Redesigning
THE MEDICAID PROGRAM

NEW YORK STATE DEPARTMENT OF HEALTH

Medicaid Redesign Team (MRT)

Behavioral Health Reform Work Group

FINAL RECOMMENDATIONS

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Work Group Charge:

As part of Governor Andrew Cuomo's efforts to "conduct a fundamental restructuring of (the) Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure," the Governor appointed a Medicaid Redesign Team (MRT). The MRT is composed of representatives from the legislature, health care industry, patient/consumer advocacy groups, New York City and State executive staff including the Commissioners of the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS), and the New York State Medicaid Director. The MRT adopted 73 recommendations for Medicaid reform, many of which were enacted into New York State law.

The MRT also created several work groups to review and provide additional follow up recommendations in key areas, including behavioral health. The Behavioral Health Reform Work Group (the Work Group) was charged by the MRT with helping to establish the parameters of the transformation to care management for New Yorkers with mental illnesses and substance use disorders. It was specifically asked to:

- Consider the integration of substance abuse and mental health services, as well as the integration of these services with physical health care services, through the various payment and delivery models.
- Examine opportunities for the co-location of services and also explore peer and managed addiction treatment services and their potential integration with Behavioral Health Organizations (BHO).
- Provide guidance about health homes and propose other innovations that lead to improved coordination of care between physical and mental health services.

The Work Group chose to address its mission in the context of MRT 93, the implementation of BHOs (see appendix A). Specifically, the Work Group identified a set of managed care principles and recommendations that should apply to behavioral health care management regardless of whether BHOs are implemented through full-benefit Special Needs Plans (SNPs), provider-based Integrated Delivery Systems (IDSs), or benefit carve-out BHOs.

The Fragmentation of Behavioral Health Care in NYS

New York's behavioral health system (which provides specialty care and treatment for mental health and substance use) is large and fragmented. The publicly funded mental health system alone serves over 600,000 people and accounts for about $7 billion in annual expenditures. Approximately 50 percent of this spending goes to inpatient care. The publicly funded substance use disorder treatment system serves over 250,000 individuals and accounts for about $1.7 billion in expenditures annually. Despite the significant spending on behavioral health care, the system offers little comprehensive care coordination even to the highest-need individuals, and there is little accountability for the provision of quality care and for improved outcomes for patients/consumers. This fragmentation problem is compounded since mental health and substance use care and treatment systems are separated, with discrete regulations and funding streams, though there are substantial rates of people with co-occurring serious mental illness and substance use disorders.

Behavioral health also is not well integrated or effectively coordinated with physical health care at the clinical level or at the regulatory and financing levels. The behavioral health system is currently funded primarily through fee-for-service Medicaid, while a substantial portion of physical health care for people with mental illness or substance use disorders is financed and arranged through Medicaid managed care plans. This also contributes to fragmentation and lack of accountability.

This lack of coordination extends well beyond physical health care into the education, child welfare, and juvenile justice systems for those under the age of twenty-one.

The fragmented and uncoordinated payment and delivery systems have contributed to poor outcomes, including:

- People with serious mental illness die 15 - 25 years earlier on average than the rest of the population. The leading contributors to this disparity are chronic, co-occurring physical illnesses, which are not prevented and are treated inadequately. (Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm)
- The majority of preventable admissions paid for by fee-for-service Medicaid to Article 28 inpatient beds are for people with behavioral health conditions, yet the majority of expenditures for these people are for chronic physical health conditions. (New York Medicaid Redesign Team, Building a more affordable, cost-effective Medicaid program, January 13, 2011 Albany, New York)
- There is an over-reliance on State psychiatric hospitals, adult homes and nursing homes, partly due to the system's inability to assign responsibility for integrated community care.
- In NYS, under the current Medicaid fee-for-service system, 20% of patients discharged from psychiatric inpatient units are readmitted within 30 days. (http://www.omh.state.ny.us/omhweb/rfp/2011/bho/databook_tables.xlsx)

- The unemployment rate for people with serious mental illness is extremely high, approximately 85% based on national surveys.
- Only 30% of youth age 14 and older with a serious emotional disturbance graduate with a standard high school diploma. (http://www.omh.state.ny.us/omhweb/News/leadership_conf/index.htm)
- Serious mental illness and substance use disorders confer significant risks of homelessness.
- The overuse of inpatient detoxification and SUD inpatient rehabilitation services by a small number of individuals results in poor outcomes and high Medicaid costs.
- The average time between onset and treatment of mental illness in children and treatment of mental illness is approximately nine years.
- Collaborative care is not widely implemented in New York, though it is recognized as a best practice.
- Early intervention for psychiatric disorders (usual onset in early twenties) is infrequent and not promoted under the current regulatory and financing approach, despite wide recognition as a best practice.

It is with these challenges in mind that the Work Group commenced its work. The recommendations in this report are intended to address the problems and poor outcomes referenced above, while contributing to Medicaid budget solutions.

Work Group Process

The Work Group began meeting on June 30, 2011 in New York City and held four additional meetings – July 12 in Albany, August 1 in New York City, August 23 in Albany, and September 12 in New York City. The Work Group recognized the need to involve experts with knowledge and experience specific to children with serious emotional disturbances and substance use disorders in a subgroup of the Work Group, and its recommendations are addressed in the child-specific section later in this document.

Meetings included expert presentations on relevant topics and discussions examining issues related to the Work Group's charge and potential recommendations to the MRT. Presentation topics included:

- Components of effective treatment and services for Serious Mental Illness (SMI), and Serious Emotional Disturbance (SED) - Mike Hogan, Ph.D. Commissioner, NYS OMH.
- Physical Health of Individuals with SMI and SUD and the Integration of Physical and Behavioral Health Care – Adam Karpati, M.D., Executive Deputy Commissioner for Mental Hygiene, NYC DOHMH and Andrea Cohen, Director of Health Services, New York City.
- Services and Medicaid in the OASAS Treatment System – Arlene Gonzalez-Sanchez, Commissioner, NYS OASAS, and Robert Kent, Chief Counsel, NYS OASAS.
- Managed care principles and practices – Ilene Margolin, Senior Vice President, Public Affairs & Communications, Emblem Health & Health Plan Association.
- The DOH health homes initiative – Gregory Allen, Director, Division of Financial Planning and Policy, NYS DOH.
- Management of SUD - Arlene Gonzalez-Sanchez, Commissioner, NYS OASAS, and Robert Kent, Chief Counsel, NYS OASAS.
- Lessons learned from the Care Monitoring Initiative (information about this initiative is available at http://www.omh.state.ny.us/omhweb/cmi/faq.html) - Robert Myers, Ph.D., Senior Deputy Commissioner, Division Director, NYS OMH, and Adam Karpati, M.D., Executive Deputy Commissioner for Mental Hygiene, NYC DOHMH.
- Performance standards to promote good care at reasonable cost – Susan Essock, Ph.D., Director, Division of Mental Health Services and Policy Research, Columbia University.
- Presentation of recommendations from the Children's sub-group – Gail Nayowith, Executive Director, SCO Family of Services and Kristin Riley, Deputy Commissioner, Division Director, NYS OMH.

Given the challenges outlined above, the Work Group proposed several key principles for behavioral health that should apply to the new financial and programmatic mechanisms being implemented in New York (BHO, IDS, SNPs, and Health Homes).

Work Group Membership:

- **Co-Chair, Michael F. Hogan, Ph.D.** *Commissioner, New York State Office of Mental Health*
- **Co-Chair, Linda I. Gibbs**, *New York City Deputy Mayor for Health and Human Services*
- **Wendy Brennan**, *Executive Director, National Alliance on Mental Illness – NYC Metro*
- **Pamela Brier**, *President & CEO, Maimonides Medical Center*
- **Alison Burke**, *Vice President, Regulatory & Professional Affairs, Greater New York Hospital Association*
- **Lauri Cole**, *Executive Director, NYS Council for Community Behavioral Healthcare*
- **Donna Colonna**, *Executive Director, Services for the Underserved*
- **John Coppola**, *Executive Director, New York State Association of Alcoholism and Substance Abuse Providers*
- **Betty Currier**, *Board Member, Friends of Recovery – New York*
- **Philip Endress**, *Commissioner, Erie County Department of Mental Health*
- **Arlene Gonzalez-Sanchez**, *Commissioner, NYS Office of Alcoholism and Substance Abuse Services*
- **Kelly Hansen**, *Executive Director, New York State Conference of Local Mental Hygiene Directors*
- **Ellen Healion**, *Executive Director, Hands Across Long Island*
- **Tino Hernandez**, *President & CEO, Samaritan Village*
- **Cindy Levernois**, *Senior Director, Behavioral Health and Workforce, HANYS*
- **Ilene Margolin**, *Senior Vice President, Public Affairs & Communications, Emblem Health & Health Plan Association*
- **Gail Nayowith**, *Executive Director, SCO Family of Services*
- **Kathy Riddle**, *President and CEO, Outreach Development Corp.*
- **Harvey Rosenthal**, *Executive Director, New York Association of Psychiatric Rehabilitation Services, Inc.*
- **Paul Samuels**, *Director & President, The Legal Action Center*
- **Phillip Saperia**, *Executive Director, The Coalition of Behavioral Health Agencies, Inc.*
- **Sanjiv Shah, M.D.**, *Chief Medical Officer, Fidelis Care NY*
- **Richard Sheola**, *Executive Vice President, Value Options*
- **Ann Sullivan, M.D.**, *Network Senior Vice President, Queens Hospital Network; NYCHHC*

Meeting Dates:

- *Thursday, June 30, 2011*
- *Tuesday, July 12, 2011*
- *Monday August 1, 2011*
- *Tuesday, August 23, 2011*
- *Monday, September 12, 2011*
- Meeting Agendas, Presentations and Minutes can be found at: http://www.health.state.ny.us/health_care/medicaid/redesign/behavioral_health_reform.htm

Principles for Behavioral Health Services in a Managed Care Environment

As charged by the MRT, the Work Group identified a number of key elements of design and practice needed for a managed and coordinated behavioral health care system in New York State relevant across the age span. Beginning with the first meeting, the Work Group engaged in a goal-setting and prioritization process to reach group consensus on these key principles. The Work Group also identified critical types of metrics and indicators that should be measured to determine the extent to which these principles are met. The following are the principles established by the Work Group:

1. **There should be mechanisms at multiple levels for connecting and coordinating all of the different participants, including healthcare providers, payers, and care managers. The delivery of clinical care should be coordinated and efficient**.

    - Mental health, physical health, and substance use should be addressed in an integrated manner.
    - APG caps on physical health services provided in behavioral health settings and behavioral health services in physical health settings must be revisited.
    - Patient/Consumer screening for mental illness and substance use disorders should be done across specialty and primary care settings and should use state-of-the-art techniques and technology.
    - Providers should use electronic medical records and available mechanisms for health information exchange. They should have access to, and use, their patient/consumers' Medicaid data.
    - There should be a "no wrong door" approach so that no matter where patients/consumers enter the system, they are guided to the right provider. Standardized screening tools should be used.
    - A system of empowered care coordination should be established, and be stratified by risk/need of patient/consumer. Payment models should incentivize coordination among physical and behavioral health providers.
    - Duplication of services should be avoided.
    - Co-location of services should be one available model to promote integrated care.
    - There should be clarity around roles and accountability across service providers.
    - Linkages to other systems, such as the criminal justice, juvenile justice, homeless, and child welfare systems, also should be developed.

2. **Payment for services should be tied to patient/consumer outcomes.**
    - Incentives should guide providers to the appropriate type and amount of care.
    - The reimbursement rate structure should recognize the varying levels and capabilities of providers.
    - There should be flexibility to finance wrap-around services.
    - The fee-for-service "mentality" should be eliminated, although that does not preclude using fee-for-service payment mechanisms within a managed care arrangement.

3. **Patient/Consumer input and choice is critical.**
    - Whenever possible, consumer choice should be preserved.
    - There should be in-person care coordination activities for high-need users.
    - Peer programs should be used to help engage patient/consumers.
    - Families should be integrated into care whenever possible.
    - Treatment should be based on condition, and not on insurance status.
    - There should be a person-directed focus on wellness and recovery.
    - Consumer access should be considered as part of any data-sharing initiative.

4. **Attention should be paid to social factors that influence individual behavior and outcomes, such as employment and financial status.**
    - Available social services outside of health care should be utilized maximally.

5. **Housing resources need to be available directly for timely use to avoid lengthy or repeat admissions, and to provide stability for patient/consumers in the community.**

6. **Money saved should be reinvested smartly to improve services for behavioral health populations.**
    - Savings from better managed behavioral and physical health care should be reinvested to the extent possible for improved outcomes and reduced health costs.
    - Reinvestment should prioritize non-clinical support services, such as housing, peer, employment, and family services.
    - Investment in preventive services that avoid the need for tertiary care should be incentivized.
    - Savings might be shared with consumers to incentivize engagement.

7. **Distinction in design and operation must be made to address the unique needs of children and their families.**

8. **The needs of older adults are unique and require special attention.**
   - For older adults, care coordination will require interface with home health services, adult day care, and a heightened sensitivity to physical health needs.

9. **Regulatory burden should be minimized.**
   - Unfunded mandates should be avoided.
   - The paperwork required of providers by government and managed care organizations should be reduced, or, at the very least, not increased.

10. **The diversity of New York State's communities should be taken into account.**
    - Varying levels of patient/consumer needs and provider capacities may dictate different approaches in different parts of the State, especially those which are predominately rural or urban.

