

Medicaid Redesign and Expansion: Can We Have One Without the Other?

Mental Health America
Regional Policy Council

November 16, 2015



Regional
policy Council

MHA
Mental Health America

Webinar is being conducted by the Mental Health America Regional Policy Council

2015 Regional Policy Council Sponsors

Actavis

Alkermes

Anonymous

Eli Lilly and Company

Genentech

Janssen

Otsuka America Pharmaceutical, Inc.

Sunovion Pharmaceuticals Inc.

Takeda Lundbeck Alliance

MHA
Mental Health America

Presenters

Scott Branam

Attorney at Law, Gardner Skelton

Moe Keller

VP of Public Policy & Strategic Initiatives, MHA of Colorado

Kate McAllister

Assistant Director, MHA of Central Carolinas

John Richter, Public Policy Director

Mental Health Association in New York

Moderated by Debbie Plotnick

VP of Mental Health Systems Advocacy, MHA





STATE OF THE STATES: MEDICAID

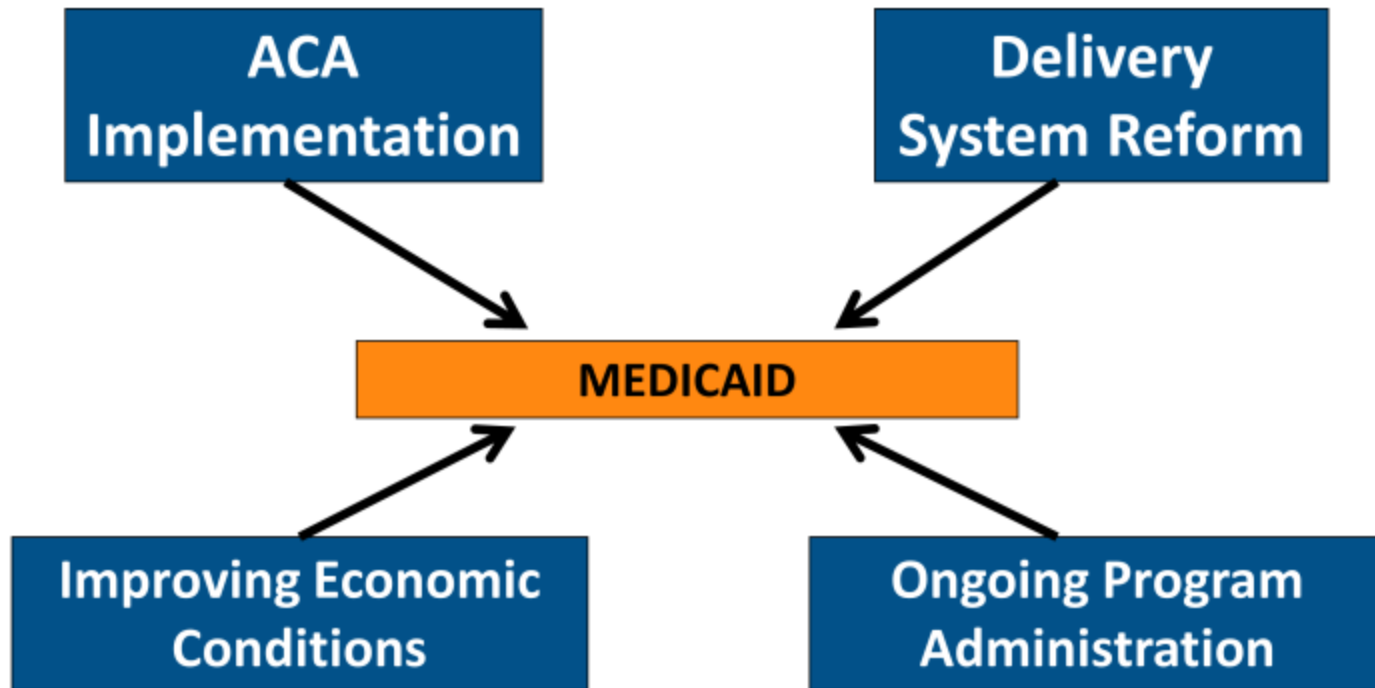
KATE MCALLISTER

ASSISTANT DIRECTOR

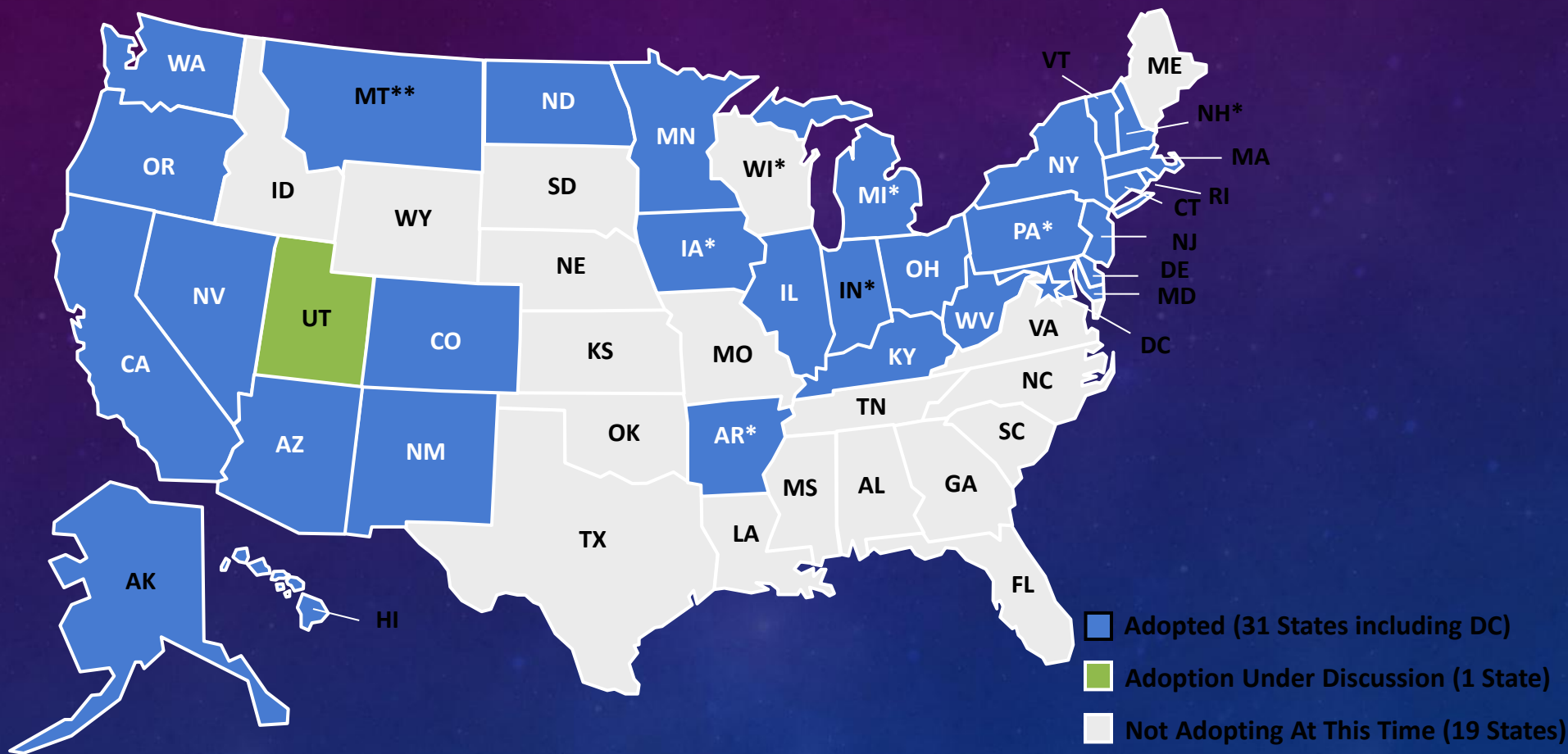
MENTAL HEALTH AMERICA OF CENTRAL CAROLINAS

Figure 1

Factors Shaping Medicaid Programs Today



CURRENT STATUS OF STATE MEDICAID EXPANSION DECISIONS



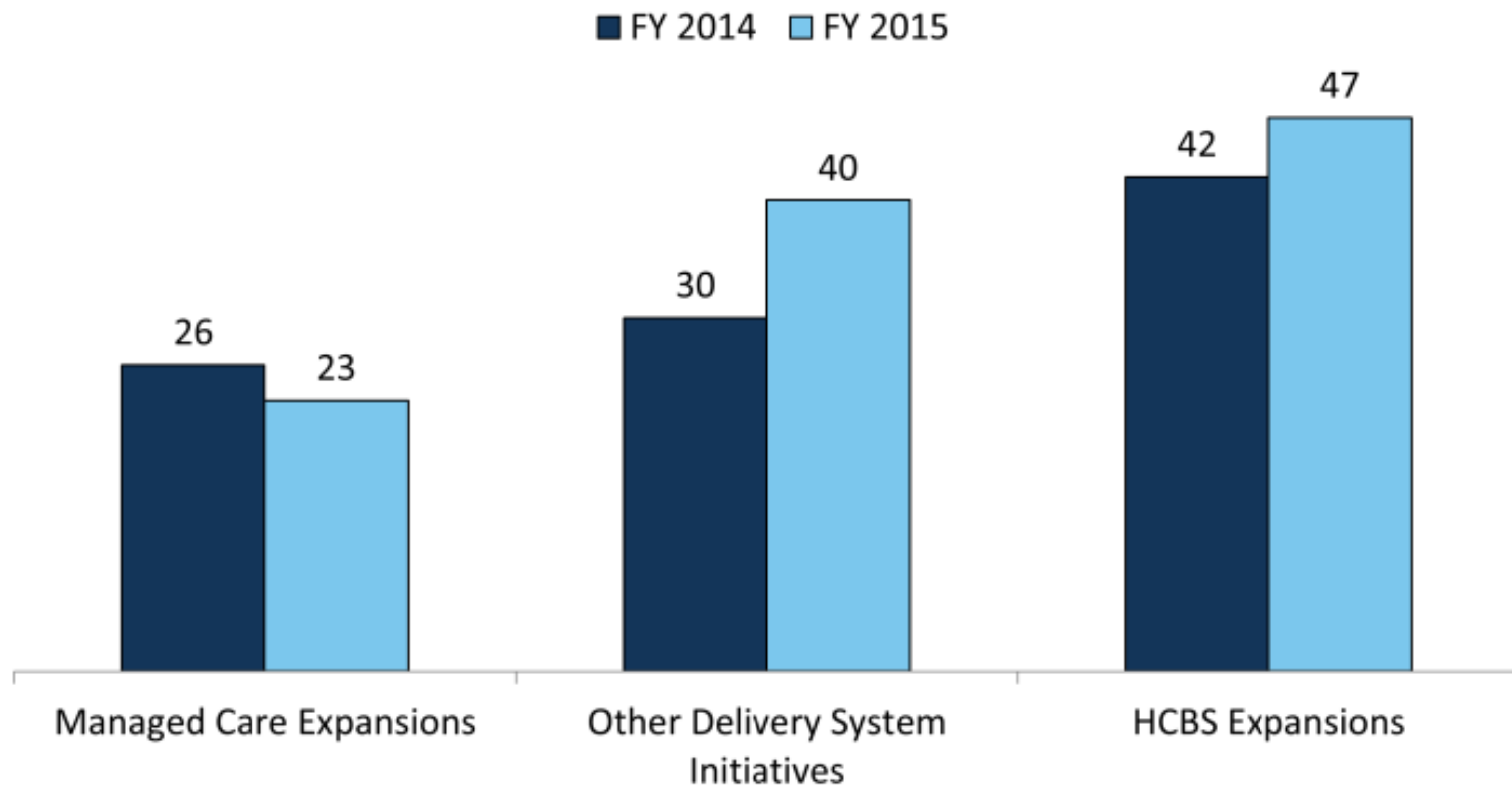
NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated September 1, 2015.

