



Geriatric Mental Health Alliance of New York State

October 30, 2014

Topics

1. New York State Medicaid Redesign Team
2. Managed Care for Special Populations
 - Behavioral Health
 - Long-Term Care
3. Health Home
4. Delivery System Reform Payment Plan
5. Geriatric BH Issues

New York State Medicaid Redesign Team

Overview

- New York State Medicaid Redesign Team (MRT):
 - Created by Governor Cuomo in January 2011.
 - Tasked with finding ways to reduce costs and increase quality and efficiency within the Medicaid program.
- Two major recommendations were enacted to drive the transition to managed care:
 - New multi-year Medicaid Global Spending Cap.
 - “Care management” for all Medicaid beneficiaries:
 - Several different models.
 - Will eventually provide fully-integrated managed care for all Medicaid enrollees.

Managed Care for Special Populations: Behavioral Health

Overview

- On March 21, 2014, RFQ released
- This process will:
 - Incorporate the full BH benefit into mainstream MMC
 - Create specialized HARP products
- Plans may pursue either option on their own, through a contract with a behavioral health organization (BHO), or through a partnership with another experienced vendor.

Quick Facts

Geography:	Statewide
Reimbursement:	Per member, per month capitated payment
Timeline:	Downstate: April 2015; Upstate: October 2015
Target Population:	Downstate: 80,000 individuals; Upstate: 60,000 individuals
Eligibility:	Non-dual individuals 21 or over may be eligible for HARPs if they have a SMI or SUD diagnosis
Scope of Services:	<ul style="list-style-type: none">• Behavioral health services currently covered by Medicaid; and• New community-based services that promote independence

Managed Care for Special Populations: Long-Term Care

Long-Term Care Plans

- Managed Long Term Care (MLTC)
- Fully Integrated Duals Advantage (FIDA)
- Program of All-Inclusive Care for the Elderly (PACE)
- Medicare Advantage
- Special Needs Plans (SNP)

FIDA Demonstration Background

- Overseen by the CMS Federal Coordinated Health Care Office and Center for Medicare and Medicaid Innovation
- Seeks to improve care, reduce cost, and coordinate benefits for the dual eligible population through alignment of Medicare and Medicaid financing streams
- The memorandum of understanding (MOU) between CMS and New York was signed August 26, 2013
- New York is the 7th state to finalize its participation in this demonstration program

Memorandum of Understanding

- New York State proposes to fully integrate services and provide care coordination to dual eligibles through a managed care capitated model
- The demonstration will target 170,000 full dual eligibles
- The eight county demonstration region includes: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester

FIDA Eligibility

Eligible populations:

- Age 21 or older;
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits; and
- Reside in a FIDA demonstration county

Individuals must also meet one of the following three criteria:

- Require community-based long-term services and services (LTSS) for more than 120 days;
- Are Nursing Facility Clinically Eligible (NFCE) and receiving facility-based long-term services and supports; or
- Are eligible for the Nursing Home Transition and Diversion (NHTD) 1915(c) waiver

Interdisciplinary Teams (IDTs)

- Service planning, coverage determinations, and ongoing care management are conducted by an IDT
- IDTs include the following (as appropriate):
 - The participant and/or an authorized representative and/or his/her designee;
 - Designated care manager;
 - Primary care physician (PCP) or a designee with clinical experience from the PCP's practice;
 - Behavioral health professional or designee with clinical experience from the same practice;
 - Home care aide or designee with clinical experience from the same agency;
 - Nursing facility representative who is a clinical professional;
 - Registered nurse who completed the participant's assessment; and
 - Other providers either as requested by the participant/designee or recommended by IDT members

FIDA Covered Benefits

- All services covered by Medicare Parts A, B, and D;
- All Medicaid services including physical health, behavioral health, LTSS, and any others deemed medically necessary; and
- Additional services or items that address a participant's needs can be included in the PCSP at the plan's discretion
- Home care services must be provided through CHHA

Plans Participating in Readiness Review

MLTC Enrollment for Plans Participating in FIDA Readiness Review

#	Plan Name	MLTC Enrollment
1	VNSNY Choice	17,150
2	GuildNet	14,363
3	Senior Health Partners	11,242
4	ElderServe	10,369
5	Elderplan	10,120
6	CenterLight Healthcare	9,139
7	Fidelis Care at Home	6,999
8	WellCare	5,819
9	Independence Care Systems	5,081
10	AgeWell New York	3,234
11	VillageCare Max	2,944
12	Amerigroup	2,798

#	Plan Name	MLTC Enrollment
13	Aetna Better Health	2,619
14	HHH Choices	2,279
15	ArchCare	1,837
16	Centers Plan for Community Living	1,669
17	EmblemHealth	1,338
18	Integra	1,263
19	Senior Whole Health	916
20	United Healthcare	746
21	North Shore LIJ Health Plan	731
22	MetroPlus	577
23	AlphaCare	554
24	Montefiore	339

* MLTC enrollment figures are limited to the eight county FIDA demonstration region and are current as of June 2014.