11. **Key outcomes at the individual, provider, and system levels include:**
    - Sustainable medical-loss ratios and reasonable levels of reinvestment
    - Elimination of inappropriate financial barriers to care
    - Adequate and promptly paid reimbursement rates to ensure appropriate capacity
    - Appropriate risk-adjustment to incentivize treatment of the harder to serve
    - Payments that promote the delivery and use of the appropriate level of care
    - Good clinical outcomes for key chronic medical conditions
    - Cultural and linguistic competency and use of peer services
    - Reduced hospital admissions inpatient detoxification and SUD inpatient rehabilitation services
    - Reduced mortality and health disparities associated with mental illness and substance use
    - Reduced gap between prevalence of service engagement and prevalence of conditions in the population
    - Reduced criminal and juvenile justice involvement
    - Reduction in use of court-ordered outpatient treatment for mental health (excluding mental health courts)
    - Improved care transitions (e.g., appointments after hospitalizations)
    - Meaningful and useful communication across providers

Summary Listing of Recommendations:

In addition to principles for managed care, the Work Group identified a number of recommendations in the area of finance and contracting with plans; eligibility; performance metrics/evaluation; children, youth, and family; peer services; and Health Homes, as well as some issues that were considered important but outside the scope of the Work Group's mission. These are provided below:

A. Overarching recommendations include:

- Managed care approaches using risk-bearing Special Needs Plans (SNPs), Integrated Delivery Systems (IDS), and/or Behavioral Health Organizations (BHOs) should be developed, consistent with MRT recommendation #93 (See Appendix A) and State statutes. In New York City, based on its population and its delivery system infrastructure, full-benefit IDSs or SNPs should be developed to include mental health, substance use, and physical health.

- Meeting the MRT's key goals of improving the outcomes for individuals with serious mental illness and/or substance use disorders and reducing the growth in costs through a reduction in unnecessary institutional care will require a strong and well-functioning community-based system of care and supports. Building this system will require investments in care coordination; in access to affordable housing; in health information exchange; and in other non-clinical services and supports.

- SNPs/BHOs should be given responsibilities to pay for inpatient care at State psychiatric hospitals and to coordinate discharge planning. This will help reduce incentives for BHOs/SNPs to institutionalize people in State psychiatric hospitals. It is expected that facility downsizing would occur on a phased basis. As State psychiatric hospital resources are freed, these funds will be reinvested to fund community-based services (housing, employment, peer support, family and children's support), with a modest amount taken as savings. OASAS State-operated Addiction Treatment Centers (ATC's) already participate in Managed Care Plans and services provided there will continue to be paid for by the SNP/BHO.

- Given the high percentage of individuals with behavioral health disabilities who are dually eligible for Medicaid and Medicare, consideration should be given to integrating Medicaid and Medicare benefits for dual eligibles through the SNP, IDS or BHO using an 1115 waiver or other mechanism. Medicare savings should be reinvested in SNP, IDS or BHO at least in part.

- Advance the core principle that managed care approaches for people with behavioral health care needs should assist enrollees in recovery and in functioning in meaningful life roles.

- Use the 1115 waiver that is being developed to advance the recommendations outlined in this report.

- The Work Group should continue to deliberate and provide guidance and recommendations as budget projections, 1115 waivers, and regulatory efforts are developed to implement these recommendations.

- The recommendations below are to be accomplished largely through the redistribution of existing resources; as inpatient and emergency room services decrease resources will be reinvested into community supports and rehabilitation services. Therefore, individual recommendations cannot be costed out separately because they are part of an overall system restructuring.

Through deliberation, the Work Group reached consensus to advance the following more specific recommendations consistent with its principles and mission as part of the MRT.

B. Financing and Payment

- Initial premium levels for managed care entities should be based on prior service spending, including Health Home and targeted case management spending, and should be designed to encourage plan investment in prevention and development of capacity for cost-effective, evidence-based services. State share savings should not be targeted for the first year of risk-based behavioral health managed care.

- There should be transparency with respect to the portion of premium attributable to behavioral health actuarial assumptions and actual behavioral health service spending by plans.

- Formal mechanisms should be established for reinvestment of resources into clinical and non-clinical services that can improve the quality and cost-effectiveness of care for people with serious mental illnesses and substance use disorders. Savings on behavioral and physical health care attributable to improved care coordination of behavioral health populations should be tracked. Reinvestment should be focused on high priority areas, including housing, employment services, peer services, and family support. Reinvestments should be based on county/City planning processes and include input from managed care entities, providers, consumers and other stakeholders, and should be approved by the State.

- Non-Medicaid savings in State and local systems serving patients/consumers with behavioral health needs also should be tracked and accounted for as savings generated by Behavioral Health reform. These systems with potential savings include criminal and juvenile justice, homeless services, cash assistance/benefits, Special Education, and child welfare, among others.

- Compliance with existing New York State Medicaid managed care legal requirements and principles are assumed unless otherwise noted.

C. Contracting with Behavioral Health Plans (BHOs, SNPs, IDSs) and Benefit Package

- The operations of behavioral health managed care entities should be tailored to local health delivery infrastructure and populations.

- Contracting responsibility for BHO/SNP/IDS should rest with OMH/OASAS coordinated with NYS DOH in consultation with the counties/City. Managed care entities in NYC, whether full-benefit SNPs, IDSs or carve-out BHOs, should be overseen jointly by the State and NYC behavioral health agencies with close NYS DOH collaboration.

- Managed care entities should offer comprehensive behavioral health benefits, and full-benefit SNPs also should offer comprehensive physical health benefits. Care coordination, care management, and health home services should be fully integrated into SNPs, and also integrated into BHOs for management and coordination of behavioral health services. Non-clinical services, including peer services that contribute to continuity of care, wellness, and recovery, should be included in the behavioral health service array. The SNP benefit should include pharmacy.

- SNPs and BHOs should be required to participate in coordination activities with the relevant social and human services system, including the criminal and juvenile justice system and children's service system.

- SNPs and BHOs should be required to coordinate with the local planning process as provided for in Article 41 of the Mental Hygiene Law and in the county/City behavioral health agencies' ongoing oversight and monitoring activities around access to mental health, substance use services, and social supports in the region.

- Protocols should be developed to ensure:

    - Coordination of services covered by BHOs with physical health payers and providers and/or social service benefits/services that are not covered by Medicaid managed care.

    - Coordination of services covered by SNPs with social service benefits/services that are not covered by Medicaid managed care. These protocols should ensure that resources are targeted to highest need populations.

- Managed care entities should develop robust care coordination activities that include intensive data-driven strategies to identify high-need consumers (e.g., those disengaged from care; those at high risk of suicide; those with history of violence); policies and procedures to exchange information with and hold accountable clinical providers, including exchange of information between psychiatrist and primary care doctor, between social worker and doctor, etc.; and programs of direct, community-based engagement with consumers. Special attention should be placed on points of transition: discharge from hospital or emergency department, from jail or prison, from shelter, and outreach to people disengaged from care, especially people potentially at high risk.

- Special attention should be given to individuals with co-occurring behavioral health and developmental disability challenges.

- Managed care entities should be required to have networks of providers that are appropriate to enrollee needs and existing provider relationships and that foster strong and collaborative plan/provider network partnerships focused on highest quality and performance. Continuity of care, access to an appropriate array of providers, and opportunities for consumer choice in providers should be prioritized. The number of managed care entities in a region should be limited, in order to ensure accountability and access. OMH and OASAS should promulgate standards for network adequacy.

- Expected best practices in behavioral health managed care include:
  - Appropriate risk sharing between payer (State) and plan.
  - A defined "floor" on services spending in sum (e.g., Medical Loss Ratio) and for key services or service categories.
  - Include Medical Loss Ratio (MLR) requirements in managed care contracts to ensure a certain percentage of funds go toward direct patient care.
  - Coordination with housing and other social services and supports, e.g., employment and rehabilitation, family support services.

- Managed care entities should focus on ensuring the appropriateness of ambulatory and inpatient services provided to enrollees through the following:

  - Expanded access to office-based ambulatory services (e.g. psychotherapy). Reduced use of inpatient care consistent with assured timely and appropriate access whenever it is clinically necessary
  - Appropriate development and substitution of less costly and more appropriate alternatives to inpatient care

- Managed care entities should be required to use standardized assessment and level of care protocols which should be made available to all network providers.

- Managed care entities should be required to use best practices in management of Electronic Health Information (EHI) (e.g. PSYCKES for medication management and reduction of polypharmacy). (See Section F)

D. Eligibility for SNPs/BHO Enrollment

- SSI status should not be the single determinant of eligibility of Medicaid recipients with behavioral health needs for specialty managed care. Eligibility should be based on clinical status and/or utilization. A mechanism should be established to ensure that disengaged individuals (those without a history of high utilization) can also be enrolled in SNPs. Clinical status should include the presence of either a mental illness or a substance use disorder (or both) and a level of illness severity and/or functional impairment.

E. Promotion of Improved Behavioral Health care in primary care/non-specialty settings, including provided through mainstream managed care plans

- OMH, OASAS, and DOH should review and revise clinic licensing requirements to allow for co-licensure, reduce duplicative or contradictory requirements, and incentivize more co-located behavioral health/physical health services.

- Mainstream plans should be evaluated on a more robust set of behavioral health performance measures than are currently used, including clinical outcomes for depression and anxiety disorders; access to specialty services; and continuity of care. Depression and Screening Brief Intervention Referral and Treatment (SBIRT) screening should be required, measured, and strongly incentivized.

- Expected savings in the cost of psychiatric medications as patents expire and generic versions are made available, can be reinvested to implement collaborative behavioral health care in primary care settings.

F. Health Information Technology and Information Exchange

- Plans should require and promote the participation of their contracted providers with the SHIN-NY (State Health Information Network of New York) through promotion of electronic health records and information exchange and the elimination of barriers to participating in health information exchanges, such as financial challenges. . Health IT should be a target for investment.

- All Medicaid managed care entities should report all paid claims and encounter data to the State in a timely manner and according to statewide protocols. The State should share claims data in a timely manner with plans for any carved out services used by their membership.

- Plans should adopt comprehensive, consent-based data-sharing protocols and make claims data available to providers and the counties/City to ensure appropriate oversight, care and care coordination. Where there is statewide or national consensus on these protocols, plans should adopt those and not pursue proprietary methodologies.

- OMH, OASAS and DOH should develop statewide standard consent protocols and guidelines for use, including for electronic health information exchange. Plans should mandate that providers use these consent protocols (as opposed to creating their own proprietary ones).

G. Performance Metrics/Evaluation

- Performance Monitoring and Incentives. Managed care entities and their networks should be held accountable for outcomes, including providing and coordinating enrollees' health care.

- Plan payment should include a performance-based premium payment incentive program that measures performance and pays more for plans that perform better.

- Plan performance should be based on validated measures across a variety of different domains – including access, network adequacy, adoption of best practices, patient/consumer satisfaction, compliance, efficiency, care coordination and continuity, and clinical and recovery outcomes. Disparities in measures between racial/ethnic and other socio demographic groups also should be tracked. Managed care entities should be measured on their performance coordinating enrollees with social services and support needs.

- There should be public reporting, by plans and aggregated by State, of Medicaid spending on behavioral health services over time, including before and after reform initiatives are implemented. The reporting should include the behavioral health sector as a proportion of total Medicaid spending and absolute spending on behavioral health services and populations. Performance Metrics should be transparent.

H. Children, Youth and Families

The Children's Subgroup met several times and submitted the following recommendations to address the unique and complex needs of children with behavioral health disorders in a managed care setting, which were adopted by the Work Group. (See appendix B for the Children's Subgroup's full report.)

Findings:

Intervening early in the progression of behavioral health disorders is effective and can reduce cost. Even with recent gains in children's behavioral health, harmful and costly developmental trajectories continue to be formed early in life:

- 30% of children in New York's public schools with a special education label of "emotionally disturbed" graduate with a standard high school diploma.
- Up to 80% of the children in the juvenile justice system have a behavioral health diagnosis.

- Adverse experiences in childhood (e.g., recurrent abuse, witnessing domestic violence, parental separation/divorce, growing up with parent with mental illness, substance abuse or incarceration) are important predictors of unhealthy behaviors, including tobacco, alcohol, and illicit drug use, and adult physical and mental illnesses . [1]

It is widely accepted that education for children has a greater return in human capital than interventions at later ages. Medicaid redesign in New York provides the opportunity for a greater return on investment in children's behavioral health by likewise investing early in preventive and therapeutic interventions that are more effective (and more cost-effective) in preventing a poor longitudinal course of emotional disturbance than interventions at later ages, when harmful developmental trajectories have already been established.

Accountability across all payers is lacking. Children are covered by a variety of insurance (public/private) products with historic dependencies on Medicaid rates and State general funds to support behavioral health needs, which increase the demand on state and county funded services. Medicaid redesign must address the historic reliance on safety net services and establish reasonable expectations for accessing services across all payers.

The current systems are "siloed." Families are often served by a disjointed, overlapping, non-comprehensive and costly series of services. Medicaid redesign must better align systems to yield continuity of care, access and cost efficiency, and promote greater integration of primary care and behavioral health. Special considerations may be required to address the complex needs of children in the foster care system.

***The current behavioral healthcare system for children and their families is underfunded*.** Per capita investment in behavioral health for adults far outweighs investment in children, which could be remedied through reinvestment of existing resources.

<u>Subgroup Recommendations:</u>

- **Identify the core elements of the benefit package and priorities for the basic Medicaid Managed Care, Child Health Plus, Family Health Plus and commercial insurance plans.** Ensuring access to a number of front-line services/benefits to prevent, screen and treat behavioral health disorders are the most important components to preventing long-term disability, significantly altering the trajectory of disability as a child enters adulthood, and reducing long-term costs. These recommendations consist of ensuring robust access to a number of interventions (see Appendix B for complete list), including: routine screening, including at well-child visits; crisis services available on a 24/7 basis; first-level interventions available within seven days; assessment, using accepted tools/diagnostic methods and that serve as the basis for determination of medical necessity.