<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

Figure 3

Delivery System Activity, FYs 2014 and 2015



NOTE: Managed Care Expansion refer to expansions to new groups, new regions, increasing the use of mandatory enrollment, and new RBMC programs. Other Delivery System Initiatives include new or expanded initiatives related to PCMH, Health Homes, ACOs and initiatives focused on dual eligible beneficiaries (both those inside and outside the CMS financial alignment demonstration.)

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2014.





THE NORTH CAROLINA EXAMPLE

SCOTT BRANAM

ATTORNEY AT LAW

GARDNER SKELTON

MHA OF CENTRAL CAROLINAS BOARD MEMBER;
ADVOCACY AND PUBLIC POLICY COMMITTEE CHAIR

NORTH CAROLINA MEDICAID

- Currently covers about 1.9 million residents

State	Medicaid Expansion	Children - Medicaid			Separate CHIP	Pregnant Women		Parents ³	Other Adults
		Ages 0-1 ¹	Ages 1-5 ²	Ages 6-18 ²		Medicaid	CHIP		
North Carolina	N	210%	210%	133%	211% (6-18)	196%	N/A	45%	0% ⁶

- Additional 804,000 would be covered under expansion
- \$39.6b “left on the table”

“NO EXPANSION WITHOUT REFORM”

- McCrory tabled Medicaid Expansion until after the June 2015 Supreme Court decision
- After the decision, McCrory indicated that more data and analysis from other states that had expanded Medicaid was needed.
 - “I don’t want a Washington plan for Medicaid, I want a North Carolina plan. It’s a very complex issue. You can’t just say are you for or against it.” –Gov. McCrory
 - “We still have a broken system in North Carolina. We cannot contemplate adding more people to the Medicaid rolls at a time when we are having difficulties sustaining the Medicaid system that we currently have.” –Senate Leader Phil Berger, R-Rockingham

REFORM BILL PASSES

- Legislators settled into two camps:
 - Managed care model (Senate)
 - Contract with accountable care organizations (ACOs) (House)
- HB 372—a hybrid “compromise”
- Gov. McCrory signed the overhaul into law on Sept. 23

HB 372/SL 2015-245

- Privatization of Medicaid
- Contracts with 3 for-profit managed care companies
 - compete with each other across the state
- 10 locally-operated Provider-Led Entities (PLEs)
 - offer plans across the six newly-created regions of the state
- Move from fee-for-service to capitated payment model
- Mental Health MCOs are “carved out” for first 4 years

CMS 1115 WAIVER

- State must send its proposal to CMS by June 2016
- Medicaid managed care system would be implemented 18 months after federal approval is obtained
- Federal Government seemingly not likely to grant the waiver, due to NC's failure to expand Medicaid

Medicaid Reform Efforts in Colorado

MENTAL HEALTH AMERICA OF COLORADO WEBINAR
PRESENTATION

NOVEMBER 16TH, 2015

A solid orange horizontal bar at the bottom of the slide.

Hospital Provider Fee

Colorado expanded Medicaid to single adults in 2009, prior to the Affordable Care Act.

Capped at 10% of poverty. (\$90 per month). Mental health and SUD included benefit.

Also covered parents up to 100% of poverty and CHIP expansion at 250% FPL.

Created the Disability buy in program.

In 2015 accrued about \$689 Million.

Benefits are now aligned with the ACA Medicaid.

