demonstrate their intent to reach out to all SNP eligible enrollees, counsel them on the advantages of SNP enrollment, and enroll them in the SNP unless the member declines. People assigned to the SNP from the mainstream plan will be able to access the Plan's primary care network and continue with the same primary care provider they had as a mainstream plan enrollee.
- Once SNPs become operational, there will be a permanent open enrollment period for eligible people to enroll in them. SNPs will also be permitted to do outreach to potentially SNP-eligible individuals who are enrolled in mainstream plans.

- DOH, in consultation with OMH and OASAS, will review expenditure and ambulatory engagement history for SNP eligible people currently in other mainstream plans that do not sponsor a SNP. Individuals who appear disengaged from appropriate ambulatory care may be reassigned to SNPs with the option to opt out of the SNP.
- State will auto-enroll SNP eligible individuals that do not choose a mainstream plan into SNPs, and develop other strategies to promote SNP enrollment consistent with CMS requirements.
- With appropriate CMS approvals, plans will be given responsibility to pay for inpatient care at State psychiatric hospitals and coordinate discharge planning. As State psychiatric centers are freed up through downsizing and admission diversion, these funds will be reinvested to fund community-based support services.
- The State will pursue CMS approval of “in lieu of” services, including for OASAS and OMH community-based and state operated inpatient rehabilitation services.
- Management of the behavioral health benefit will be closely monitored by DOH, OMH and OASAS, and specific requirements for how the benefit is managed will be developed; and as appropriate, stated in the supporting federal or state waivers; contracts; and supporting legislation. The State will closely monitor network capacity, service access and behavioral health quality outcomes.
- Both health and behavioral health service savings will be identified and made available for reinvestment (under a State approved reinvestment plan) into the Special Needs system to promote crisis response, recovery outcomes, employment support, housing and collaborative care in primary settings.
- SNP capitation rates should reflect the high needs of the eligible population, the additional responsibilities related to care management, greater administrative costs and enhanced benefit package for this special needs population.
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GUIDING PRINCIPLES FOR DESIGN

The design of both SNPs and mainstream plan/BHO models will be guided by the [Behavioral Health Reform Workgroup Report](#). 

CHILDREN

- The State is working to identify a model to serve children with behavioral health issues and those in foster care. Consideration is also being given to children with chronic medical conditions. The State is looking at the possibility of addressing both managed care and health homes in this process. A model with a specialized provider product connected with mainstream plans is currently being reviewed.

DUALS

- Dually eligible (Medicaid and Medicare) members requiring more than 120 days of community-based long term care services will be enrolled in managed long term care plans with behavioral health benefits included in the Managed Long-Term Care/Fully Integrated Dual Advantage (MLTC/FIDA) benefit package. MLTC/FIDA providers may be required to contract with a BHO to manage the behavioral health benefit. Dually eligible members that do not meet the 120 day requirement will remain in FFS and will be managed under the health home program with provider gain sharing for both Medicaid and Medicare (when approved). Beginning in 2015, the Medicaid and Medicare benefits for the non-120 day population will be transitioned to management by the SNPs and mainstream plans. Similar to Medicaid reinvestment for behavioral health, any Medicare shared savings would be available for reinvestment in the behavioral health system.