

## **CLMHD RECOMMENDATIONS FOR LGU ROLE AND REGIONAL PLANNING IN PHASE 2 MANAGED CARE FOR BEHAVIORAL HEALTH**

The proposals for transforming behavioral healthcare in New York under Medicaid Redesign through care management for all, the development of Health Homes and national healthcare reform have created an opportunity for all of us to improve the lives of individuals with behavioral health conditions by building needed services and supports in the community, fostering recovery and resiliency for clients and meeting the State’s goals around access and integration, quality and cost.

As the Chief Executive Officer of their Local Governmental Units (LGU’s), Directors of Community Services (DCSs) have a statutory responsibility and a prominent role in oversight of the mental hygiene system in New York, comprised of the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services and the Office for People with Developmental Disabilities. In addition, the LGUs have a legal responsibility for ensuring the local, state and federal dollars supporting the system are being used for appropriate, quality services and that limited state and local resources are being maximized to meet the needs of **all** residents with mental illness and substance use disorders, not only those individuals who are insured through Medicaid (see MHL 41.13 (8)).

The City of New York and the 57 other counties pay a local share of the total Medicaid costs in New York. Although the local share is capped, Medicaid costs continue to consume the lion’s share of local budgets. In addition, the localities of which the LGU is a part, contribute local tax levy dollars to their mental hygiene systems to pay for services and supports to the uninsured and to cover services that are not reimbursed by Medicaid. Local funds often support services that are either ancillary to traditional treatment systems and/or subsidize the safety net for high-risk people with serious mental illness, such as crisis responders, case finding, jail and shelter outreach and services, and social services programs.

As an example, Westchester County funds outreach services where a social worker and a peer together find individuals with co-occurring mental health and substance use disorders who are living in shelters or on the streets and connect them with long-term housing, case management and supportive services. The County also provides 60-90 day “bridger support” to people with co-occurring disorders re-entering the community from state or local correctional facilities.

The Conference is encouraged by New York State’s fidelity to the recommendations of the Medicaid Redesign Team (MRT) Behavioral Health Reform Work Group, which emphasized the need for experienced, specialized behavioral healthcare services in Phase 2, full risk managed care, and the State’s commitment to directing a portion of the Medicaid savings generated under full-risk managed care for reinvestment into community-based behavioral health services and supports.

**The Conference membership has developed and endorsed the following:**

- 1. Initial recommendations for the criteria MCOs would need to meet to be approved to manage the full behavioral health benefit under Phase 2.**
- 2. A framework for a regional LGU role under Phase 2 in the context of our responsibilities and authority under Article 41 of the Mental Hygiene Law and the LGU's system management expertise among local mental health and substance abuse providers, local social services, criminal justice, courts, housing, shelters, and general hospitals and state inpatient hospitals, among others.**
- 3. A transparent and inclusive process for allocating reinvestment of the Medicaid savings from the Phase 2 managed care waiver back into the community, based on regional priorities which meet State's overarching priorities.**
- 4. Protect the safety net for the uninsured.**

### **1. CLMHD PROPOSED MCO CRITERIA TO MANAGE FULL BEHAVIORAL HEALTHCARE BENEFIT**

The presentation of the framework for proposed Phase 2 managed care at the October 18<sup>th</sup>; MRT Behavioral Health Subcommittee indicated that the MCOs that currently provide the physical healthcare benefit and limited behavioral health benefits will have the opportunity to manage the full behavioral health benefit, provided they meet criteria established by the OMH/OASAS and DOH.

The Conference is very encouraged that OMH/OASAS and DOH have made a commitment to carefully construct the criteria the MCOs would need to meet in order to demonstrate capability to meet the needs of enrollees with behavioral health conditions.

The MCOs are currently responsible for the medical and pharmacy benefit, but they have limited programmatic or payment experience with the management of comprehensive mental health and substance abuse benefits, and in the coverage of people with serious mental illness. The SMI and the substance abuse population, however the latter term is defined under the criteria, would be new populations for the MCOs many of which do not have relationships with the LGU's, the housing and shelter systems, criminal justice and others.

This is not a criticism of the MCO operations but rather an acknowledgment of the learning curve before the MCOs on the complex behavioral and social service needs of people with SMI or chronic substance use disorder and the multi-level community system in place to find and support these individuals.