[1] Green et al. Childhood adversities and adult psychiatric disorders in the NCS-R-I. *Arch Gen Psych*. 2010; 67:113-123. Shevlin M, et al. Childhood adversity and hallucinations: a community-based study using the National Comorbidity Survey Replication. http://cdc.gov/ace/

- **Identify the enhanced elements of the benefit package and processes for a Special Behavioral Healthcare Managed Care Plan for children with special needs.** For all children, eligibility for the specialty managed care program should be based on a combination of clinical/functional status, i.e., DSM diagnosis of serious emotional disturbance or substance use disorder or the presence of complex symptoms and behaviors even in the absence of a formal diagnosis, and utilization of specialty services or risk of such utilization. In addition, because of their high risk for behavioral health problems, children with an individualized educational plan (IEP) or who are served in the child welfare or juvenile justice systems should have presumptive eligibility for enrollment in the specialty managed care program; for these children, the clinical and utilization thresholds should be lower than for the general child population and enrollment processes should be streamlined and facilitated.

- Recommendations (see Appendix B for complete list) for components of the specialty benefit to be made available to those children that qualify include: residential treatment (MH and SUD), HCBS waivers (HCBW, B2H); Medication management; Family support and guidance; Cross-system communication and coordinated case planning (reports to Family Court, status updates to foster care agency, juvenile justice program and/or school); Recovery-oriented services.

- **Develop outcome measurements and standards to review program performance.** A number of key outcomes should be used to anchor quality in both regular and specialty care and defined processes should be established to measure and use outcomes to appraise performance and improve quality. The outcomes were selected considering the following principles: 1) Meaningful - indicators capture progress toward symptom reduction, risk reduction, improved functioning and well-being; Easy to measure – include indicators universally used by all plans and not overly burdensome to implement; Validated and readily available - indicators are based on established measurement tools with established validity, reliability and are available in the public domain; Easy to use - indicators can be easily used to improve quality.

  Overall, nine recommendations (see Appendix B) are submitted, along with specific ways in which outcomes should be measured and used. The critical outcomes are:

  - Improvement in psychiatric symptoms for which treatment is sought
  - Improvement in functional status (e.g. social, school function)
  - Consumer satisfaction/involvement
  - Critical incidents
  - Success/failure at transition to less intensive level of care
  - Access to care
  - Medication management
  - Cross-systems communication/case planning
  - Network adequacy

I. Peer Services and Engagement

Consistent with MRT 1058, it is appropriate to incorporate peer services into a new behavioral health managed care system that prioritizes physical and behavioral health as well as other necessary aspects of successful functioning in the community (housing, employment, education, etc.). A subgroup related to peer services and engagement identified the following core recommendations, which were adopted by the Work Group. (For the subgroup's full report, see Appendix C.)

- Promote acknowledgement and respect for the unique contributions and value of peers in delivering services that help people, promote wellness, and decrease costs.
- Facilitate ways to accommodate Medicaid funding for peer services, such as waivers, grants, and funding for programs rather than for the position itself. Funding for training and education, certification, and leadership development would strengthen the peer workforce.
- Establish an accreditation process for peer-run agencies which would professionalize the unique, whole health/wellness approach that peers provide.
- Incorporate peer services into Health Homes, given the recognition that peer series are evidence-based practices which can improve outcomes while being cost effective.
- Address children and their care separately from care of adults.

J. Services for the Uninsured.

The Work Group agreed this issue warranted special attention and formed a subgroup to review issues related to the uninsured. The subgroup made the following recommendations which were adopted by the Work Group. (See appendix D for their full report.)

- A mechanism for funding an appropriate level of services to the uninsured and underinsured needs to be maintained as the system moves into managed Medicaid for all clients with mental health and substance use disorders and previous funding streams (such as disproportionate share hospital (DSH) payments) are reduced or no longer available.
- The uninsured population should access care coordination services in the same way as the insured population does in order to prevent inappropriate use of high cost emergency services, and cost-shifting to other systems.
- For the uninsured and underinsured, promote Medicaid buy-in options for people with behavioral health issues.
- For insurance offered in new health insurance exchanges, the State should promote benefit package designs that ensure appropriate coverage of services for individuals with SMI and SUD.

- For the underinsured, mental health and substance use parity as required by State and federal law needs to be enforced in all insurance programs, including commercial programs to which the laws apply.

K. Health Homes

Consistent with its mandate to provide guidance on Health Homes, the Work Group reviewed current plans for development of health homes at its August 1 meeting. Because development of Health Homes proceeded prior to completion of this final report, the following interim recommendations were shared with the Department of Health to help shape the development process over the next several months.

- **Health homes must include behavioral health expertise and leadership.** Individuals with Serious Mental Illness (SMI) and those with substance use disorders (SUD) are a priority for early enrollment in health homes. The [Work Group] recognizes there is great potential to improve the quality and continuity of care for this population (e.g. by integrating medical with behavioral care). There is also potential for harm; many individuals in the population with SMI rely primarily on behavioral health providers, may have limitations or reluctance in using other health services, and need specialty attention. Therefore, the [Work Group] recommends that there should be health homes with specific specialty capacity (e.g., network, staffing, care coordination practices) to serve individuals with SMI and SUD. In addition to specialized capacity, health homes serving the SMI/SUD population should be evaluated on specific and robust performance and outcome indicators related to this population. Government behavioral health officials should play a key role in selecting and guiding the development of and overseeing these health homes.

- **A transitional strategy must be in place to assure the smooth transition of behavioral health services (especially "case management" services) from the 2 year enhanced FMAP stage into the SNP/BHO/IDS environment that will be put in place for 2013.** Before patient/consumers and funding are shifted to health homes, the State should formulate and articulate a strategy ensuring that people, funds and services are maintained and transitioned into the managed care environment now being designed for 2013. A critical part of such a strategy will be ensuring that funding at its current levels moves along with consumers into new models of care organization, payment and delivery, especially dollars slotted for targeted case management and Managed Addiction Treatment Services (MATS).

- **All Health homes should include networks providing both physical and behavioral health care and rules should not distort spending on category of care, whether in health homes with a specialty capacity to serve individuals with SMI and SUD, or other health homes.** An integrated approach to health and behavioral health care necessitates routine basic screening for BH disorders and other medical problems in all health homes, and the presence of routine ambulatory health services (e.g. internal medicine) and behavioral health services (e.g. addiction, mental health counseling) in all health homes. Current licensing barriers and rules that limit behavioral health providers billing for routine outpatient physical health services severely limit successful integration. These rules should be abolished. Health homes must also

- ensure access to essential specialty services such as obstetrics and gynecology that are often underutilized by BH clients.

- **Health homes must coordinate with non-health service providers and have explicit relationships with local governments that often coordinate these services.** Since health problems are often exacerbated by non-health situations—such as a lack of stable housing or employment—the State must assure that health homes take into account social and other non-health services when designing an approach to treatment, especially for seriously mentally ill patient/consumers. Part of this structure should be a requirement and procedure for health homes to work with county governments. Explicit partnerships with local governments, particularly those that employ a single point of access (SPOA) process, may be the only feasible way to provide key connections to non-health social services.

- **Screening and Brief Intervention for Referral to Treatment (SBIRT) and standard depression screening should be a mandatory element of every Health Home patient assessment.** Use of these evidence based practices will greatly assist with proper assignment and care of patients and has been identified by SAMHSA as an important element of any Health Home program.

- **The State must clarify the roles and responsibilities of health homes participants**. At present, the roles of various entities, including providers and insurance plans, have not been adequately defined. While local collaborations leading to an application can help refine arrangements, the State must provide some direction. Among the issues that need immediate clarification are the roles, responsibilities, and lines of accountability for health homes, insurance plans, and participating providers. For example, an explanation of what happens to a patient/consumer who is assigned to a health home that uses providers with which the patient/consumer's insurance plan does not have contracts is a pressing concern. Further special attention should be paid in clearly indentifying the role of the first phase BHOs.

- **The State should work to preserve patient/consumer choice.** Certain individuals, such as people with significant BH issues, are much more likely to seek and accept care from providers with whom they are familiar. To the extent possible, patient/consumers should be allowed to choose which health home they join, and be permitted to transfer health homes when/if they change providers.

- **If patient/consumers are automatically assigned to health homes, the State should take steps to ensure that assignment is appropriate.** Before any patient/consumers are assigned to health homes, the State should establish and implement a process of ensuring that patient/consumers are funneled to appropriate health homes, and that critical service relationships (e.g. relationships with case managers or long term behavioral health treatment by a non-participating provider) are not impaired. One criterion of appropriateness is having a physical location the patient/consumer can easily travel to. It is critical to confirm the current residence

- of patient/consumers before health home assignment, as many patient/consumer records, especially those of the seriously mentally ill, are out-of-date on this point.

- **The State should incentivize health homes to reach culturally diverse communities and measure performance in this domain.** As part of this incentive structure, the State should encourage the use of peer and family services.

- **Clearer timelines and paths for the implementation of health homes are needed.** A key part of this timeline should be a detailed explanation of how complete a health home must be in order to start operation. A process of technical assistance and consultation by potential health home providers should include the responsible BH agencies. If there are different levels of readiness, contingencies for readiness to commence operations are important.

- **Both the State and health homes should present consumers with user-friendly information.** The transition to health homes can be a complicated one. It is incumbent on both the State and health homes themselves to create user-friendly documents to distribute to consumers to educate them about the process and their rights, and the availability of personal advice/assistance to explain these rights. These documents should be written at a grade-school reading level.

- **Health home employees should be held to appropriate qualification standards, in which the standards of the state BH agencies should be considered.** The development of health homes will bring an expanded role for care managers and other sorts of health-industry employees.

- **The State should implement health homes in a fashion that reduces regulatory burden while improving the quality and continuity of care.** The implementation of health homes should proceed in an expedited fashion with an eye towards mandate and regulatory relief.

- Children's issues related to Health Homes are still under discussion and will need to take child/family/insurance issues specific to children into account.

Report Appendices
(following recommendations 1-12)

A. MRT Recommendation number 93

B. Children, Youth, and Family Subgroup Documentation

C. Peer Services

D. Services for the Uninsured

E. MRT Behavioral Health Subcommittee Meeting Agendas*

F. MRT Behavioral Health Subcommittee Meeting Minutes*

G. MRT Behavioral Health Subcommittee Meeting Presentations*

***Appendices E-G can be accessed at the link below**

http://www.health.state.ny.us/health_care/medicaid/redesign/behavioral_health_reform.htm

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 1

Recommendation Short Name: Create Risk-Bearing Managed Care Entities for High-Need Behavioral Health Populations

Program Area: Behavioral Health

Implementation Complexity: High

Implementation Timeline: Enrollment/Implementation by April 2013

Required Approvals:

- ☒ Administrative Action
- ☒ Statutory Change
- ☒ State Plan Amendment
- ☒ Federal Waiver

Proposal Description:

- Develop managed care systems using risk-bearing Special Needs Plans (SNPs), Integrated Delivery Systems (IDSs), and/or Behavioral Health Organizations (BHOs), consistent with MRT recommendation #93 and State statutes. In New York City, based on its population and its delivery system infrastructure, develop full-benefit SNPs or IDSs that cover the full range of mental health, substance use, and physical health benefits.
- Limit the number of managed care entities in a region in order to ensure accountability and access.

Financial Impact: short term - neutral; long term - savings

Health Disparities Impact: Disparities in behavioral health take multiple forms, including significantly higher mortality rates and rates of chronic diseases among those with serious mental illnesses and substance use disorders compared to the general population and differences in access to behavioral health care and in behavioral health outcomes between different racial/ethnic, socioeconomic, or other groups. In addition, the disability associated with having a behavioral health disorder often leads to poverty, housing instability, and other social disadvantages. Instituting a managed care system that focuses on accountability, measurement and monitoring, and outcomes will improve the overall health and recovery of these often vulnerable populations and promote equity among all New Yorkers affected by these disorders.

Benefits of Recommendation:

- This proposal helps to achieve the MRT goal of ensuring that all Medicaid enrollees are in care management within 3 years
- It recognizes variation in health care infrastructure and population with behavioral health needs across all of New York's regions
- It promotes the integration of mental health, substance use, and physical health treatment and care management

Concerns with Recommendation:

- Risk of transition disruptions for enrollees and providers
- Structure does not guarantee good outcomes – there are critical implementation decisions and challenges, many addressed in subsequent recommendations

Impacted Stakeholders:

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families
- Managed care entities
- Behavioral health and physical health providers

Redesigning THE MEDICAID PROGRAM

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 2

Recommendation Short Name: Financing for Behavioral Health Managed Care Entities

Program Area: Behavioral Health

Implementation Complexity: High

Implementation Timeline: By April 2013

Required Approvals: ☒ Administrative Action ☒ Statutory Change ☒ State Plan Amendment ☒ Federal Waiver

Proposal Description:

- Base initial premium levels for managed care entities on prior service spending for all services and populations covered, including Health Home and Targeted Case Management services, with appropriate growth and other adjustments. For full-benefit SNPs and IDSs, prior spending on physical and behavioral health care services should be included.
- Do not target savings for the first year of risk-based behavioral health managed care.
- Establish formal mechanisms, within and/or outside managed care entities, for reinvestment of resources into clinical and non-clinical services that can improve the outcomes, quality, and cost-effectiveness of care for people with serious mental illnesses and substance use disorders.
    - Focus reinvestment on high priority areas, including housing, employment services, peer services, family support, and health information technology.
- SNPs/BHOs/IDSs will be given responsibility to pay for and separately track spending on inpatient care at State psychiatric hospitals, and to coordinate discharge planning. State psychiatric hospital resources that are freed through gradual facility downsizing should be reinvested into community-based services, with a modest amount taken as savings.
- If appropriate arrangements can be developed with CMS, Medicaid and Medicare benefits for dually eligible individuals will be integrated through the SNPs, BHOs, or IDSs.
- Incorporate recommendations, into the 1115 waiver being developed by the State DOH, where appropriate.