** MLTC enrollment figures and list of participating plans are from the DOH website.

Implementation Timeline

New York City and Nassau County:

Enrollment Date	
Voluntary	January 1, 2015
Passive	April 1, 2015

Suffolk and Westchester Counties:

Enrollment Date	
Voluntary	April 1, 2015
Passive	July 1, 2015

Health Homes

Overview

- A Health Home is a care management service model.
- All services are coordinated.
- Enrollees are assigned a care manager.
- Payment is flexible including structuring a tiered payment methodology.
- Health Home have role in HARP and DSRIP

Quick Facts

Geography:	Statewide
Enrolled:	125,000 individuals (52,000 - outreach; 73,000 - active case management)
Eligibility:	Individuals with: <ul style="list-style-type: none">• At least two chronic conditions; or• One qualifying chronic condition (HIV/AIDS or SMI)
Reimbursement :	Per member per month engagement and case management payments adjusted for acuity
Scope of Services:	<ul style="list-style-type: none">• Comprehensive care management;• Care coordination and health promotion;• Comprehensive transitional care;• Individual and family support services;• Referral to community and social support services; and• Use of health information technology to link services

Examples: Designated Health Homes

- North Shore LIJ Health Home
- Bronx Lebanon Hospital Center
- Bronx Accountable Healthcare Network Health Home
- Coordinated Behavioral Care Inc.
- New York City Health and Hospitals Corporation
- New York and Presbyterian Hospital
- North Shore LIJ Health Home
- Maimonides Medical Center
- Visiting Nurse Service of New York Home Care

Delivery System Reform Incentive Payment Program

Medicaid Waiver

- On April 14th, NYS received approval from CMS on the Terms and Conditions of its \$8 billion Medicaid waiver.

Medicaid Waiver

- The State's Medicaid Redesign Team waiver:
 - Delivery System Reform Incentive Payment (DSRIP) Plan: \$6.42 billion
 - Interim Access Assurance Fund (IAAF): \$500 million
 - Other Medicaid Redesign: \$1.08 billion
 - Health Home development
 - Behavioral health
 - Workforce training

Moving Away from FFS

Current System

- Encourages volume
- Fragmented
- Variable quality
- Costly
- No incentive to keep communities healthy

Ideal System

- Encourages value
- Coordinated
- Data-rich
- High quality
- Patient-centered
- Focuses on population health