Current delivery system

- Five Behavioral Health Organizations hold Medicaid contracts to delivery mental health and substance use disorder treatments .
- 2015-16 Medicaid behavioral health caseload is 1,189,338.
- 17 behavioral health centers throughout the state.
- These contracts are a managed care, “carve out” model.
- \$616 Million was spent on Medicaid behavioral health in capitated payments in 2015.

Colorado Created the Accountable Care Collaborative in 2010.
A Product of three state agencies: Medicaid, Department of
Public Health and the Department of Human Services

Three Main Components:

- 1) Primary Care Medical Homes
- 2) Data Collection and Analysis Contractor
- 3) Care Coordination and Support through Regional Care Collaborative Organizations. (RICCO)

MEDICAID REFORM EFFORTS IN COLORADO

Purpose of the ACC

Cost savings by changing emergency rooms as the primary care office to a doctor, nurse or clinic as the office.

Treating the whole person – integration of mental health and physical health care.

Building networks of providers who will receive payment based on whole health.

Providing more prevention and early intervention treatments.

Provisions of this Model

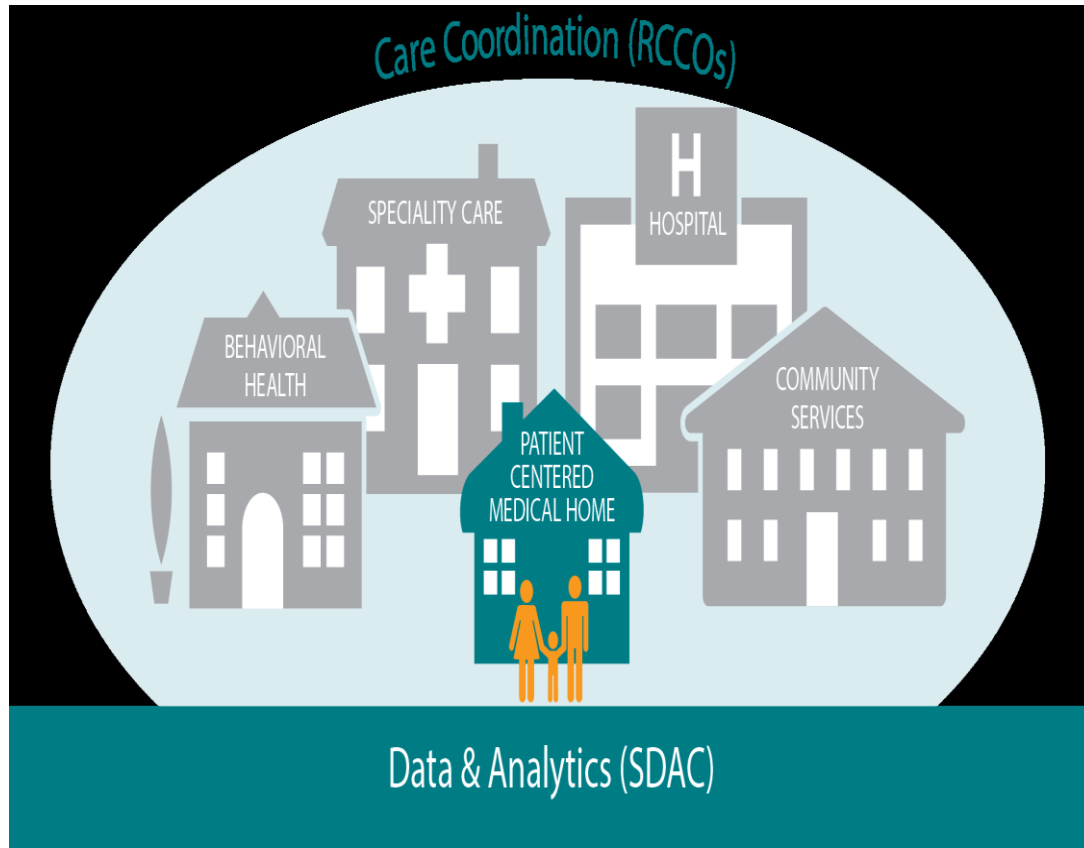
Enroll Medicaid members into a medical home.