- There must be transparency and tracking with respect to the portion of BHO/SNP/IDS premium or capitation and actual plan spending attributable to behavioral health services; also, savings in behavioral and physical health care attributable to improved care and care coordination of behavioral health populations should be tracked.

- Track non-Medicaid savings in State and local systems serving patients/consumers in behavioral health managed care and appropriately attribute savings to behavioral health care reform. These systems include criminal and juvenile justice; homeless services; child welfare; Special Education.

Financial Impact: Short term - neutral; Long Term - Substantial savings possible from care management

Health Disparities Impact: Reduce, see explanation on #1

Benefits of Recommendation:

- Reinvestment will help to strengthen the community-based system of care, which could improve quality and outcomes for patients/consumers while further reducing costly use of institutional care.

- Avoiding first-year savings targets for new managed care entities will help to support up front plan investment in cost-effective, evidence-based practices, services, and capacity. Eliminating a blanket "carve out" for State psychiatric hospitals aligns incentives with State and managed care entities to provide institutional care only when absolutely necessary.

Concerns with Recommendation:

- Savings will not be available in first year of implementation

  Successful negotiations with CMS are critical to ensuring that the specialty behavioral health system can best serve dual eligibles.

Impacted Stakeholders:

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families

- Managed care entities

- Behavioral health and physical health providers

- Taxpayers

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 3

Recommendation Short Name: Governance of Behavioral Health Managed Care Entities

Program Area: Behavioral Health

Implementation Complexity: Medium

Implementation Timeline: Implementation by April, 2013

Required Approvals: ☒ Administrative Action ☒ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description:

- OMH/OASAS will have contracting responsibility for BHO/SNP/IDS, coordinated with NYS DOH and in consultation with the counties/New York City ("City"). Managed care entities in New York City will be overseen jointly by the State and City behavioral health agencies, with close NYS DOH collaboration.
- OMH and OASAS will promulgate specific standards for behavioral health managed care network adequacy and set standards for contract performance and outcome/performance measurement.
- Require SNPs/BHOs/IDSs to participate in coordination activities with the relevant social and human services system, including the criminal and juvenile justice systems and children's services systems.
- Require SNPs/BHOs/IDSs to coordinate with the local planning process as provided for in Article 41 of the Mental Hygiene Law and in the county/City behavioral health agencies' ongoing oversight and monitoring activities around access to mental health, substance use, and social services in the region.
- Tailor the operations of behavioral SNPs/BHOs/IDSs to local health care delivery infrastructure and populations.
- Reinvestments from system savings to support community-based care and treatment based on county/City planning processes and include input from consumers, managed care entities, providers, and other stakeholders, with approval by the State.

- The BH Reform Work Group will continue to deliberate and provide guidance and recommendations as budget projections, 1115 waiver applications, and regulatory efforts are developed to implement these recommendations.

Financial Impact: Neutral

Health Disparities Impact: Reduce, see explanation in #1.

Benefits of Recommendation:

- Agencies with the greatest expertise in special needs of individuals with serious mental illnesses and substance use disorders must have a lead role in regulating managed care entities serving those populations.
- Local behavioral health agencies/LGUs must play key roles and ensure coordination with other systems serving this population; system reinvestments from savings should be aligned with local planning activities.
- This recommendation sets up a functional and necessary partnership between government agencies with different capacities to oversee specialty managed care plans.

Concerns with Recommendation:

- Functional partnership among agencies requires good communication and commitment to coordinating activities

Impacted Stakeholders:

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families
- Local governments
- Managed care entities
- Behavioral health and physical health providers

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 4

Recommendation Short Name: Eligibility for Behavioral Health Managed Care Entities

Program Area: Behavioral Health

Implementation Complexity: High

Implementation Timeline: Enrollment /Implementation by April, 2013

Required Approvals: ☒ Administrative Action ☒ Statutory Change ☒ State Plan Amendment ☒ Federal Waiver

Proposal Description:

- SSI status will not be the sole determining factor regarding eligibility of Medicaid recipients with behavioral health needs for specialty managed care. Rather, eligibility for BHO/SNP/IDS enrollment will be based on clinical status and/or utilization. A mechanism should be established to ensure that disengaged individuals (i.e., those without a history of high utilization) can also be enrolled in SNPs/IDSs and/or served by BHOs.
    - Clinical status includes the presence of either a mental illness or substance use disorder and a level of illness severity and/or functional impairment
- Enroll Medicare/Medicaid dual eligibles in SNP/BHO/IDS arrangements, assuming a favorable arrangement can be established with CMS.

Financial Impact: Substantial long-term savings possible

Health Disparities Impact: Reduce, see explanation in #1.

Benefits of Recommendation:

- Eliminate distinctions based on Medicaid "eligibility pathway" (e.g., SSI vs. non-SSI Medicaid enrollee), which has little bearing on care management needs of Medicaid enrollees.

  Given the high percentage of individuals with behavioral health disabilities who are dually eligible for Medicaid and Medicare, many high need individuals will be excluded from the benefits of specialty care management if dual eligibles are not included in the SNP/BHO/IDS system.

Concerns with Recommendation:

- Implementation complexity

Impacted Stakeholders:

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families
- Managed care entities – both mainstream and specialty plans

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 5

Recommendation Short Name: Behavioral Health Managed Care Contract Requirements

Program Area: Behavioral Health

Implementation Complexity: High

Implementation Timeline: Implementation by April, 2013

Required Approvals: ☒ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☒ Federal Waiver

Proposal Description:

These requirements should apply to all types of behavioral health managed care entities:

- BHOs/SNPs/IDSs offer comprehensive behavioral health benefits and full-benefit SNPs also offer comprehensive physical health and pharmacy benefits.
    - Care coordination, care management, and other Health Home services will be fully integrated into SNPs and into BHOs for management and coordination of behavioral health services.
    - Non-clinical services, including peer services, are included in the behavioral health service package.
- Managed care entities will develop robust care coordination activities that include intensive data-driven strategies to identify high-need consumers (e.g., those disengaged from care; those at high risk of suicide; those with history of violence); policies and procedures to exchange information with and among clinical providers; and programs of direct, community-based engagement with consumers.
- Contract requirements must place special attention on points of transition – discharge from hospital or Emergency Department, from jail, prison, or shelter; and outreach to people disengaged from care.
- Managed care entities must have networks of providers that are appropriate to enrollee needs and existing provider relationships, and that foster plan/provider partnerships focused on highest quality and performance. Continuity of care, access to an appropriate array of providers, and opportunities for consumer choice in providers will be prioritized.

- Managed care entities will be required to use standardized assessment and level of care protocols that will be made available to all network providers.
- Managed care contracts must promote the use of best practices in behavioral health managed care and in management of electronic health information (e.g. PSYCKES for medication management and reduction of polypharmacy)
- Managed care contracts will establish appropriate Medical Loss Ratio minimums for overall spending and for spending on key services and service categories

Financial Impact: Long-term savings from appropriately managed high need populations

Health Disparities Impact: Reduce, see explanation in #1.

Benefits of Recommendation:

- Detailed contract requirements will facilitate effective implementation of specialty managed care and promote effective care management across plans and regions

Concerns with Recommendation:

- Costs associated with plan implementation of detailed requirements

Impacted Stakeholders:

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families
- Managed care entities
- Behavioral and physical health care providers and peers

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 6

Recommendation Short Name: Improving Behavioral Health Care in Primary Care/Non-Specialty Settings

Program Area: Behavioral Health

Implementation Complexity: Moderate

Implementation Timeline: 2012

Required Approvals: ☒ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description:

- OMH, OASAS, and DOH must review and revise clinic licensing requirements to allow for co-licensure, reduction of duplicative or contradictory requirements, and incentives to increase co-located behavioral health/physical health services.
- Evaluate mainstream Medicaid managed care plans on a more robust set of behavioral health performance measures as part of the Quality Incentive Program than are currently used. These measures will include clinical outcomes for depression and anxiety disorders; access to specialty services; and continuity of care. Plans will be required to measure, promote and incentivize routine depression screening and Screening Brief Intervention Referral and Treatment (SBIRT) for alcohol and substance abuse in primary care settings.
- Reinvest expected savings in the cost of psychiatric medications as patents expire while implementing collaborative behavioral health care in primary care settings.

Financial Impact: Neutral

Health Disparities Impact: Reduce, see explanation in #1.

Benefits of Recommendation:

- Implementation will facilitate increased use of collaborative care and earlier identification of depression and substance use disorders

Concerns with Recommendation:

- Implementation complexity

Impacted Stakeholders:

- Medicaid beneficiaries with mild/moderate mental illnesses and substance use disorders or those early in their course of illness.
- Managed care entities: mainstream plans
- Behavioral and physical health care providers

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 7

Recommendation Short Name: Promoting Health Information Technology and Information Exchange

Program Area: Behavioral Health

Implementation Complexity: Moderate

Implementation Timeline: Implementation/Enrollment April 2013

Required Approvals: ☒ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description:

- Managed care entities will require and promote the participation of their contracted providers with the State Health Information Network of New York.
- Managed care entities will report all paid claims and encounter data to the State in a timely manner and according to statewide protocols. The State will share claims data in a timely manner with plans for any carved out services used by their membership.
- Managed care entities must adopt and promote comprehensive, consent-based data-sharing protocols and make claims/encounter data available to providers and the counties/City. Where there is statewide or national consensus on these protocols, plans will adopt those and not use proprietary methodologies.
- OMH, OASAS and DOH will develop statewide standard consent protocols and guidelines for use, including for electronic health information exchange. Managed care entities will be required to mandate the use of these protocols for providers.

Financial Impact: Some cost, funded through reinvestment

Health Disparities Impact: Reduce, see explanation in #1.

Benefits of Recommendation:

- Improves care coordination and reduce system fragmentation via information exchange
- Improves clinical care and promote best practices via meaningful use of electronic health records
- Standardizes protocols across plans and providers

Concerns with Recommendation:

- Statewide and federal standards and guidelines development is a complex and ongoing process

Impacted Stakeholders:

- State and local government
- Managed care entities
- Physical and behavioral health care providers
- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 8

Recommendation Short Name: Managed Care Performance Measurement/Evaluation

Program Area: Behavioral Health

Implementation Complexity: Moderate

Implementation Timeline: Enrollment/Implementation April 2013

Required Approvals: ☒ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description:

- Hold managed care entities and their networks accountable for patient/consumer outcomes, as well as for providing and coordinating enrollees' health care.
- Include a performance-based payment incentive program that pays more for plans with higher performance outcomes in all forms of behavioral health managed care.
- Assess performance using validated measures across a variety of different domains – including access, network adequacy, adoption of best practices, patient/consumer satisfaction, compliance, efficiency, care coordination and continuity, coordination with social services and supports, and clinical and recovery outcomes.
- Track disparities in measures between racial/ethnic and other socio-demographic groups.
- Make performance measures and managed care entity performance transparent and available to the public.
- Require public reporting by plans - aggregated by the State - of Medicaid spending on behavioral health services over time, including before and after reform initiatives are implemented.

Financial Impact: Moving to a managed care structure is anticipated to result in the movement of funds from an overuse of inpatient care to expansion of community services. The movement of funds into community services will promote and sustain improved outcomes for those with behavioral health needs. Public monitoring of performance and outcome evaluation for individuals served by managed care plans will provide a level of transparency that ensures accountability not only for positive outcomes, but for promoting the continued reduction of costs.

Health Disparities Impact: Reduce, see explanation in #1.

Benefits of Recommendation: Moving to managed care is intended to improve outcomes and reduce costs. This recommendation provides a level of accountability to that process, tracking the outcomes for populations served by managed care entities. Without robust measurement and monitoring, performance toward the goal of moving to a better managed care system would be unknown.

Concerns with Recommendation: Poor performers will be identified via the publicity of performance and outcome data, which could lead to the necessity for action on the part of the State.

Impacted Stakeholders:

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families
- Managed care entities
- Behavioral and physical health care providers
- Taxpayers

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 9

Recommendation Short Name: Children, Youth, and Families

Program Area: Behavioral Health

Implementation Complexity: Moderate

Implementation Timeline: 2012

Required Approvals: ☐ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description:

The children's behavioral health system lacks capacity to best serve the needs of the State's children and youth; community-based care should be targeted for planned investments and reinvestments. This need for investment must be taken into account when savings targets are being considered.

In sum: Behavioral Health services should promote wellness and healthy development and meet the secondary and/or tertiary mental health and/or substance use/addiction needs of children and their families.

The following identifies the building blocks that support a comprehensive operating framework:

- Children and their families should be looked at through a holistic lens that sees health, behavioral health and ability to function at home, in school and in the community as necessary capacities to be supported and enhanced for each child.

- Healthy development takes many paths and is dynamic. Accordingly, children's unique individual, social, cultural, linguistic and learning needs must be fully assessed and integrated into all efforts to promote and restore healthy development.

- Peer and family support, self help and natural supports should be integrated with other behavioral health services to empower children and their families, offer choice in approach to care and reduce reliance on formal systems of care.

- All children must have access to effective behavioral health services where and when needed. Services should be responsive, timely and adaptable to complex and changing needs and evolving situations.

