NEW JERSEY
DEPARTMENT
OF HUMAN SERVICES

Integrating Behavioral Health Coverage for Whole Person Care

Division of Medical Assistance and Health Services

September 2021

State of New Jersey DHS Department of Human Services

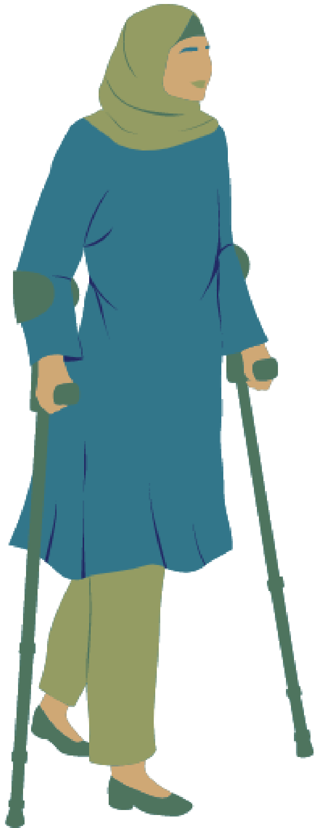
Goals for our conversation today

1. Begin with the people we serve
2. Discuss the 1115 Renewal Process
3. Understand the proposal and explore opportunities/challenges of integrated coverage
4. Plan for ongoing stakeholder discussions

This is about better care.

Thank you for being part of our community and our dialogue.

Meet an NJ FamilyCare Member: Ayelet



Coverage of behavioral and medical health care is currently split for most members.
Medical care is covered by Managed Care Organizations (MCOs).
Behavioral health care is covered by Fee-for-Service.

Ayelet dreams of being a graphic designer. She has a diagnosis of alcohol use disorder and opioid use disorder. She has a history of seizures related to withdrawal. She doesn't have a solid support network; she also has legal and financial issues related to her substance use.

Ayelet has recently had acute admissions, short-term residential treatment, and outpatient detox programs. Providers are mostly unable to include the MCO in treatment meetings or in discharge planning.

Today, there is no single entity for NJ to consider responsible for coordinating Ayelet's behavioral health care with her medical care to help her on her path to recovery. Her behavioral health outpatient services remain "carved-out" to fee-for-service, separate from the rest of her medical care, and largely invisible to her MCO.

Meet an NJ FamilyCare Member: Orin

New Jersey has been on a path to better integrate behavioral and medical health care coverage

Orin is the loving uncle of seven-year-old twins. He has a diagnosis of schizophrenia and a history of incarceration and state psychiatric hospitalization on the forensic unit. Orin has been with his MCO for many years with an extensive admission and readmission history. He has a trusting connection with his MCO care manager, but has trouble remembering events and his treatment plan.

In 2018, acute inpatient psychiatric care was integrated in MCO coverage. Prior to that time, Orin had 76 psychiatric admissions at many different hospitals, with readmissions typically within 72 hours. With the acute inpatient benefit "carve-in," Orin's MCO gained visibility to his admissions, but his outpatient treatment remained "carved out." Even after participating in discharge planning, it was challenging for the MCO to support his outpatient treatment because they had no claims record to review, and Orin's outpatient providers were not obligated to work with the MCO care manager.

In 2020, Orin became eligible for Managed Long-Term Services and Supports. Now, his outpatient behavioral health care was also integrated into his MCO coverage. The outpatient benefit "carve-in" allowed his MCO care manager to see patterns and talk with Orin when she saw that he was not attending appointments. This was very important to avoiding readmissions – and also because Orin's parole officer told his MCO care manager that attending psychiatry and therapy appointments were conditions of his parole. Fulfilling these requirements was essential to helping Orin maintain his independence in the community.