Medical home is a primary care provider; mental health centers can be a medical home.

Most mental health centers now provide some physical care .

Integration of physical and behavioral health care is current focus but will be a stronger focus in second phase of the ACC.

Accountable Care Project



Regional Care Collaborative Organization

To administer the ACC in an orderly and efficient manner, Colorado Medicaid created seven regional organizations, called the Regional Care Collaborative Organizations.

- connect an enrollee to Medicaid providers and specialists
- Help health care providers communicate with each other for coordination of care
- Help the enrollee get the right care after coming home from the hospital or nursing home
- Help with changes, like moving from children's health services to adult health services
- Help the enrollee to find community and social services in the area.

Elimination of the Carve Out Model

Colorado is moving forward with eliminating the Behavioral Health Managed Care Carve Out Model for Medicaid recipients.

The Managed Care Carve Out Model has proven to be unsatisfactory because:

- Services in the carve out model are based on a covered diagnosis – making it hard to provide prevention and early intervention for individuals enrolled in Medicaid.
- Co-occurring disorders, such as developmental disabilities, are not covered in the managed care carve out model.
- Coordination of services is difficult to provide.
- Coverage for life events, such as grief counseling, cannot be offered.

State Innovation Model

Colorado has been awarded \$65M from the Center for Medicaid and Medicare services through the ACA to design an integrated model of care.

Intent is to change reimbursement structure

Create networks of providers, including peers

Treat the whole person

Improve outcomes

Bid design is underway – bids for networks to apply should be early next year.

Colorado Medicaid & SIM

- As of May 2015, about half of all Primary Care Medical Providers in the ACC (about 270 practice sites) have been validated as meeting the standards for enhanced payment.
- Practices serve over 500,000 clients statewide
- Introducing new performance measures to facilitate behavioral health integration at practice level and for improvements in adolescent and adult depression screening rates.
- Investing in telehealth technology to support behavioral health integration and to support plan to create medical neighborhoods.

ACC Enhanced Primary Care Indicators

Includes incentives to encourage:

- On-site access to behavioral health care providers
- Behavioral health screening (including substance use) for adults and adolescents and/or developmental screening for children (newborn to five years of age)
- Procedures to address positive screens and established relationships with providers to accept referred patients.

Accountable care Collaborative – Phase Two

Collaboration between three state agencies: Department of Human Services, Department of Public Health and Department of Health Care Policy and financing. (Medicaid).

Opportunity Project

Working together, provide interventions at life stages, beginning with birth, early childhood, childhood/adolescence and adulthood and seniors.

Middle Class by Middle Age

Focus is upward mobility through alignment of services to support low income persons through Life Stages

OVERVIEW OF BEHAVIORAL HEALTH TRANSITION TO MEDICARE MANAGED CARE IN NYS

John Richter, MPA
Director of Public Policy
MHANYS



MEDICAID EXPANSION IN NYS

- Between 2000-2012, Medicaid enrollment in NYS grew by more than 80%
- Medicaid currently covers over 5 million New Yorkers
- Program cost is \$54 Billion Dollars

HIGHEST PERCENTAGE OF MEDICAID USERS

- 20% of Individuals on Medicaid utilize 80% of the Funding
- 40% of that 20% have Behavioral Health Conditions
- 20% of People with psychiatric disabilities in public hospitals were readmitted within 30 days

MENTAL HEALTH AND MEDICAID

- In New York State, we spend over \$7 Billion in annual expenditures for Mental Health
- NYS Public MH System serves 700,000 and licenses 2500 Programs
- Medicaid spending represents 48% of the Public Mental Health System

DO WE GET OUR \$7 BILLION WORTH?