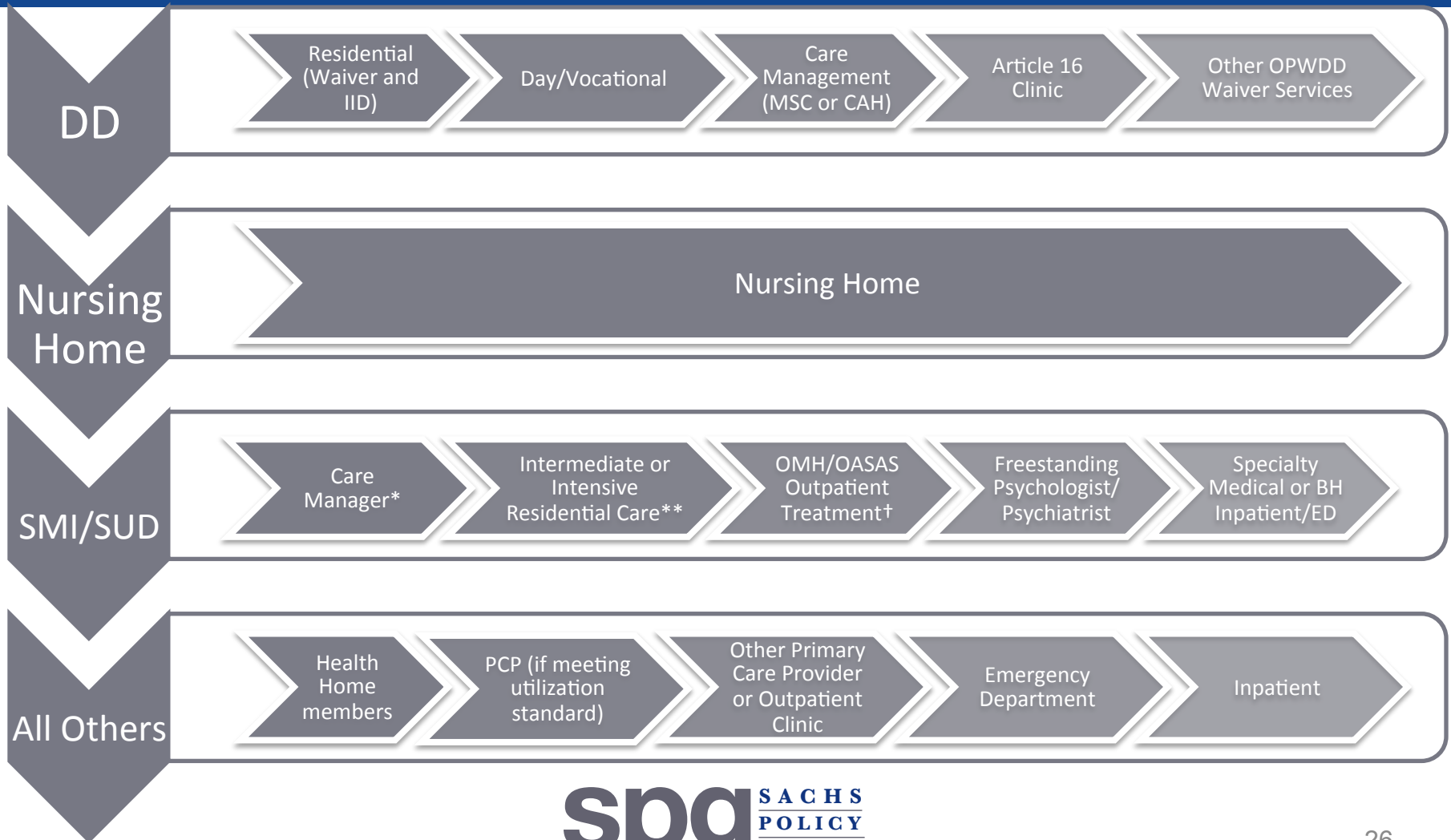
DSRIP Overview

- The new Delivery System Reform Incentive Payment (DSRIP) program provides funding for new initiatives by providers to improve care, reduce costs, and improve outcomes.
- The overall goal is to reduce avoidable hospitalizations and emergency department (ED) use by 25 percent over five years.
- Metrics for will include four measures of avoidable hospitalizations:
 - Potentially Preventable Emergency Room Visits (PPVs);
 - Potentially Preventable Readmissions (PPRs);
 - Prevention Quality Indicators – Adult (PQIs); and
 - Prevention Quality Indicators – Pediatric (PDIs).
- More than \$6.42 billion will be made available over five years to public hospitals and safety net providers through this program.

DSRIP Attribution Model

*Health Home TCM, or ACT, or children in the HCBS waiver.

**RTF, PRSY, rehabilitative services for residents of a Community Residence, etc.
 †Outpatient clinic, CDT, PROS, day treatment, MMTP, or outpatient rehabilitation.



Quick Facts

Geography:	Statewide
Eligible Applicants:	Public hospitals and safety-net providers; partnerships are highly encouraged
Funding Categories:	Project types three focus areas: <ul style="list-style-type: none">• System improvement• Clinical improvement• Population-wide strategies
Additional Information:	Projects must: <ul style="list-style-type: none">• Demonstrate community need;• Show a commitment to life-cycle change and a willingness to commit sufficient resources; and• Represent a “transformative” change for the provider

Reform Issues – Geriatric Behavioral Health

Geriatric BH Issues

- FIDA Implementation
 - Carve in of Behavioral Services
 - IDT Process
 - Plan size and finance
 - Dual eligibles
- Home Based Services
- Access to 1915i services – Other Flexible Services
- Future of “Medicaid Only” MLTC Plans
- LTC Plans and Behavioral Health Readiness
- DSRIP Opportunities

Questions?