Meet an NJ FamilyCare Member: Arnetta

We currently "carve-in" behavioral health care coverage for certain populations: MLTSS, DDD, FIDE-SNP

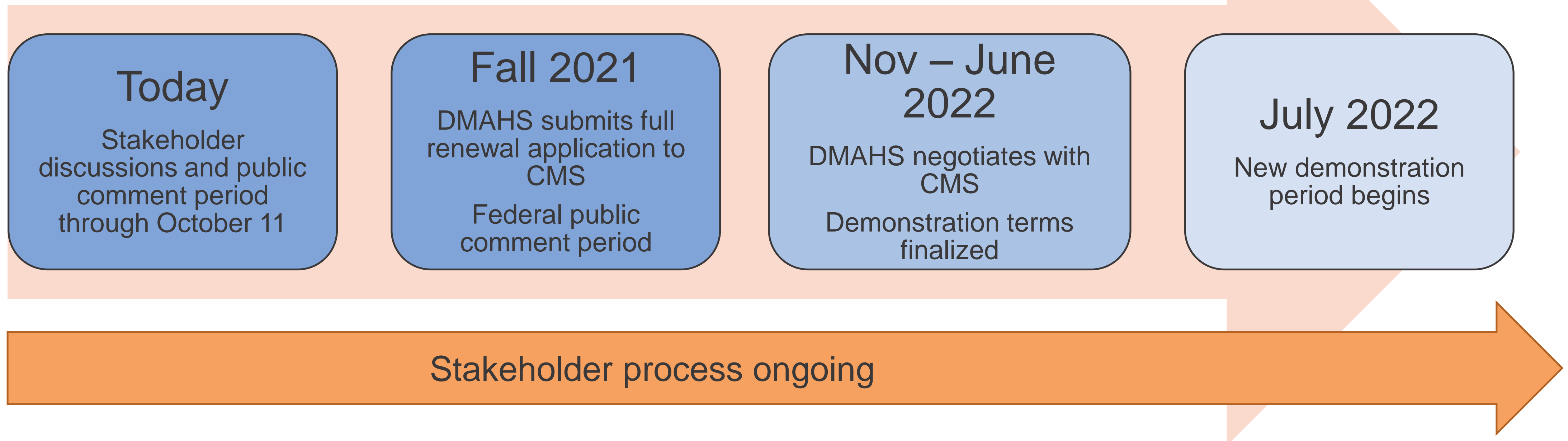
Arnetta is a clarinet player in their community band. They've had trouble making it to rehearsals after a fall and head injury. When Arnetta enrolled in MLTSS, their MCO care manager went through a comprehensive assessment to understand their medical, behavioral, and functional abilities, needs, and preferences.

The MCO care manager suggested Behavioral Health services as part of Arnetta's care plan. Arnetta agreed to attend partial care treatment, and the MCO worked closely with the partial care provider on their progress and treatment needs.

Arnetta's MCO care manager saw claims indicating that Arnetta had been filling prescriptions from two different psychiatrists – one at their partial care program and the other in the community. The MCO care management team coordinated with both psychiatrists to help Arnetta align to a safe and consistent treatment plan.

Arnetta's story is an example of how an integrated benefit can support better outcomes.

The Section 1115 Comprehensive Demonstration gives New Jersey authority to operate and innovate in important ways.



How to comment on the 1115 renewal proposal

- The Renewal application will be found on DMAHS's website at: https://www.state.nj.us/humanservices/dmahs/home/1115_demo.html
- The public comment period ends October 11.
- Comments can be sent via email to dmahs.cmwcomments@dhs.nj.gov or by mail or fax to:

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We have the opportunity to better integrate members' medical and behavioral health care coverage. ***This is about better care.***

Behavioral Health Coverage under NJ FamilyCare today is broad but largely detached from the rest of a member's medical care

BH Services covered by Managed Care Organizations

For all NJ FamilyCare members

- Hospital emergency department visits and inpatient stays with behavioral health diagnosis
- Specialty psychiatric hospital admissions provided on an "in lieu of" basis
- Autism services up to age 21
- Prescription drugs
- Office-Based Addiction Treatment (OBAT) for Medication Assisted Treatment (MAT)

BH Services provided mostly through Fee-for-Service

Covered by MCO for members enrolled in MLTSS, DDD, and FIDE-SNP only

Mental Health

- Outpatient hospital or independent clinic services
- Independent clinician (psychiatrist or psychologist)
- MH partial hospitalization
- Adult MH rehabilitation (level A+, A, B group homes)

MH and SUD partial care

Substance Use Disorder

- Long and Short-Term Residential
- Non-hospital detox
- Opioid Treatment Programs (OTPs)
- Outpatient and Intensive Outpatient (OP/IOP)