- Pockets of Innovation Across New York State including MHA's and Other Providers but most programs are small in scale
- Unfortunate Reality is that:
 - People with Psychiatric Disabilities die 25 years younger than the general population
 - Riker's Island is New York's largest defacto psychiatric hospital with 33% of individuals having a psychiatric disorder
 - New York and the rest of the country still faces an 85% unemployment rate for people with psychiatric disabilities
 - Only 30% of Youth with Severe Emotional Disorders at age 14 graduate with a standard high school diploma

NYS ATTEMPTS TO BEND THE COST CURVE

- Governor Cuomo came to office 5 Years Ago facing an \$8 Billion Budget Deficit
- Clearly Targeted Medicaid as a big ticket item
- Creates Medicaid Redesign Team to Address Issues including Behavioral Health MRT

NYS MOVEMENT TO MEDICAID MANAGED CARE

- Recommendations from the Behavioral Health MRT to include recovery services as an integral part of the transition to managed care
- Advocates fought to make sure that there was a transition period before managed care implementation
- NYS developed an interim step of Behavioral Health Organization to work with hospitals and providers to do a record review of hospital admissions and lengths of stay for people with psychiatric disabilities

Medicaid Managed Care Has Arrived

- Medicaid Managed Care Began in New York City in October 2015
- It will begin in the Rest of the State in July of 2015
- Everyone in public mental health system will qualify for
 - A) The Mainstream Plan
 - B) 140,000 will qualify for Health and Recovery Plans (HARPS)

MAINSTREAM PLAN

- 700,000 Lives to be covered
- Mental Health Services in a Capitated Model
- Will Cover Physical Health and Pharmacy Benefits
- Inpatient and Outpatient Hospital Services
- Clinic Services
- ACT, PROS, IPRT, CDT and Partial Hospital

THE GAME CHANGER--HARPS

- 140,000 People will Qualify for HARPS, based on historic data and functional assessment
- An Integrated Product Line for People with Significant Behavioral Health Issues
- HARPS are the 1915 I Waiver Services that Community Advocates have long worked for

HARP Services

- Peer Support
- Psychosocial Rehab
- Short and Long Term Crisis Intervention
- Educational Supports
- Employment Supports
- Family Engagement
- Self Directed Services (i.e. WRAP)
- Non-Medicaid Transportation

HARP IMPLEMENTATION

- These are the services that MHA's and other recovery providers have been doing successfully for years
- Traditional Non Medicaid Providers will have the ability to become HARP Eligible Providers
- These non Medicaid Providers will be an integral part of the recovery plan and work closely with the Health Plans to insure successful outcomes

THE GREAT POTENTIAL OF HARPS

- Great potential for changing the landscape of behavioral health in New York
- All the recovery services that have meant so much for community engagement and keeping people out of the hospital including peer services, family engagement, crisis services, supported employment and supported education will now become an integral part of an individual's plan of care
- Additional funding of \$600 million over the next five years for recovery services

MHANYS RECOMMENDATIONS TO TRANSITION TO MEDICAID MANAGED CARE

- In order to insure the best possible outcomes MHANYS has continued to advocate for several initiatives including:
 - Widespread efforts to educate stakeholders about the changes
 - Have a strong safety net in place through existing non Medicaid funding for dual eligibles and non-Medicaid individuals that we serve
 - Metrics that impact quality of life such as employment, education, housing, links to social services and other social determinants
 - Use this opportunity to also focus on greater family engagement

(Con't)

- A Continued Oversight Role for NYS
- Reinvestment of Savings
- Medication Accessibility
- Workforce Engagement with entities that traditionally are not involved in behavioral health through learning collaboratives and mental health literacy tools such as Mental Health First Aid
- Outside Oversight and Involvement beyond State Government

Questions and Contact Info

Glenn Liebman, CEO

Gliebman@mhanys.org

www.mhanys.org

John Richter, Policy Director

jrichter@mhanys.org

www.mhanys.org



Questions & Discussion



Thank You!

Slides and a recording will be posted to mentalhealthamerica.net/mha-webinars within the next two weeks. You will receive an email when these have been uploaded.

- Mental Health America Regional Policy Council