- Intervention should occur at the earliest possible juncture through screening and other methods of early identification. Health and behavioral health services should be provided through a perspective that is informed about childhood trauma, child and adolescent development, family life and is adept at identifying and providing effective services to this significant population.

- Outcomes of behavioral health services for children and their families should be clearly articulated, measured, reported and used to inform policy, services, reimbursement and practice quality.

    - Accountability mechanisms should focus on achieving specific child outcomes.
    - Accountability should occur at the BH provider level and occur across relevant child-serving systems. BH outcomes for children are often achieved by services that extend beyond the BH system.
    - Outcome data should be used to improve the quality of services and be linked to performance incentives. Outcomes measures should be reported at the child, provider, system and population levels.

- Efficiencies can be achieved by ensuring that services and case planning is integrated, coordinated and lead to outcomes that can be achieved both within the behavioral health system and other relevant systems.

- Current regulatory and process management requirements should be replaced by systems oriented around accountability for outcomes.

- Continuity of the child's care and relationship with primary care and behavioral health providers should be maintained regardless of changes in health insurance coverage or managed care plan.

- Technology should be financed and harnessed to improve outcomes, communication (electronic health records) and access to specialty care (telemedicine).

- Financing mechanisms should incentivize clinical outcomes and coordinated case planning. Entities receiving behavioral health financing must exercise the highest degree of fiscal integrity, transparent reporting and quality practice to create a high-performing, high-quality system of care.

- Behavioral health services for children and families are significantly underfunded and not sufficiently available. Investments in early identification and effective interventions for children yield short and long term savings for government as well as improvement in the lives of children. Commitments should be made to return savings generated from Medicaid managed care arrangements associated with children for use in developing additional BH services, supports and clinical capacity in the community.

- Managed care arrangements must support providers across child-serving systems in maintaining compliance with statutory, court ordered and/or public obligations for child safety, public safety, access to appropriate education and primary and preventive health care.

(**Children relates to infants, children, adolescents and young adults from birth to 21 years)

Summary Listing of Recommendations:

1. General Behavioral Health Recommendation for Basic Behavioral Health Benefits for Children in Medicaid Managed Care, Child Health Plus, Family Health Plus or Commercial Insurance

   The behavioral health benefit in mainstream managed care for children should include routine screening, including at well-child visits; crisis services available on a 24/7 basis; first level interventions available within 7 days; assessment using accepted tools/diagnostic methods and that serve as the basis for determinations of medical necessity.

2. Specific Recommendation for Specialty Behavioral Health Managed Care for SED/SUD or Categorically Eligible Children with Medicaid

   The behavioral health specialty benefit should be comprehensive and include residential treatment, services currently available through home and community based waivers (HCBW and B2H), medication management; family support and guidance; cross-system communication and coordinated case planning (reports to Family Court, status updates to foster care agency, juvenile justice program and/or school); recovery-oriented services.

   Eligibility for specialty behavioral managed care should be based on a combination of clinical/functional status, i.e., DSM diagnosis of serious emotional disturbance or substance use disorder or the presence of complex symptoms and behaviors even in the absence of a formal diagnosis; and utilization of specialty services or risk of such utilization. In addition, because of their high risk for behavioral health problems, children with an individualized educational plan (IEP) or who are served in the child welfare or juvenile justice systems should have presumptive eligibility for enrollment in the specialty managed care program; for these children, the clinical and utilization thresholds should be lower than for the general child population and enrollment processes should be streamlined and facilitated.

3. Behavioral Health Outcomes to be Tracked, Reported and Incentivized for all Managed Care Plans

   Outcome measures should be developed and applied to appraise performance and improve quality. Critical outcomes are:

   - Improvement in psychiatric symptoms for which treatment is sought
   - Improvement in functional status (e.g., social, school function)
   - Consumer satisfaction/involvement
   - Critical incidents
   - Success/failure at transition to less intensive level of care
   - Access to care
   - Medication management
   - Cross-systems communication/case planning
   - Network adequacy

Financial Impact:

- Early identification and treatment will reduce emergency room visits, inpatient stays and costs associated with these services. School-based or school-linked services will reduce symptoms and behaviors that drive referrals to and placement in high-cost special education settings and/or out of home placement. Reinvest savings from reduced ER, inpatient length of stay and diverted special education placements and build out treatment and support services in the community.
- Incentives tied to performance outcomes
- Reduced emergency room visits and inappropriate hospital stays
- Controls on pharmacy spending

Health Disparities Impact: Reduce, see explanation in #1.

Benefits of Recommendation:

- A cross-system integrated, comprehensive system of care will diminish silo approaches to care, improve continuity for children and families; resulting in decreased disability, reduce reliance on crisis oriented services and decrease costs.
- Consistency of care provision will enhance engagement and retention of children and families in lower levels of care system.
- Outcomes and using outcome information to improve services will establish a formal Quality Improvement system.
- Improved functioning in children.

Concerns with Recommendation:

- Presupposes adequate resources and reasonable utilization of children's services.
- Presupposes non-traditional relationships between BHO and other child-serving systems.
- Behavioral health providers will need regulatory realignment and/or relief to achieve network access and performance outcome expectations.

Impacted Stakeholders:

- Children and Families
- Medicaid Managed Care Providers
- Behavioral Health Providers
- Child Welfare
- Juvenile Justice

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 10

Recommendation Short Name: Peer Services and Engagement

Program Area: Behavioral Health

Implementation Complexity: Low/Moderate

Implementation Timeline: Enrollment/Implementation April 2013

Required Approvals: ☒ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☒ Federal Waiver

Proposal Description:

- Peer services are incorporated into the new behavioral health specialty managed care system.
- To the extent possible, Medicaid funding will be sought for peer services through waivers, grants, and program funding.
- Advance and improve the peer workforce through funding for training and education, certification, and leadership development, as well as through the establishment of an accreditation process for peer-run agencies.
- Peer services will be incorporated into Health Homes

Financial Impact: Peer engagement is a proven cost-effective means of engaging individuals with behavioral health needs. Therefore, it is anticipated that this recommendation would in the very least result in long-term budget neutrality, if not produce savings, including potentially large savings.

Health Disparities Impact: Reduce, see explanation in #1.

Benefits of Recommendation: Peer engagement is recognized as a very effective means of engaging individuals with behavioral health needs. Individuals with experience in dealing with mental health and/or substance use issues are often best situated to related to and engage individuals currently dealing with behavioral health issues. This recommendation with help establish peer involvement in the new managed care structure and support it as it continues to grow.

Concerns with Recommendation: None

Impacted Stakeholders:

- Individuals with behavioral health needs and their families
- Managed care entities
- Providers of service
- Taxpayers

Medicaid Redesign Team
Behavioral Health Reform Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 11

Recommendation Short Name: Services for the Uninsured

Program Area: Behavioral Health

Implementation Complexity: Moderate

Implementation Timeline: Enrollment/Implementation April 2013

Required Approvals: ☒ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description:

- Maintain a mechanism for funding an appropriate level of services to the uninsured and underinsured as the system moves into Medicaid managed care and previous funding streams (e.g. Disproportionate Share Hospital and Comprehensive Outpatient Program Services) are reduced or no longer available.
- The uninsured population with serious mental health or substance use disorders must be able to access care coordination services in the same way as the insured population does in order to prevent inappropriate use of high cost emergency services and/or cost-shifting to other systems.
- Promote the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) for the uninsured and underinsured with behavioral health issues.
- The State should promote benefit package designs in forthcoming health insurance exchanges that are appropriate for individuals with serious mental illness and substance use disorders.
- Enforce State and Federal mental health and substance use parity laws across all insurance programs to which the laws apply.

Financial Impact: Moving to a managed care structure is anticipated to result in savings, much of which must be re-invested into services that promote and sustain improved outcomes for those with behavioral health needs. Moderate re-investments in services for the uninsured will result in short-term costs that will quickly produce savings through improved health outcomes for this population who – one way or another – will receive health services at the expense of government, either in emergency rooms, State psychiatric centers and addiction treatment centers, prisons/jails, etc.

Health Disparities Impact: Reduce, see explanation in #1.

Benefits of Recommendation: This recommendation addresses the needs of those individuals with behavioral health needs that are not, or are not yet, eligible to receive Medicaid. Without addressing this population, individuals with untreated/undertreated mental health and substance use disorders will continue to show up emergency rooms, state-operated psychiatric hospitals and addiction treatment centers, and become involved with the criminal justice system. Implementing this recommendation will provide the opportunity to engage individuals with appropriate behavioral health services before they show up in costly settings and assist with getting them enrolled with Medicaid. Without these measures, the flow of people with serious mental health and substance use disorders needing the most extensive and expensive care will continue in the front door of hospitals, inpatient settings, and into various other systems.

Concerns with Recommendation: Engaging and enrolling individuals without Medicaid is technically outside the scope of this work group, however, given the potential benefits outlined above, and the potential negative impact on the lives of uninsured individuals with behavioral health care needs and the health care delivery system that currently serves them, the group reached consensus that an attempt needs to be made to mitigate the impact on this group as the overall system redesign takes place.

Impacted Stakeholders:

- Uninsured New Yorkers with behavioral health care needs and their families
- Behavioral health care providers
- Taxpayers

Medicaid Redesign Team
Behavioral Health Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 12

Recommendation Short Name: Health Home Recommendations

Program Area: Behavioral Health

Implementation Complexity: High

Implementation Timeline: Through June 2012

Required Approvals: ☐ Administrative Action ☐ Statutory Change ☒ State Plan Amendment ☐ Federal Waiver

Proposal Description:

- Health Homes must include behavioral health expertise and leadership
- A transitional strategy must be in place to assure the smooth transition of behavioral health Health Home services and funding into the SNP/BHO/IDS systems that will be implemented in 2013.
- All Health Homes should include networks providing both physical and behavioral health care and rules should not distort spending on category of care.
- Health Homes must coordinate with non-health service providers – especially housing and employment service providers and county governments -- and have explicit relationships with local governments that often coordinate these services.
- Screening and Brief Intervention, Referral to Treatment (SBIRT) and standard depression screening should be a mandatory element of every Health Home patient assessment.
- Health Homes should preserve patient/consumer choice to the extent possible, including being allowed to transfer Health Homes when/if they change providers.
- If patients/consumers are automatically assigned to Health Homes, the State should take steps to ensure that assignment is appropriate, by maintaining critical service relationships (e.g., relationships with case managers or long-term behavioral health treatment by non-participating providers) and ensuring that the physical location is easily accessed by the consumer.
- The State should incentivize Health Homes to reach culturally diverse communities and measure performance in this domain.

- Both the State and Health Homes should present consumers with user-friendly information to assist with a complicated transition.
- Health Home employees should be held to appropriate qualification standards, in which the standards of OMH and OASAS should be considered.
- Children should not be enrolled in Health Homes until special issues related to the children's system are considered by the Subcommittee and relayed to the Department of Health.

Financial Impact: With 90/10 Federal match, savings to the State for the first two years.

Health Disparities Impact: Reduce, see explanation in #1.

Benefits of Recommendation: Improved care coordination of health and behavioral health integration, reduced readmission rates and improved health outcomes.

Concerns with Recommendation: Implementation complexity.

Impacted Stakeholders:

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families Managed care entities
- Behavioral health and physical health providers

Appendix A
Behavioral Health Organizations

One of the many MRT recommendations enacted into law is the creation of BHOs. When fully implemented, all currently unmanaged Medicaid behavioral health services will be managed through some combination of regional Special Needs Plans (SNPs), Integrated Delivery Systems (IDSs), or Behavioral Health Organizations (BHOs).

Implementation of the BHOs is divided into two phases with Commissioners of OMH and OASAS having the authority to determine readiness for Phase II (Chapter 59 of the laws of 2011, Part H Section 42.d). In Phase I, regional BHOs will perform the following functions:

- Monitor behavioral health inpatient length of stay;
- Reduce unnecessary behavioral health inpatient hospital days;
- Reduce behavioral health inpatient readmission rates;
- Improve rates of engagement in outpatient treatment post discharge;
- Improve understanding of the clinical conditions of children diagnosed as having a Serious Emotional Disturbance (SED);
- Profile provider performance; and
- Test metrics of system performance.

In addition to reducing the incidence and length of unnecessary inpatient behavioral health care and increasing the rate of engagement in outpatient care, Phase I is designed to assist stakeholders in transitioning from the current unmanaged, fee-for-service environment to an environment in which the delivery and financing of behavioral health services is managed.

Implementation of Phase I is scheduled to begin on Nov. 1, with the BHOs fully operational by Jan. 1, 2012. Additional information is available at: http://www.omh.state.ny.us/omhweb/rfp/2011/bho/

For Phase II of BHOs, OMH, OASAS, and DOH will implement one or more risk bearing care management options. These include:

- Special Needs Plans (SNPs). These are specialty managed care networks that manage physical and behavioral health services for a defined behavioral health population;
- Integrated Delivery Systems (IDS). These are provider operated risk bearing entities that take on financial risk and manage the physical and behavioral health services for a defined behavioral health population;
- Carve-out BHOs. These are risk bearing managed care entities with a specialization in behavioral health. They only manage behavioral health services.
- The mechanism for care management may be different in different regions of the State, but payment will be risk-based for all of them. In New York City, full-benefit SNPs or IDSs should be implemented by April 1, 2013.

Appendix B1
Medicaid Redesign Team
Children's BHO Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 1

Recommendation Short Name: Basic behavioral health benefits for children in Medicaid Managed Care, Child Health Plus, Family Health Plus or Commercial Insurance Plans

Program Area: Behavioral Health

Implementation Complexity: Moderate. Align scope of services and amend contracts to provide consistent BH coverage, benefits and access across plans

Implementation Timeline:

Required Approvals: ☐ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description:

The following core behavioral health standards for children should be met by all public and private health insurance plans.