BH Services provided through Fee-for-Service Only

For all NJ FamilyCare members

- Psychiatric Emergency Services (Screening Centers)
- Behavioral Health Homes (BHH)
- Programs in Assertive Community Treatment (PACT)
- Community Support Services (CSS)
- Targeted Case Management (TCM)
- Children's System of Care (CSOC) Care Management Organizations (CMOs)
- SUD Residential Treatment (Youth Only)
- Targeted Case Management (TCM)
  - Integrated Case Management Services (ICMS)
  - Projects for Assistance in Transition from Homelessness (PATH)

DHS envisions two distinct phases for integration discussions, with stakeholder involvement throughout

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For all NJ FamilyCare members

- Hospital emergency department visits and inpatient stays with behavioral health diagnosis
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1115 PHASE 1 CONSIDERATION

Review existing MCO carve-ins to determine optimal levels of integration

For all NJ FamilyCare members

Mental Health

- Outpatient hospital or independent clinic services
- Independent clinician (psychiatrist or psychologist)
- MH partial hospitalization
- Adult MH rehabilitation (level A+, A, B group homes)

MH and SUD partial care

Substance Use Disorder

- Long and Short-Term Residential
- Non-hospital detox
- Opioid Treatment Programs (OTPs)
- Outpatient and Intensive Outpatient (OP/IOP)

1115 PHASE 2 CONSIDERATION

Review opportunities for further integration

For all NJ FamilyCare members

- Psychiatric Emergency Services (Screening Centers)
- Behavioral Health Homes (BHH)
- Programs in Assertive Community Treatment (PACT)
- Community Support Services (CSS)
- Targeted Case Management (TCM)
- Children's System of Care (CSOC) Care Management Organizations (CMOs)
- SUD Residential Treatment (Youth Only)
- Targeted Case Management (TCM)
  - Integrated Case Management Services (ICMS)
  - Projects for Assistance in Transition from Homelessness (PATH)

Our stakeholders have acknowledged opportunity in increasing integration of behavioral and medical health care coverage:

- Supports whole person care through alignment with other medical care
- Provides MCO care management as a resource to members and providers to address adherence and gaps in care
- Creates an accountable entity for coordination of behavioral health care with medical care
- Opportunity to negotiate rates and quality incentives with managed care payers
- Reduces complexity for members who have other coverage in addition to Medicaid
- Aids the referral process by consolidating provider directory resources

Our stakeholders have also shared important concerns about increasing integration of behavioral and medical health care coverage:

- Concerns about ensuring quality, continuity, and improved access for our members
- Adequacy and enforcement of MCO networks
- True integration within MCO clinical processes to produce better outcomes
- Provider enrollment, credentialing, and claims processes
- Member protections
- Implementation timelines
- Community awareness and involvement

Moving into the future together

Our NJ FamilyCare community is moving into a new chapter focused on better integration of behavioral and physical health care.

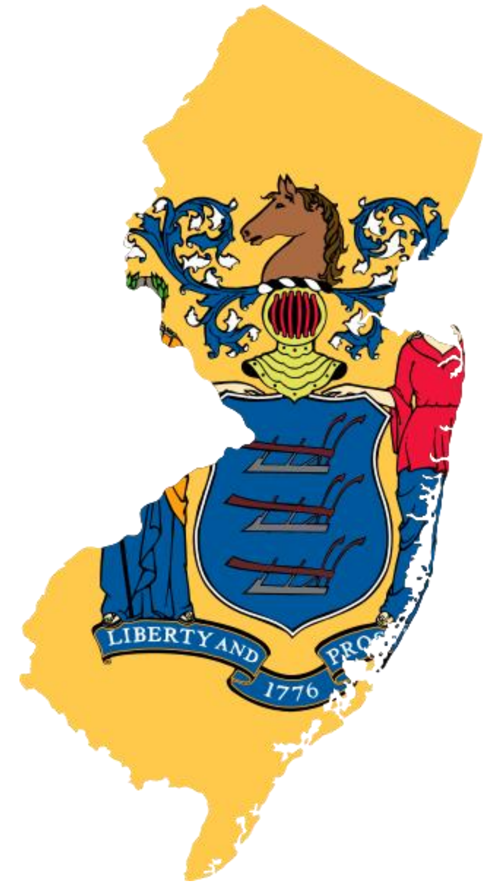
As we have done with other transitions, we will bring together our stakeholders in an energetic dialogue that guides our thinking and our implementation at each stage.