The Conference provides the following initial recommendations for consideration in developing the criteria MCOs would need to meet in order to demonstrate competency for managing the full behavioral healthcare benefit of services and supports to individuals with serious mental illness and/or substance use disorders.

#### **OVERALL APPROACH AND PRIORITIES:**

- MCO/BHOS must demonstrate to OMH/OASAS that their philosophy, services and treatment plans are recovery focused, person-centered and evidence-based.
- The plans will give equal consideration to substance abuse and mental illness services with recognition of the unique features of each and must demonstrate how their approach for engagement and coordinated treatment will improve outcomes for individuals with co-occurring disorders.
- Plans must demonstrate their ability to implement a robust care coordination system to meet behavioral health, physical health, long term care and all relevant social service needs of individuals with high needs in collaboration with Health Homes.

- The plans, and the State, will ensure a prominent LGU role as a government partner, a payer through county tax dollars and Medicaid local share, and a partner in oversight, monitoring, planning and making adjustments to the system to meet regional and local needs.
- The plans will ensure a meaningful role for peers and family members throughout the program implementation to ensure the voice of peers and family members informs policymaking.
- Plans outside of New York City will have a formal requirement to work in partnership with a stakeholder group called a Regional Planning Consortium comprised of the LGUs, substance abuse and mental health providers, peers and health home leads. The group's defined purpose would be to provide local oversight, knowledge and guidance to the MCO/BHO and collaborate with the plans to best treat and support people with MI/SA in the managed care program.
- The plans will establish a robust health information technology infrastructure with connectivity to RHIOs, and share Medicaid encounter, performance data and other relevant data with the LGU and state offices.

#### **BENEFIT PACKAGE:**

- Access to non-medical community supports and wraparound services are critical components of the benefit package. There may be an opportunity to facilitate access to these services which would not otherwise be included in the benefit package, if CMS supports the use of "in lieu of" SPA services.
- In addition to the specialty mental health services that will be removed from fee for service to managed care, the following services are important for ensuring inpatient hospital diversion and recovery oriented care.
  - Crisis respite
  - Comprehensive Psychiatric Emergency Program (CPEP)
  - Peer support
  - Assertive Community Treatment (ACT) and other evidence based practices
  - Supported Employment
  - Off-site clinic services
  - Clubhouses
  - Outreach and case finding capacity
  - Outpatient chemical dependency withdrawal and stabilization
- Behavioral health consumers will have access to a treatment team comprised of an appropriate combination of a physician, nurse practitioner, social worker, qualified behavioral health professional, peer and family support.

#### **PROVIDER NETWORK AND SERVICE AUTHORIZATIONS:**

- Many of the community based and wraparound services for people with SMI/SA are not medical in nature and therefore may not meet traditional "medical necessity" criteria MCOs apply for authorization of services. An appropriate standard which recognizes the critical role of such supports must be in place for these psycho-social type services.
- For services and medications that require prior authorization, the State' contract with MCOs should require them to establish fast and efficient prior authorization processes to ensure that there are no delays in treatment.
- Plan must provide adequate payment for Out of Network providers to avoid disrupting existing therapeutic relationships between clients, therapists, family members etc., and for specialized behavioral health treatment.
- Plan networks must include non-medical supports and providers. Support and wraparound services to develop and maintain individualized "natural supports" are important components of recovery and access must be available.

- It is important that MCO and BHO provider networks include outpatient and community based providers who accept Medicaid patients. We often have situations where many providers will be listed as participating in a plan, only to find that in fact they are not accepting new Medicaid patients. This instance should not “count” for purposes of measuring network adequacy as it clearly does not address the issue of capacity.
- The LGU provides formal comment on PAR/CON applications for OMH/OASAS licensed services. The LGU should also have an opportunity to formally comment on MCO/BHO provider networks to provide an opinion on access and capacity of the overall provider network. This is not an approval/disapproval, but rather an opportunity to provide formal comment from the LGU. In many counties, the recommendations made by the DCS on current PAR/CON applications are made in collaboration and discussion with the Community Services Board (CSB) members and the needs of the community as a whole are considered.