Access: Early identification and intervention with children reduces long term disability and cost burden.

Networks must be adequate to ensure access to care within the following parameters: Crisis services are available 24/7, preventive and screening must be available at well child visits and behavioral health first-level intervention and consultation within seven days. Geographic network adequacy should be measured by access within 30 miles or 30 minutes. Access to service should include flexible, non-traditional hours as well as office based, mobile, school-based/school-linked and home visitation approaches.

Medical Necessity: Medical necessity is an important tool to ensure that the right service is provided at the right time in the right amount.

Medical necessity determination criteria should be clearly stated in operational terms. The determination of medical necessity should be based upon an individualized clinical assessment of service or therapeutic need using accepted tools and/or diagnostic methods within the context of availability of services and capacity of the child's primary caregiver.

Court ordered behavioral health services and those needed to ensure the safety of children in the child welfare and juvenile justice systems should not be subject to medical necessity determination.

Basic Behavioral Health Benefit:

- Routine behavioral health and developmental screening, early detection and assessment
- Screen, Brief Intervention and Referral for Treatment (SBIRT for Substance Use Disorders)
- Behavioral Intervention
- Outpatient Treatment (i.e. Clinic)
- Day Rehabilitation
- Inpatient Treatment
- Crisis Intervention
- Peer Support (Youth and Family)
- Toxicology Screening
- Residential Rehabilitation
- Detoxification Services
- Primary Care Coordination
- Services to collaterals directly involved in the care of the child (parents/caregivers, teachers, etc)
- Pre-School and school age school-based or school-linked services
- Psycho-education, anticipatory guidance, behavior management

Provider Network:

Individual practitioners providing care should be credentialed and/or licensed in New York State (exception for Youth Peer Support) and should be screened prior to employment in compliance with current Federal and State requirements regarding safety assessments for those working with children. Priority should be given to practitioners who demonstrate cultural competence and aptitude in engaging children and their families. Provider networks should include a mix of trained and experienced primary care practitioners as well as behavioral health specialists.

Reimbursement/Fiscal:

A risk-adjusted rate structure with rates based upon acuity and regional variation.
Reinvestment of savings

Outcomes:

The primary way in which accountability will be determined is accountability for meeting benchmarks for outcomes. Please refer to recommendation #3 for detailed information.

Financial Impact:

Early identification and treatment will reduce emergency room visits, inpatient stays and costs associated with these services. School-based or school-linked services will reduce symptoms and behaviors that drive referrals to and placement in high-cost special education settings and/or out of home placement. Reinvest savings from reduced ER, inpatient length of stay and diverted special education placements and build out treatment and support services in the community.

Benefits of Recommendation:

- Early identification and intervention with children reduces long term disability and cost burden for families and New York State.
- A cross systems integrated, comprehensive system of care will diminish silo approaches to care, improve continuity for children and families; resulting in decreased disability, reduce reliance on crisis oriented services and decrease costs.
- Consistency of care provision will enhance engagement and retention of children and families in lower levels of care system.
- Outcomes and using outcome information to improve services will establish a formal Quality Improvement system.
- Improved functioning in children.

Concerns with Recommendation:

- Presupposes adequate resources and reasonable utilization of children's services.
- Presupposes non-traditional relationships between BHO and other child-serving systems.

Impacted Stakeholders:

- Children and Families
- Medicaid Managed Care Providers
- Behavioral Health Providers
- Child Welfare
- Juvenile Justice

Appendix B2
Medicaid Redesign Team
Children's BHO Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 2

Recommendation Short Name: Children with SED/SUD, Complex Symptoms and Behaviors Should Be Served in Specialty Behavioral Health Managed Care for Children with Medicaid.

Program Area: Behavioral Health

Implementation Complexity: Significant. Despite conversion challenges, gains in access and improved service availability, cross-system communication and case planning can result if BH outcomes are incentivized, additional resources invested and savings reinvested in the development of a managed system of care for SED/SUD children and their families.

Implementation Timeline:

Required Approvals: ☐ **Administrative Action** ☐ **Statutory Change**

☐ **State Plan Amendment** ☐ **Federal Waiver**

Proposal Description:

A specialty managed care program should be designed for children eligible for Medicaid who meet defined clinical criteria (DSM diagnosis of serious emotional disturbance or substance use disorder) or who display complex symptoms and behaviors AND meet a risk assessment threshold. Children meeting the clinical criteria above and who also have an individualized educational plan (IEP) or are served in the child welfare or juvenile justice systems would have presumptive eligibility.

Access: Early identification and intervention with children reduces long term disability and cost burden.

Networks must be adequate to ensure access to care within the following parameters: Crisis services available 24/7. Outpatient treatment access within 5 days and inpatient treatment within 24 hours. Geographic network adequacy should be measured by access within 30 miles or 30 minutes. Access to service

Should include flexible, non-traditional hours as well as office based, mobile, school-based/school-linked and home visitation approaches. Links must be made to pediatric primary care, child welfare, juvenile

and special education to facilitate referral, enrollment, and continuity of care, communication, case planning and coordination of care.

Medical Necessity: Medical necessity is an important tool to ensure that the right service is provided at the right time in the right amount.

Medical necessity determination criteria should be clearly stated in operational terms. The determination of medical necessity should be based upon an individualized clinical assessment of service or therapeutic need using accepted tools and/or diagnostic methods within the context of availability of services and capacity of the child's primary caregiver.

Court ordered behavioral health services and those needed to ensure the safety of children in the child welfare and juvenile justice systems should not be subject to medical necessity determination.

Specialty Behavioral Health Benefit:

- Behavioral Intervention
- Outpatient Treatment (Clinic, Day Treatment, Partial Hospital)
- Inpatient Treatment
- Crisis Intervention
- Peer Support (Youth and Family)
- Toxicology Screening
- Residential Treatment (MH and SUD)
- Detoxification Services
- Respite
- Transitional Care
- Care Coordination (ICM)
- HCBS Waivers (HCBW, B2H)
- Services to collaterals directly involved in the care of the child (parents/caregivers, teachers, etc)
- Pre-school and School age school-based or school-linked services
- Psycho-education
- Medication Management
- Family Support and guidance
- Cross-system communication and coordinated case planning (reports to Family Court, status updates to foster care agency, juvenile justice program and/or school)
- Primary care coordination
- Recovery-oriented services

Provider Network:

Individual practitioners and licensed providers should be credentialed and/or licensed in New York State (exception for Youth Peer Support) and should be screened prior to employment in compliance with current Federal and State requirements regarding safety assessments for those working with children. Priority should be given to practitioners who demonstrate cultural competence and aptitude

in engaging children and their families. Provider networks should include a mix of trained and experienced primary care practitioners coupled with access to behavioral health specialists.

Reimbursement/Fiscal:

- A risk-adjusted rate structure with rates based upon acuity and regional variation.
- Stratified case payments for high/medium/low risk
- Incentivized rate structure to ensure that the child receives the right level of service
- Incentivize Outcomes
- Reinvestment of savings

Outcomes:

The primary way in which accountability will be determined is accountability for meeting benchmarks for outcomes. Please refer to recommendation #3 for detailed information.

Financial Impact:

- Reduced ER and inpatient stays

Benefits of Recommendation:

- A cross-systems integrated, comprehensive system of care will diminish silo approaches to care improve continuity for children and families; resulting in decreased disability, reduce reliance on crisis oriented services and decrease costs.
- Consistency of care provision will enhance engagement and retention of children and families in lower levels of care system.
- Outcomes and using outcome information to improve services will establish a formal Quality Improvement system.
- Improved functioning in children.

Concerns with Recommendation:

- Presupposes adequate resources and reasonable utilization of children's services.
- Presupposes non-traditional relationships between BHO and other child-serving systems.
- Behavioral health providers will need regulatory realignment and/or relief to achieve network access and performance outcome expectations.

Impacted Stakeholders:

- Children and Families
- Medicaid Managed Care Providers
- Behavioral Health Providers
- Child Welfare
- Juvenile Justice

Appendix B3
Medicaid Redesign Team
Children's BHO Work Group
Final Recommendations – October 15, 2011

Recommendation Number: 3

Recommendation Short Name: Behavioral Health Outcomes to be Used by All Plans and Payers

Program Area:

Implementation Complexity: Moderate. Align scope of work and requirements and amend contracts with all plans.

Implementation Timeline:

Required Approvals: ☐ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description:

Recommendations #1 and #2 place the locus of accountability for providers and managed care entities on the achievement of benchmarks related to outcomes. This recommendation details how outcomes may be used to achieve accountability. It is beyond the scope of our work to recommend specific measures or instruments. Rather, these recommendations relate to the requirement that a small number of key outcomes be used to anchor quality in both regular and specialty care; and defined processes are established to measure and use outcomes to appraise performance and improve quality. Overall outcomes should be specific and relevant to children. Nine recommended outcomes are listed in table one. Table one also provides examples of ways the outcomes can be measured and used. The following four principles were used in selecting the nine outcomes. The selected outcomes must be:

1. Meaningful: they are indicators that capture what we are trying to achieve through BH interventions including: symptom reduction, risk reduction, improved functioning and well-being

2. Easy to measure: they are indicators that will be used universally by all plans and must not be too burdensome to implement

3. Validated and readily available: they are indicators that are based on established measurement tools with established validity, reliability and are available in the public domain (don't require purchase)

4. Easy to use: they are indicators that can be used relatively easily to improve quality.

OUTCOMES: Regular and Specialty Behavioral Health Managed Care for Children with Medicaid		
Outcome	**Examples of Measure**	**Example of Process**
Improvement in psychiatric symptoms for which treatment is sought	Select measure depending on primary psychiatric diagnosis	Require baseline and reassess every X months and specify improvement goal (e.g. 20% improvement in symptoms within 1 year of treatment). Inpatient and residential standards need to be adjusted accordingly.
Improvement in functional status (e.g. social, school function)	Global Assessment of Function (GAF), SDQ, GAIN	Require baseline and reassess every X months and specify improvement goal (e.g. 20% improvement in function within 1 year of treatment). Inpatient and residential standards need to be adjusted accordingly.
Consumer Satisfaction/Involvement	Assessment of the degree to which family and child (when age appropriate) feel satisfied with treatment and involved in the process of treatment.	Assess every X months or at the end of treatment and specify improvement goal (ex. 75% satisfied and involved). Inpatient/residential assessment at discharge
Critical incidents	Define critical incident (e.g. suicidal or violent episode for which ER visit is required) and assess number of incidents within a period of time (e.g. 1 year)	Assess based on cohort of consumers/patients managed by a given agency.
Success/failure at transition to less intensive level of care	Mean length of time between discharge from one level of care (e.g. inpatient, residential, emergency) and child's return to that same level of care.	Assess based on cohort of consumers/patients managed by a given agency.

Access	Mean length of time between referral call and first visit. Mean length of time between discharge from one level of care (e.g. inpatient) and first visit at next level of care (e.g. outpatient).	Assess based on cohort of consumers/patients managed by a given agency.
Medication Management	Monitoring poly-pharmacy and interaction of medication for BH and medical conditions.	Deviations from standard practice are 'flagged' in OMH's **PSYKES** system. Cases in this system are sampled yearly at the provider level. Number of deviations per agency per year are flagged. Performance is appraised based on number of deviations
Cross Systems Communication/Case Planning	Proportion of children/families within a given agency who receive a required yearly family collaborative meeting with all relevant providers. HIPPA compliant reports and clinical updates submitted timely to Family Court, Child Welfare Agency, Juvenile Justice Program, and/or schools	All children in specialty care are required to have one provider meeting per year with the family to develop and monitor the treatment plan. Representation from each service agency that provide care for the child should be represented at this yearly meeting. The proportion of children/ families who receive such a required meeting will be the metric for this outcome.
Network Adequacy	30 minute/30 mile geographic access.	

All children's behavioral health plans should report on child specific outcomes measures in HEDIS or CAHPS. Measures related to Access, Network Adequacy and Cross-System Communication/Case Planning should be included.

Financial Impact:

- Incentives tied to performance outcomes
- Reduced emergency room visits and inappropriate hospital stays
- Controls on pharmacy spending

Benefits of Recommendation:

- An outcome driven system of care will improve results for children and families. Most current outcome standards are focused on adult care.
- Clearly defined outcome measures will help establish provider performance standards
- Outcomes and using outcome information to improve services will establish a formal Quality Improvement system.
- Improved functioning in children.

Concerns with Recommendation:

- Contracts to be written to ensure measurement of the standards.
- Standards need to be flexible enough to accommodate changes in care, information technology, etc.

Impacted Stakeholders:

- Children and Families
- Medicaid Managed Care Providers
- Behavioral Health Providers
- Child Welfare
- Juvenile Justice

Appendix C

Introduction The Medicaid Redesign Team (MRT) Peer project #1058, merges suggestions received through the MRT process regarding peer support services as a cost effective, successful way to assist in the recovery wellness process. This MRT project committee's charge is to submit a report with recommendations for maximizing the use of peers in a redesigned health care system that is more efficient, effective and person-centered.

Public suggestions to the MRT on this topic included: comprehensive care coordination teams that recognize individualized needs, including peer supports that target independent living skills; peer-run respites as diversion from hospitalization; peer-run recovery centers; peer services in Behavioral Health Homes, Patient Centered Medical Homes, and Health Homes; regionally managed behavioral health care carve outs to preserve peer services and the integrity of peer agencies; State (Department of Health) certification for peer support specialists, support and recovery coaches, to facilitate Medicaid reimbursement; Medicaid funding for peer services; and NOT having direct Medicaid reimbursement per service but paying peer-run organizations for providing appropriate, needed supports; opposition to managed care plans (HMOs) handling special needs of people with mental health disabilities.