In phases 1 and 2, we will discuss topics like:

- Current carve-in experience (pros and cons)
- Concerns and benefits of optimizing integration of coverage
- Anticipated impacts on member access to care and quality of care
- Performance standards for MCOs and contract amendment process
- Appropriate safeguards for members
- Building understanding for members and providers

This stakeholder process will build on work already done and lessons learned. For example:

- Member protections consistent with the Guiding Principles from 2012 behavioral health stakeholder recommendations
- Payment reform recommendations developed for Community Support Services



North Star Principles (to be finalized with stakeholders)

Vision: To provide better coordinated behavioral and physical health care to NJ FamilyCare members.

Serve people the best way possible	We will continue our progress towards whole person care with an emphasis on integration of physical and behavioral health care management
Ensure access to and availability of behavioral health services	We will require robust MCO provider networks that support wellness and recovery with appropriate reimbursement to providers
Center the voices of the people we serve	Thoughtful processes will help us deliver person-centered care that reflects the strengths, resources, challenges, and needs of our members
Collaborate to address real-life problems	We will engage in a strong and energetic stakeholder dialogue to assess options and solutions
Support our community	Empathy, positive energy, and collaborative focus will be our hallmark, both internally and externally

Supporting our members and providers may take many forms as we move into this new chapter

- Encourage streamlined and consistent processes across MCOs
- Develop performance metrics for MCOs around the provision of behavioral health services
- Establish and enforcing standards around the volume of services expected to be provided by MCOs
- Set payment rates though state-directed payments
- Develop client-centered interdisciplinary teams, comprised of the member (and family, if desired), MCO care management team, and DMAHS staff
- Create a robust provider education and technical assistance plan to assist with provider enrollment, authorizations, and billing
- Introduce transitional “any willing provider” requirements for MCO networks
- Require MCOs to conduct screening and assign behavioral health specialists aligned with medical care management for members determined to be high risk
- Maintain current system of public facing, real time bed management information for residential SUD services (NJSAMS)
- Frequent review of MCO contract with the ability to modify components of the contract when issues arise
- Restrict prior authorizations for certain services

We can also learn from other states with integrated coverage of behavioral health care

Washington: The State evaluated outcomes of people who enrolled in integrated behavioral health care coverage in an early-adopter region showed improvements. Many results were not yet statistically significant, but significant differences were almost all positive.

- Some of the greatest improvements were in access to care, including mental health treatment and ambulatory and preventive care, including for those with SMI and those with co-occurring mental illness and SUD.
- There were also statistically significant results related to quality, coordination of care, and utilization. As an example, there was a significant positive relative change in diabetes screening for individuals with schizophrenia or bipolar disorder and follow-up after ED visits for SUD.
- For Medicaid beneficiaries broadly, including those with co-occurring mental illness and SUD, there was significant reduction in homelessness and in criminal justice interactions

Washington State Department of Health and Social Services, "Evaluation of Integrated Managed Care for Medicaid Beneficiaries in Southwest Washington: First Year Outcomes," 2019.

Arizona: A Mercer evaluation found that adults with SMI who enrolled in integrated behavioral health plans in Maricopa County showed improvements in 75% of indicators, including measures of patient experience, ambulatory care, preventive care, and chronic disease management.

- Hospital related measures were mixed (5 showed improvements, 3 showed declines). These mixed results may be due to previous untreated medical conditions that are now being identified and treated.

Mercer Health & Benefits LLC, "Independent Evaluation of Arizona's Medicaid Integration Efforts," 2018;

Next steps in our journey

- *Listening:* Stakeholders can weigh in on the 1115 renewal proposal formally or informally. Once we have completed our public comment period, DMAHS's formal dialogue with CMS will begin.

- *Talking:* DMAHS and DMHAS together will gather diverse stakeholders throughout our planning process, including members, providers, families, and advocates.
  - Using stakeholder feedback, we will finalize the North Star principles that will guide our discussions and decisions.
  - We will identify opportunities to improve on our existing system, strengths we want to bring into the next chapter, and concerns we want to be mindful of as we move forward together.

- *Learning:* We are continuing to work closely with the Center for Health Care Strategies to collect best practices and insights from other state Medicaid programs.

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