#### **OUTCOME AND QUALITY MEASURES:**

- The existing HEDIS measures for mental health are medically based and inadequate to measure quality, consumer outcomes and define recovery. (Antidepressant Medication Management, Follow up care of Children Prescribed ADHD Medication, Follow-Up After Hospitalization for Mental Illness and, new in 2013 for Medicaid, Adherence to Antipsychotic Medications for Individuals with Schizophrenia)
- There is one HEDIS access measure for substance abuse – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment and it too is inadequate as a measure of quality.
- The Conference recognizes the challenges in developing national performance measures, however, it is important to develop the performance measures or indicators an MCO/BHO would report to demonstrate that clients with mental illness and substance use disorders are being effectively engaged in services and are moving forward in overall functioning in the community and recovery.

#### **OVERSIGHT AND MEANINGFUL COMMUNITY COLLABORATION**

- The responsibility for oversight of the MCO/BHO will require a collaborative effort. We recommend the formation of Regional Planning Consortia comprised of each LGU in the region, and representatives of mental health and substance abuse service providers, peers, families and health home leads. The RPC would work closely with the MCO/BHO and State agencies to guide policy and problem solve. An “advisory committee” falls short of the intention for the Plan to work in collaboration with the community.
- The tools for oversight would include state Medicaid data, PSYCKES, potentially newly required MCO performance data, LGU data and feedback including the impact on other local systems such as local jail services and transitions from jail to services and health homes, peer advisory groups, provider experience and MCO/BHO data and experience.
- MCO/BHO must work with the LGU on AOT cases, recognizing the LGU’s authority under the Mental Hygiene Law as the lead entity on AOT cases.

## **2. THE LGU ROLE IN THE MANAGED CARE ENVIRONMENT**

#### **The recommendations are based on the following principles:**

- The LGU brings a unique, cross-system expertise that comes from LGUs being embedded in the community and working in partnership with social services, criminal justice, the court system (family

and criminal courts), State operated psychiatric centers and Addiction Treatment Centers and others.

- The LGU's statutory authority under Article 41 MHL and role in programmatic oversight of the local impact – positive or negative - of managed care and health homes on clients and families, access, cost and quality.
- The LGU role in the allocation and fiscal oversight of federal dollars (including administration of the Medicaid program), state aid and local tax levy funding.
- The need for a regional, multi-county approach to our work including oversight of the mental hygiene system, local planning with the MCO/BHO and Health Homes, and to work together to solve issues specific to our regions.
- The process for allocation of the Medicaid savings that would be reinvested in the community must be driven by unique regional needs which meet the overarching state objectives.
- The safety net for the uninsured must be maintained.

**The LGU cross-system expertise is a crucial component.** The majority of people served by the public mental hygiene system do not need a singular service. Their needs are complex. Co-occurring mental health, and/or substance use disorders and/or developmental disabilities as well as co-morbid physical health conditions are the norm. People struggling with these conditions often live in poverty and need a range of supports related to income, employment, housing and nutrition. They are disproportionately likely to be involved with the criminal justice system, often have serious physical health diagnoses and die at a much earlier age than those without behavioral health issues.

The LGU, in accordance with Mental Hygiene Law, engages in planning, quality improvement and programmatic and fiscal oversight activities required to meet the diverse needs of individuals and families. The LGU contracts with a broad range of service providers and maintains partnerships with a diverse group to connect the pieces including, but not limited to, the following:

- Mental health service providers
- Substance use service providers
- Developmental disability service providers
- Housing service providers and shelters for MH/SA/DD
- Criminal Justice (prisons, jails, probation/parole, police, sheriffs, family and criminal courts)
- Social Services (DSS)
- Hospitals (Emergency Departments and CPEPs)
- State operated psychiatric and substance abuse treatment centers
- Primary health care
- Public health
- Technology (RHIO)

OMH and OASAS each have expertise in their area of service and the field offices cover a multitude of communities. The hospital and outpatient behavioral health providers specialize in their settings and are working to integrate with primary care. LGUs are embedded in the local community and work to address the needs of the people within our local system of care. We know the people in need and we know the service system as a whole with its many moving parts. This cross-system, specialized capacity is essential to integrating care, achieving the goal of care coordination for all and oversight from a systems perspective.

The following are two examples of LGU initiatives to address high-need, complex Medicaid enrollees to improve integration with physical health and quality outcomes.