To carry out its charge Department of Health (DOH) staff held four meetings, and had significant correspondence with representatives of the Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), Office for People with Developmental Disabilities (OPWDD), DOH Long Term Care (LTC), DOH Chronic Illness Demonstration Projects, and 16 other stakeholders, including several who had provided input to the MRT process (Attachment 1), and conducted a survey of forty-six stakeholder organizations from across the state (Attachment 2) and had input from an OMH Regional Advisory meeting of approximately 400 individuals. Participants represent the interests of persons with mental health, substance use, developmental and intellectual delays, multiple disabilities, chronic and/or severe physical disabilities, and the parents/families of children with any of these conditions. The purpose was to learn more about how peers are currently providing various services throughout New York State (NYS), and to discuss how they might be included to further the Medicaid Reform initiative.

This Report summarizes the input DOH received from peer agencies including the scope of peer support services currently operating throughout NYS, concerns and recommendations of representatives from several populations utilizing peer support services, and suggestions about how peer services could be further utilized in the Medicaid Redesign of NYS's health care system.

Peer Supports are Unique Peer support programs have grown out of the Independent Living Movement, the emergence of self help groups, the movement of people with special needs out of institutions into the community, and ideas of consumer inclusion and of recovery. Peer support is a relationship system of giving and receiving help founded on principles of respect, shared responsibility and mutual agreement as to what is helpful.

The basis of peer support differs from the traditional medical model. Introducing and incorporating peer services into health homes or other medical models changes the focus to the well being of the whole individual and can provide necessary connections to community supports. Shifting from a Medical Model to a Recovery Model changes the provider focus from tasks of stabilization and custodial care based on staff wisdom to education and involvement in an environment conducive to recovery based on consumer wisdom, increased self-advocacy and taking responsibility for one's own recovery.

Peer support also differs from case management in that case management primarily should be a link and brokerage service, to help the consumer locate and obtain services delineated in the service or treatment plan. Peer support models recovery and or wellness, and engages the individual as a co-equal with mutual responsibility, while case management is a relationship with a professional, someone at a different level. Because of the differences described here, many peer support organizations express concerns about having peers work in a medical environment, although they believe that their services are very appropriate and effective in promoting wellness.

Research Supports Theory Research is too broad to summarize here but is available in the Resources provided (Attachment 3). The Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized peer supports as evidenced based, and research reviews indicate that the impact of peer supports is sufficiently rigorous and outcome based to consider peer support services as an evidence-based practice. Studies show symptom improvement, reduced hospitalization/shorter in-patient stays, improved daily functioning, self-esteem and illness management, all with associated cost benefits. Including families in care and treatment has shown to promote treatment adherence and psychiatric stability, and to reduce relapses and substance use. The impact of peer services is as effective as those of non-peers when peer-delivered services are the alternative to traditional mental health services. Peer-run respite as alternative to hospitalization shows a marked decrease in number of hospitalizations/length of inpatient stays, and increased recipient satisfaction.

Survey Results

Forty-six peer stakeholder organizations from across the state completed a survey detailing the populations they serve, types of services provided, qualifications and training, documentation and supervision, settings, if and how the services are paid, and other concerns and best practices. Great variability in types of services, qualifications and sources of reimbursement/payment was reported. From stakeholder discussion subsequent to the survey, other differences between and within disability groups became apparent. Terminology is population-specific but the relational aspect of peer supports is key to all concerned. For example, "increased wellness and quality of life" may be more useful goals for some than "recovery". Whether as wellness or recovery, the peer model expands the health home ideal of linking individuals to community supports, beyond a psychiatric or medical condition to whole health well-being.

All the participant peer groups offered in-depth definitions of the special and unique characteristics of peer services as applicable to particular populations (Attachment 4). Funding sources and compensation range from donations, grants, state, county and local funding to Medicaid funded waiver services and from volunteers to salaried employees. NYS agencies have facilitated the following credentials for peer

workers within their own organizations: OMH initiated a civil service title of peer support specialist and trains peer specialists who work throughout the state; OMH's Division of Children and Families is working with Families Together of NY to achieve a family advocate credential; OASAS sponsors a Recovery Coach credential based on CCAR training; Long Term Home Health Care's Nursing Home Diversion /Transition waiver has a peer mentor waiver service.

Concerns expressed through the survey include that Medicaid funding may reduce services through capitation and managed care; governmental regulation may hamper ability to provide customized flexible services; peers may be ineffective when under oversight of traditional providers. Current challenges for provider agencies include limited funding, disparity from other providers in pay and in opportunities for growth and advancement, limited number of peers relative to demand, Medicaid documentation requirements as a disincentive, limited access to services due to lack of transportation, confidentiality issues when peers receive services in the same agency, and potential conflict of interest concerns if peers will have to go against their employer when advocating for a recipient. Stakeholders indicated barriers to recovery coaching that include lack of understanding of the peer role, lack of respect for peers by professional staff, and lack of certification for peers.

At present, most of the peer-run groups recommend and advocate for funding of peer services that is flexible and grant based (e.g. via state and local aid and Medicaid managed care contracts) to ensure fidelity to true peer support and self-directed recovery centered approaches. They support the concept of peer agency/program accreditation rather than peer practitioner credentialing which would more likely lead to placing peer staff in non-peer supported roles supervised by non-peer staff. The following suggestions were made as important to program administration: clearly defined role of peer, provider qualifications and/or certifications, service oversight responsibilities, payment mechanisms, state entity oversight of health homes with peer & family representation. Choice and careful matching of individuals with peers is very important; personal characteristics may mean that some people are better in certain peer roles than others. To avoid the drift toward traditional medical model structure a clear job description, standards, qualifications and expectations should be communicated prior to hiring. A culturally appropriate and sensitive approach allows more individuals to respond to peers. Peers should be independent of managed care, not trying to convince people to join a plan.

Services suggested that peer run programs could deliver to managed care programs include Wellness Recovery Action Planning (WRAP), advance directives, cultural and gender specific issues groups, alternative and holistic supports, self advocacy, a recovery- focused, trauma informed approach to services, hospital diversion/peer respite services, 24/7 peer support line. Further suggestions included implementing the CIDP model in the Forensic Hospitals and for people with mental illness in the Department of Corrections; using a transition or Bridger program for inpatient/forensic recipients coming into the health homes.

Peer Services in NYS

Mental Health

In 1994, the NYS Office of Mental Health created a Civil Service position of Peer Specialist, Grade 9, which currently has 48 filled positions. Approximately 2000 peer support specialists, trained under OMH auspices, are employed around the state in OMH facilities and in agencies that OMH supports. OMH utilizes Family Advocates of which there are 10 employed fulltime across the state. There are 400 trained advocates.

OMH recently has undertaken two initiatives to promote peer services: 1. the State's Medicaid Infrastructure Grant (MIG) "New York Makes Work Pay" (NYMWP), a statewide initiative to improve the rate of employment among people with disabilities, with a strategic planning goal to improve the use of peer-driven employment services; 2. a Transformation Transfer Initiative Grant to explore Recovery Centers which would be run by peers and provide supported education and employment.

New York has three peer- run crisis centers/respites which provide a cost-effective alternative to psychiatric hospitalization: Rose House Hospital Diversion Program operated by PEOPLe, INC.; Essex County Crisis Alternatives Program operated by the Mental Health Association; and Voices of the Heart, Inc. Respite Program. For 2010, the annual cost for Rose House to provide care for 227 guests, for 748 resident days was $264,000 compared to $1,047,200 based on the average cost in local hospitals. Parents with Psychiatric Disabilities (PWPD) need programming to support families for reunification or to stay intact as they often are reluctant to reach out for mental health services for fear of being under scrutiny that will result in losing custody of their children. Offering respite to allow these parents to get necessary help to stay out of hospitals and participate in treatment is cost effective and helps families stay intact.

Substance Use

Primary peer services for people with substance use are provided by Recovery Coaches. OASAS reports nine paid trainers and 117 recovery coaches statewide who are trained through a self-directed program modeled on the Connecticut Center for Addiction and Recovery (CCAR) and paid by organizations that receive state funding. OASAS hopes to establish a NYS Recovery Coach Academy to ensure the integrity of the CCAR model, to develop standards and a code of conduct, and to maintain a database of recovery coaches and a statewide learning collaborative.

Recovery Community Centers (RCC) offer nonclinical specialty services such as linkages to clinical services, peer-led support groups, transportation support, training in parenting, nutrition and meal planning, financial management, facilitating education and career planning, resume writing and computer skills. OASAS recently awarded funding to three Recovery Community Centers which have served about 1000 people to date: Phoenix House of New York, Inc., Center for Community Alternatives in Rochester and Friends of Recovery of Delaware and Otsego Counties, Inc.

OASAS has a SAMSHA grant to implement the New York Supports Opportunities for Accessing Recovery Services (NY SOARS) initiative, a vouchering system for consumer- determined choices of faith based and community based recovery support services and/or enhanced opportunities for treatment services including Recovery Coaching. Recent revisions to Part 822 of 14NYSRR include changes to facilitate Ambulatory Patient Group (APG) Medicaid billing for peers to deliver Peer Support Services in clinics.

Multiple Disabilities

At least a quarter of the individuals who have the greatest behavioral needs, often have both substance use and mental health issues, and are in both the OMH and OASAS system. Many people have a combination of disabilities that include physical impairment and chronic conditions. NYS agencies are working to help those with cross-system problems get the proper help they need but the current governmental structure is not organized to facilitate this.

Advocacy groups such as Centers for Independent Living (ILCs) address the multiple needs of individuals with multiple needs and several survey respondents were ILCs. The New York State Independent Living Council (NYSILC) is a not-for-profit, non-governmental, consumer controlled organization, with 37 independent living centers (community-based organizations) statewide, directed by and for people with disabilities. The council is composed of 27 appointees from around the state, a majority with disabilities, representing diverse cultures and needs. The council's state plan partners are New York State Education Department/Office of Vocational and Educational Services for Individuals with Disabilities (VESID) and the Office of Children and Family Services and Commission for the Blind and Visually Handicapped (CBVH).

Intellectual/Developmental Disabilities

The Office for People with Developmental Disabilities (OPWDD) provides peer support through family support services for those families who have a child with a developmental and/or intellectual disability, most of whom are in the Home and Community Based Services waiver.

The Developmental Disabilities Planning Council (DDPC) includes a Consumer Caucus of peers who are involved throughout Council functions. DDPC sponsored The *Peer Mentoring and Supports in Employment*, a collaboration to implement peer-based support, mentoring and other consumer-led approaches that positively impact individuals' with disabilities ability to obtain, maintain and sustain employment. Individuals who successfully utilized the vocational rehabilitation system (e.g., VESID, CBVH, One Stops) were paired with individuals just entering the system or who had previously been unsuccessful in benefitting from vocational rehabilitation. Participating agencies developed new service opportunities through the VESID Unified Contract Services (UCS). In January 2009, twenty-five independent living centers established VESID UCS contracts totaling about $1 million.

The Self-Advocacy Association of New York State, Inc. (SANYS) is a not-for profit, grassroots organization run by and for people with developmental disabilities with the goal to create a person-centered and person-directed system of supports. Through supporting self-advocates and self-advocacy groups regionally and statewide, SANYS is providing peer supports to its members.

Chronic Conditions

Four of the six DOH Chronic Illness Demonstration Projects (CIDP) utilize peers as part of Interdisciplinary Care Teams composed of a registered nurse, social worker, care manager and peer support specialist (PSS). The PSS services include outreach and enrollment, health coaching, relapse prevention, reminding enrollees of appointments and escort services, assisting with links to needed services, assisting enrollees with building social skills, identifying recovery goals with enrollee, and participating in treatment meetings and case rounds. An example of cost savings for one individual in this project: the year prior to enrollment in CIDP $52,282 was spent in Medicaid claims, and for the year in CIDP $20,650 was paid in Medicaid claims.

DOH's Office of Long Term Care Nursing Home Transition Diversion Medicaid waiver utilizes Peer Mentoring as an individually designed service intended to improve the waiver participant's self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community through education, teaching, instruction, information sharing, and self-advocacy training. Peer Mentoring is a short-term service only, to address specific goals for waiver participants (seniors and people with disabilities) who have recently transitioned into the community from a nursing home, or as needed during times of crisis.

Serving Children and their Families in NYS

Children are best treated within the structure of their families who will continue to care for and support them. Best practices include programs that promote mental and physical wellness for the entire family, parents/caregivers and children. A special Children's Team for MRT Behavioral Health Reform is considering how best to address children's issues in the BHO model. To prevent the progression of children's mental health problems, intensive parenting skill building and supports, continuity of primary care provider, direct assistance and skill building in systems navigation, natural supports and resiliency, therapeutic mentoring and respite, could all be provided by peer support services.

The Medicaid waivers that currently provide peer support through a variety of family support services are Home and Community Based Services 1915(c) waivers for Children and Adolescents with Serious Emotional Disturbance (OMH SED); the Long Term Home Health Care Waiver for Medically Fragile Children; the HCBS Comprehensive Waiver for People with Developmental Disabilities (OPWDD); and the Bridges to Health Waivers for children in all three disability areas (SED, Developmentally Disabled, and Medically Fragile). Parent to Parent of NYS is a statewide organization staffed by parents or close relatives of individuals with disabilities, health care and/or behavioral needs, who provide support, information, referral and training to families of individuals with similar disabilities. Parent matching and systems navigation are important family to family peer services.

Other States - What have they done?

To date, over 30 states have some form of peer support in place although not all are Medicaid reimbursable. The following are examples of peer support programs recommended by our participants as possible models.

Arizona – This state's program is recommended as an exciting model because of its unique training and certification set-up and its extensive use of peers throughout its programs. Arizona is distinguished for promoting family roles in its children's behavioral health system. The Arizona Community Services Agencies Waiver for peer and family services maximizes the ability of peer-run programs to offer creative services by not "certifying" workers, by using more than one curriculum, by not requiring a licensed clinician to sign off on everything done by peers and by offering a career ladder for peer supervisors and a specialized type of licensure, developed just for peer- and family-run programs. For Medicaid reimbursement, a service must be a measureable step toward stated goals. The Arizona Department of Health Services as the single state Medicaid agency contracts with BHOs. (Attachments 5 and 6)

Georgia was the first state to implement peer support as a Medicaid billable service under the Medicaid Rehabilitation option. The service is structured with scheduled activities that promote recovery, self-advocacy, development of natural supports and maintenance of community living. The Certified Peer Specialist (CPS) is under the direct supervision of a mental health professional, who is a psychiatric rehabilitation specialist credentialed by the US Psychiatric Rehabilitation Association and who is also a CPS. CMS approved Peer Supports Services directed to specific individualized service plan (ISP) goals, supervised by Mental Health Professional, provided in a clinic or the community. Georgia has also used a CMS Real Choices Grant to develop a position of peer supports to help people with disabilities learn to advocate for themselves through a "train the trainer" program. This program focuses on skills such as listening and communicating, understanding self-directed care, connecting to community services, developing relationships, knowing when to refer or dealing with a crisis and employment issues.

Minnesota uses Community Health Workers (CHWs) to bridge the gap between communities and the health and social service systems, navigate the health and human services system, and advocate for individual and community needs. CHWs work in a variety of settings: health clinics, mental health centers, public health departments, mutual assistance associations and other community organizations and agencies that provide counseling, advocacy and health education. In Minnesota, CHWs are now serving deaf, aged and disabled populations. Their work includes health education; information and referral to medical care and a range of social services; outreach; cultural consultation to clinical and administrative staff; social support, such as visiting homebound clients; informal counseling, goal setting, encouragement, motivation; advocacy; and follow-up to ensure compliance with treatment.

Pennsylvania In February, 2007 CMS approved Pennsylvania's State Plan Amendment to include Peer Support Services in rehabilitation services for behavioral health. Efforts are underway to expand these

services to seniors, transitional youth and forensics. This state's program is similar to, and perhaps based on Arizona's and has been recommended by some stake holders as outcome based.

Rhode Island. The Pediatric Practice Enhancement Project (PPEP), one of the most successful and innovative programs nationwide, is a medical home initiative that seeks to increase the capacity and quality of care for children with special health care needs through the use of Family Resource Specialists in pediatric primary and specialty care practices. These Family Resource Specialists are true "peers" to parents raising children with disabilities and special health care needs—they are all family members in similar situations themselves. Family Resource Specialists work in medical practices for 20 hours per week, five of which are paid for by the physician practice. They save staff time and provide patient families with support and information and the medical staff with help in understanding the family's questions and perspective. Data from 2004-7 show 38% lower average inpatient utilization for PPEP participants, and 15% lower annual healthcare costs than for non-PPEP participating families, and high satisfaction ratings from PPEP participants.

Federal Involvement and Funding

The CMS State Medicaid Directors' letter dated August 15, 2007 supplied guidance to states interested in providing peer support services under Medicaid in the mental health field. With the emphasis on recovery, "a process in which people are able to live, work, learn and participate fully in their communities", peer support services are considered an evidenced-based mental health model of care for mental illness and substance use in which peer support services are part of a comprehensive service delivery system.

To qualify for federal Medicaid funding and receive Federal Medical Assistance Percentage (FMAP), states must provide a core set of services to all eligible persons under the State Plan. An option allows for providing additional services and supports using the rehabilitation services option under the State Plan 42 CFR 440.130(d) and under the 1115 and 1915 waiver authority. Section 1915(b) (3) allows states to use cost savings from a Freedom of Choice Waiver to provide additional services. In 2010, CMS amended the section 1915(i) waiver benefits allowing states to provide "other services" as permitted under the 1915(c) waiver.

The Medicaid Rehabilitation Option is designed for mental health and substance abuse services and has been used by states adopting a recovery model for their state-funded programs, so that consumer-driven values for recovery can be integrated into all mental health services. Section 1905(a) (13) allows states to provide rehabilitative service in the Medicaid State Plan. Additionally, states can use CMS's Real Choice Systems Grants for Community Living to increase opportunities for people with disabilities living in the community.

Pillars of Peer Support (a joint initiative by SAMHSA, Center for Mental Health Services (CMHS), National Association of State Mental Health Program Directors (NASMHPD), Depression and Bipolar Support Alliance (DBSA), OptumHealth, Carter Center, Wichita State University, Appalachian Consulting Group, Georgia Mental Health Consumer Network) was designed to develop and foster the use of Medicaid funding for peer support services in mental health settings. Two summit conferences were held. The

first, in 2009, included those states currently providing formal training and certification for peer providers in mental health systems to identify the state support necessary for a strong workforce. Nationally recognized experts and stakeholders identified twenty-five "pillars" as strengths for a peer specialist certification program. Seventeen states surveyed indicated that they had a distinct certified peer support service that was Medicaid billable. Fifteen of the 17 indicated that they had certification processes. The most common barriers to implementing peer services were: acceptance of peers in mental health centers, financial issues, and understanding of the Certified Peer Service (CPS) role. (Attachment 7 includes the 8/15/07 CMS letter to state Medicaid Directors.)

The second Pillars summit in 2010 gathered several states not currently billing Medicaid for peer support services to identify opportunities and assistance to begin the process. Reported results of a survey on states' use of peer supports listed some concerns also expressed by our MRT participants: need to recognize the uniqueness of peer support providers, system co-option of peers addressed by adequate training and job description, and incorporating peers into routine operations. Supervisor training is essential and must include focus on recovery. The supervisor should also be a peer, who has had the same training as those being supervised. Half of the 22 responding states indicated that their Medicaid reimbursement was embedded in payment to another entity, e.g. MCOs, behavioral health carve out vendors. Five states (23%) received Medicaid payment for peer services as a distinct service.

The SAMHSA Evidence Based Practices publication "Building Your Program" lists the following funding sources that have been or are being used for consumer-operated services: Federal Mental Health Block grants; other community federal sources such as SAMHSA, National Institute of Disability and Rehabilitation Research (NIDRR), Departments of Veterans Affairs (VA)and of Housing and Urban renewal (HUD); state or county general funds; other state funds such as Vocational Rehabilitation; community reinvestment; Medicaid; grants from foundations; contracts with MCOs and BHOs.

Certification, Accreditation, Assessment and Evaluation: Evaluation can foster program improvement and add intrinsic value to services. As the value of peer supports gains recognition and acceptance, peer-run provider agencies seek association with delivery models such as health homes and behavioral health organizations, as well as continued funding for their own programs in the community. Lack of certification for individuals and accreditation for programs and agencies may disadvantage consumer operated support programs in competing for Medicaid and other funding. States, Medicaid and Medicare, and insurance companies who would reimburse provider agencies for peer services will have requirements for workers to be qualified or certified on a comprehensive set of workforce competencies.

Certification for the individual worker fosters a qualified, ethical, diverse workforce through a test-based certification and/or licensing process and enforcement of code of ethics. Some states run their own certification programs for peers, with accepted curriculum and other criteria. Peer-run organizations need valid, reliable skill assessment tools, training protocols and management information systems to measure outcomes. They need to identify program functions and staff competencies and to develop appropriate information management systems. Fidelity is a systemic effort to identify critical operational components of programs that are key to producing desired outcomes. SAMHSA's Multisite Study identified common elements in peer programs: program structure, program environment, belief systems, peer support, education and advocacy. The Fidelity Assessment Common Ingredients Tool

(FACIT) is an anchored scale based on the identification and definition of the common program ingredients above. The Peer Support Outcomes Protocol Project developed, validated and field-tested a peer outcomes protocol (POP) that measures the effectiveness of peer support services for persons with mental illness.

Recommendations: It is appropriate and cost effective to incorporate peer services into the Medicaid Redesign shift toward whole wellness by integrating physical and behavioral health with other necessary aspects of successful functioning in the community (housing, employment, education, etc.)

1. **Promote acknowledgement and respect for the unique contributions and value of Peers in delivering services that help people, promote wellness and decrease costs.** Peer support providers need the respect of others in their fields as well as the support of upper management wherever they work, and in the health care industry and in government. All boards, committees, advisory groups and planning activities for organizations or programs pertaining to peers and peer services must have meaningful and significant peer representation.
2. **Facilitate ways to accommodate Medicaid funding for peer services, such as waivers, grants and funding for programs rather than for the position itself. Funding for training and education, certification, and leadership development would strengthen the peer workforce.** Currently in NYS peer services are delivered in many ways addressing different types of needs. This allows providers more flexibility than would be possible if a position were to be specifically defined in regulation.
3. **Establish an accreditation process for peer-run agencies which would professionalize their activities and require that supervision be provided by a trained peer to preserve the unique, whole health/wellness approach that peers provide**. A core evaluation would be appropriate for all peer-run organizations with additional modules for the specific populations. Model development must include consultation with and active participation of peers in the field.
4. **Incorporate peer services into health homes as a required element in health home applications, given the recognition that peer services are evidence-based practices which can improve outcomes while being cost effective.** Peer-run organizations are optimal for providing peer services and therefore, the model of a Health Home contracting with an outside peer support agency to provide services is the best model for integrating peer services and Health Homes. Any contract or RFP must identify how peer services will be incorporated into the Health Home. Peer support services should appropriately and effectively be extended into more situations, such as hospitals and nursing homes, to augment transitions to the community.
5. **Address children and their care separately.** Services appropriate for families and caregiver needs must be addressed by the same health care unit. Family peer support must be a required service of each Health Home. Best practices include programming that promotes mental and physical wellness for families, parents and children.

Appendix D

PROBLEM STATEMENT/PRINCIPLES REGARDING THE UNINSURED

ISSUE

As all Medicaid recipients of mental health and substance use services are moved into a managed care system of care in two years there could be serious unintended consequences for the uninsured seriously chronically mentally ill and substance abuse clients currently served in our system. The care provided to these high risk and vulnerable clients must continue to be available, especially the community treatment and support services which prevent avoidable hospitalizations and maintain clients safely in our communities. The current state of services for the uninsured, followed by principles and recommendations for future planning are presented for consideration.

CURRENT STATE

1) Clients are uninsured or underinsured for multiple reasons which increase the complexity of providing appropriate services to this population. The uninsured and underinsured include:

- Clients who are not eligible for Medicaid, Medicare or commercial insurance.
- Clients in transition who are eligible for Medicaid or Medicare services but are temporarily uninsured due to changes in financial status, failure to reapply, unaware that benefits are available. These clients can receive benefits once properly enrolled.
- Clients may have commercial insurance but have exhausted their mental health or substance use benefit and be unable to afford needed care.
- Clients may have high co-pays for insurance that prevents their access to care.
- Undocumented clients are uninsurable

2) Treatment and supportive services to uninsured clients are currently financed to be able to be seen in our system of care through a variety of ways that ensure they can access appropriate care. These include but are not limited to:

- Some state funded services such as TCM, ACT and some OMH and OASAS grant programs are deficit funded to cover some program costs related to serving the uninsured.
- Housing programs receive deficit funding for a percent of uninsured served.
- City and County tax levy fund services to the uninsured in addition to local tax levy paying the 20% local share of Medicaid.
- Prior funding through mechanisms such as COPS enabled agencies to have the flexibility to design their services to also include varying numbers of uninsured clients while remaining fiscally viable. (We are aware that this is being phased out for mental health as part of clinic restructuring.)

- Public sector city, state and county hospitals and agencies provide extensive community based services to the uninsured. For example, 13% of HHC's ambulatory mental health services for the seriously mentally ill and 14% of substance abuse services are for uninsured clients.
- DSH (Disproportionate Share) and UPL (Upper Payment Limit) dollars support hospital based services in safety net providers throughout New York State. These dollars will be significantly decreased as the Affordable Care Act is implemented.
- Current community based services to the uninsured help to decrease the costs to Medicaid for emergency room visits and emergency inpatient care and to localities for the cost in jail services.

PRINCIPLES

1) As all behavioral Medicaid patients are moved into managed care, the needs of the uninsured that our system of care currently provides must continue to be addressed.

2) If appropriate services are not provided for this high risk vulnerable population there will be further cost shifting to other systems such as the criminal justice and juvenile justice systems and increased expenditures in the inpatient and emergency room services, inflating emergency Medicaid costs.
3) All children need to have appropriate mental health and substance use services in the benefits provided by their insurers.

RECOMMENDATIONS

1) A mechanism for funding the appropriate current level of services to the uninsured and underinsured needs to be maintained as the system moves into managed Medicaid for all clients with mental health and substance use disorders as previous funding streams are no longer available.

2) The uninsured population that accesses services in the same way as insured clients needs to be managed and have access to care coordination services in order to prevent inappropriate use of high cost emergency services, and cost shifting to other systems that is a wasteful and inappropriate use of resources.

3) For the uninsured and underinsured, increasing the ability to buy into Medicaid and the design of the proposed insurance exchanges need to address the complex issues for seriously chronically ill adult and child clients in need of behavioral health and substance abuse services.

4) For the underinsured, parity as required by state and federal law needs to be enforced in all insurance programs including commercial programs subject to the parity laws.

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