**Monroe County - Helping People Stay Engaged in Care:** The Monroe County Recovery Connections program was developed to address the needs of individuals frequently receiving inpatient detoxification or rehabilitation services and who have had difficulty successfully engaging in sustained chemical dependency or mental health treatment. This program has been locally funded in the Monroe County community since 2005 and serves approximately 100 individuals each year. Evaluation of the Recovery Connections program has demonstrated the following outcomes for Recovery Connection enrollees; increased use of non-clinical recovery supports (57% increase), decreased episodes of homelessness (43% reduction), and decreased Medicaid spending (analysis of 175 enrollees demonstrated a savings of \$365,626 when comparing pre-Recovery Connections Medicaid spending to Medicaid spending 24 months after enrollment).

**Chemung County – Building Integration of Physical and Behavioral Health in the Community:** Chemung County’s Medicaid Medical Home, called the Priority Community Healthcare Center, provides on-site clinical mental health services and intensive care management by medical professionals at the NCQA Level III Medical Home and at the largest pediatric practice in the community in Elmira. The medical home enrollment is generally 20% of the Medicaid population as they serve only individuals on Medicaid. In the first 12 months since the Medical Home opened, the Medicaid costs for this cohort of individuals has decreased by 5.98% or \$212,073.

## **RECOMMENDATIONS AND PRIORITIES: THE STRUCTURE FROM THE SYSTEMS LEVEL**

### **A REGIONAL APPROACH TO THE BEHAVIORAL HEALTHCARE REFORM**

#### **Quality Oversight, Monitoring and Planning of Implementation of managed care and system transformation through Regional Planning Consortia.**

The Conference believes that in order to maximize dollars and re-build the capacity for treatment and supportive services in the community, we must take a regional and collaborative approach with a focus on where clients access care as opposed to hard and fast county borders.

OMH/OASAS/DOH have made a commitment to vigorously monitor how plans implement the standards/requirements of the benefit, network capacity, service access and behavioral health quality outcomes. At the state level, DOH/OMH/OASAS central offices will monitor operations through Medicaid claims and utilization data, reports from the MCO/BHO about the type and number of grievances filed against the Plans, among other indicators.

While Medicaid data are important and can be an indicator of global or population-level progress over time, data cannot report the human element and the impact on the other moving parts of the community. A combination of state and MCO/BHO data along with local level oversight of the system is crucial to understanding and evaluating the full effect of managed care on the individual and the local service system.

The Conference recommends a regional structure designed to promote excellence through regional planning, oversight and monitoring of the MCO/BHO Phase 2 managed care contract and Health Homes and the impact on local communities. The individual authority of each LGU and the state and local funding to or by each LGU would not change solely as a result of the creation of the Regional Planning Consortium structure.

- If a BHO structure is used outside of New York City, the State will need to use large geographic areas in a BHO region to configure the number of covered lives needed for BHO fiscal viability. The current BHOs regions under Phase 1, which are the OMH Regions, are too large and unwieldy for the State alone to effectively oversee and monitor the impact of managed care on the community.

For example, the current Central New York BHO Region includes 20 counties extending from the Canadian border to the Pennsylvania border. There are at least three separate, naturally occurring systems of care within this region. A region this size may be necessary to meet the covered lives actuarial standards, but for purposes of oversight and monitoring of the impact and effect of managed care and health homes, the size is unwieldy and doesn't reflect where people access services.

The groupings of counties proposed as Regional Health Improvement Collaboratives (RHIC) put forward by the DOH Public Health and Planning Council in its Certificate of Need (CON) Redesign Recommendations more accurately reflect the natural geographic areas of where New Yorker's access their behavioral health care. These grouping make sense.

The Conference endorses using these 11 regions for MCO/BHO oversight and to enable collaboration with our proposed Regional Planning Consortia (RPCs) to better coordinate physical health and behavioral health planning.

**NYS County Population Map** (See NYS Regional Map Showing Population by County)

## **REGIONAL PLANNING CONSORTIUMS: WHAT THEY WOULD LOOK LIKE**

Based in part on the successful models developed by the New York Care Coordination Project (NYCCP) and the Pennsylvania HealthChoices relationship between the counties and the BHO, this model provides for oversight and problem solving at the local level with a strong mechanism for provider and consumer input and influence in the governance structure. (**Attachment 1**)

We recommend the establishment of a Regional Planning Consortium (RPC) comprised of the stakeholders, and organizations or agencies that provide a diverse array of services to people with mental illness and substance use disorders in the region. The RPCs would include, at a minimum, each LGU in the region and representatives of mental health and substance abuse providers, peers, families, and health home leads. In its contract with the MCO/BHO, the state would require a memorandum of understanding between the RPC and the MCO/BHO for purposes of improving care and recovery for clients, integration of care and cost stabilization through care management and oversight of the managed care contract through:

- Data sharing
- Service system planning
- Reinvestment of savings
- Facilitating linkages with social services and criminal justice/courts
- Identifying and engaging in care, people who are underserved and/or disconnected from care (e.g. through the SPOA process)
- Identifying gaps in services and increasing access
- Facilitating continuity of care
- Identifying areas warranting concentrated efforts (e.g. Opiate addiction)
- Identifying best practices among the regions

The governance structure of the Regional Planning Consortia would mirror that of the successful New York Care Coordination Project model whereby the LGUs hold 49% of policy-making authority and the representatives of providers, consumers, and health home leads hold 51% of the policy making authority. The MCOs/BHOs and State agencies would be ex-officio members of the RPC. This model of governance fosters collaboration among stakeholders and recognizes that LGUs have a different and statutory level of

responsibility for oversight of the mental hygiene system in its entirety and to assure the best use of state, federal and local taxpayer funds.

This model is intended to build on the time-tested NYCCP experience and establish the structure for collaboration and system transformation around planning, oversight, monitoring of managed care/health homes and their impact within the local communities.

### **3. EQUITABLE AND TRANSPARENT DISTRIBUTION OF REINVESTMENT DOLLARS DRIVEN BY REGIONAL NEEDS**

The Conference was very pleased with the State's public recognition of the need to reinvest a portion of the Medicaid savings generated through managed care into the community behavioral health system to promote crisis response, recovery outcomes, employment support and housing. We also support the behavioral health premium being separately identified and tracked from the health care premium and savings would be available for reinvestment under a state-approved plan.

The Conference feels strongly that the allocation of resources and projects funded by reinvestment be locally-driven through a transparent and inclusive process to ensure the unique needs and priorities of the regions are given strong consideration so long as the proposals meet the State's objectives for the triple aim and care coordination for all.

It is vitally important to maximize the reinvestment dollars to build the needed services and supports the community to prepare the system for more individuals covered by insurance, the continued downsizing of the state inpatient psychiatric centers, in addition to addressing service shortage areas in the New York State. How these reinvestment dollars are allocated must take regional needs into account.

Attached is a flow chart of the proposed process for allocation of the Medicaid savings identified for reinvestment. The Conference believes this is an equitable and transparent process. **(Attachment 2)**

### **4. PROTECT THE SAFETY NET FOR THE UNINSURED:**

The discussion over the past two years has focused on the Medicaid population. However, even after the implementation of the Insurance Exchange and the Medicaid expansion in 2014, it is estimated that over 1 million New Yorkers will remain uninsured, including undocumented immigrants.

State OMH, OASAS and the LGUs are responsible for ensuring access to mental health and substance abuse treatment services for the uninsured. Some funding streams which historically supported services to the uninsured have been eliminated and the viability of others is in question, such as;

- The COPS dollars, which began as local assistance dollars before being "Medicaidized" into COPS dollars, have now been eliminated.
- Targeted Case Management (TCM) dollars which included funding for people who were uninsured and not eligible for Medicaid, yet based on the severity of their mental illness, required TCM services, will be converted into Health Homes. DOH has stated the intention for Health Home TCM providers to continue to serve the uninsured through a contract with the LGU for funding until 2014. However, in the future, it is critical that sufficient dollars are provided to cover treatment and services to uninsured, "high risk/high need" individuals.
- The authority for Uncompensated Care Pool funding for Art. 31 mental health clinics expire in 2013.
- The uncertainty around if and how net deficit funding for substance abuse clinics will be treated under Phase 2 managed care.



- The poor fiscal condition of County Governments and their revenue restrictions under the property tax cap are impacting the amount of local tax levy available for all public services, including mental hygiene.

The Conference remains hopeful that CMS will approve New York's 1115 Waiver Reinvestment Plan which would allow the state to use reinvestment funding to support care for the uninsured. The safety net funding through State Aid to the LGUs must continue to support the cost of treatment and services to uninsured people with SMI/SA needs who the state and LGU are responsible for serving.

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The Conference appreciates your consideration of these recommendations endorsed by the LGUs and we look forward to working together to transform the behavioral healthcare system in New York into one which is person-centered, recovery oriented, integrated and locally driven in its development.