

**New York State Office of Mental Health**

# Interim Report

**July 1, 2014**



New York State  
Andrew M. Cuomo, Governor



Office of Mental Health  
Ann Marie T. Sullivan, MD, Commissioner

# Message from the Commissioner

July 1, 2014

Since assuming the position of Commissioner, many people have expressed to me their ideas and suggestions on the enormous change underway in the public mental health system. Many are excited about the new opportunities to support recovery and resiliency in our communities where we work, go to school, volunteer our time and live. At the same time, I have also heard from many that such changes need to be done incrementally, with ongoing analysis and stakeholder consultation on how we are achieving our desired goals. We have an obligation to maximize our opportunities for community service growth with these changes, but also to “get it right” and preserve our safety net services. We need to ensure that system transformation yields the promise of hope and real community integration for people diagnosed with mental illnesses.

This year’s Interim Plan focuses on two central areas: the transformation of State-operated and community-based services and integrated behavioral and physical Medicaid managed care. Both offer everyone involved with the public mental health system a chance to make it stronger and more resilient. Our system of care is on its own recovery journey. We have been encouraging recovery and resiliency at the personal level, but it will not be possible unless our delivery system supports that change. As noted mental health advocate, Pat Deegan wrote, “Recovery often involves a transformation of the self wherein one both accepts one’s limitation and discovers a new world of possibility. This is the paradox of recovery i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do.”

Similarly, the transformation of State and community-based services, and integrated behavioral and physical managed care demonstrate what we can no longer accept as a system of care, for example, providing inpatient services where community services are appropriate and available, supporting clinical practices that science tells us are no longer relevant, and maintaining silos of mental health and physical health. These two transformational efforts—in addition to the many initiatives that are helping to move them forward—provide a roadmap to what is possible and attainable. They will enable the system to better meet the clinical and support needs of New York’s Medicaid beneficiaries and those who require specialty care to cope with chronic behavioral and physical illnesses.

In order to balance the significant transformations before us with systemic stability, you will see that the State fiscal year 2014-2015 enacted Budget will allow for measured change, giving us time to study and consult with our stakeholders on the success of these efforts in moving the system toward our desired goals. In addition, you will see that this Interim Plan begins to outline some of the community service enhancements planned across the State, following from the recommendations and advice of the five Regional Advisory Committees that presented to the statewide Steering Committee in December. These plans are the beginning of an ongoing local, regional, and statewide planning cycle which is all the more critical in times such as these.

Planning requires flexibility, and a close eye on the ever-changing environment. We will continue to make these principles our priorities through all of the transformations underway and we are grateful for the many people engaged in care and their families, advocates, organizations and communities who are passionate about transforming the current system of care. With your help we will transform the system to one that builds on the strengths of each person, enables each person with mental illness to have a sense of identity and purpose, and be full participants in their communities. We look forward to the work ahead and your continuing guidance and feedback.

Ann Marie T. Sullivan, MD  
Commissioner

Statewide Comprehensive Plan  
Interim Report

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## Chapter 1

# The Need to Meet the Imperative for Change: The Current System of Care

With one of the world's largest and most complex mental health systems, the Office of Mental Health (OMH) has as its mission to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults diagnosed with serious mental illness and children diagnosed with serious emotional disturbance. To achieve this, OMH has a dual role as the lead authority for the public mental health system to (1) set policy and provide funding for community services and (2) operate inpatient and outpatient services. Consistent with the science of mental health evaluation, diagnosis and treatment, the OMH vision has evolved over time to one that today is more community-oriented and recovery-focused. Nonetheless, OMH's "safety net" role as a hospital provider—which had its beginnings in the 1840s—remains premised on a chronic disease and caretaker way of thinking from centuries past.

The current mental health system was developed more than a century ago with a focus on in-hospital

care in a time when a mental health diagnosis would have relegated some individuals to a lifetime of hospitalization and care. As with other state hospital systems of care around our nation, the New York State (NYS) inpatient psychiatric hospital system serves as a "safety net" designed to support people with the most significant mental health needs.

### What is Recovery?

Having a serious mental illness does not mean that it lasts long, gets worse, and prevents an individual from social engagement and productive community living. Research shows that people can and do recover from mental illness.

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. The four major dimensions of recovery include:

- **Health:** Overcoming or managing one's disease(s) or symptoms and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being
- **Home:** A stable and safe place to live
- **Purpose:** Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society
- **Community:** Relationships and social networks that provide support, friendship, love, and hope

Substance Abuse and Mental Health Services Administration "Working Definition of Recovery from Mental Disorders and Substance Abuse Services," 2013

The current safety net, as described in this Chapter, requires realignment to better support people in their communities and prevent prolonged hospitalizations and the accompanying dependency that develops from institutionalization. Research and experience demonstrate that high quality psychiatric treatment and supports help adults in recovering from serious mental illnesses and promote resiliency in children with challenging behavioral conditions. A realigned system of care offers the promise of relying upon the latest findings from psychiatry and behavioral health care to effectively support people who are working toward recovery, while providing the best return on investment for New York's communities and citizens.

# The Prevalence of Mental Illness

Mental health problems are prevalent and concerning. In any given year, 1 in 4 adults in NYS has a diagnosable mental disorder, while 1 in 17 has a serious mental illness. In many cases, individuals living with serious mental illnesses also experience a range of chronic and disabling medical conditions, such as diabetes, asthma, obesity, and heart disease. Moreover, persons with serious mental illnesses in this country die on average approximately 25 years younger than those without serious mental illnesses.

The public mental health system in NYS has evolved over time from one dominated by large State psychiatric hospitals serving a tiny fraction of those with serious mental illnesses to a highly dispersed system of non-profit organizations, county mental hygiene departments, and State and private hospitals serving about 715,000 individuals yearly. Currently, OMH funds and/or licenses more than 2,500 mental health programs operated by local governments and private agencies. They provide outpatient, inpatient, emergency, residential, community support and vocational care and services.

Of note, the OMH civil psychiatric hospital census, which in the 1950s stood at 93,000, today is below 4,000. Nonetheless, approximately 10,000 adults and children served in the public mental health system in 2012 received services in OMH inpatient hospitals.

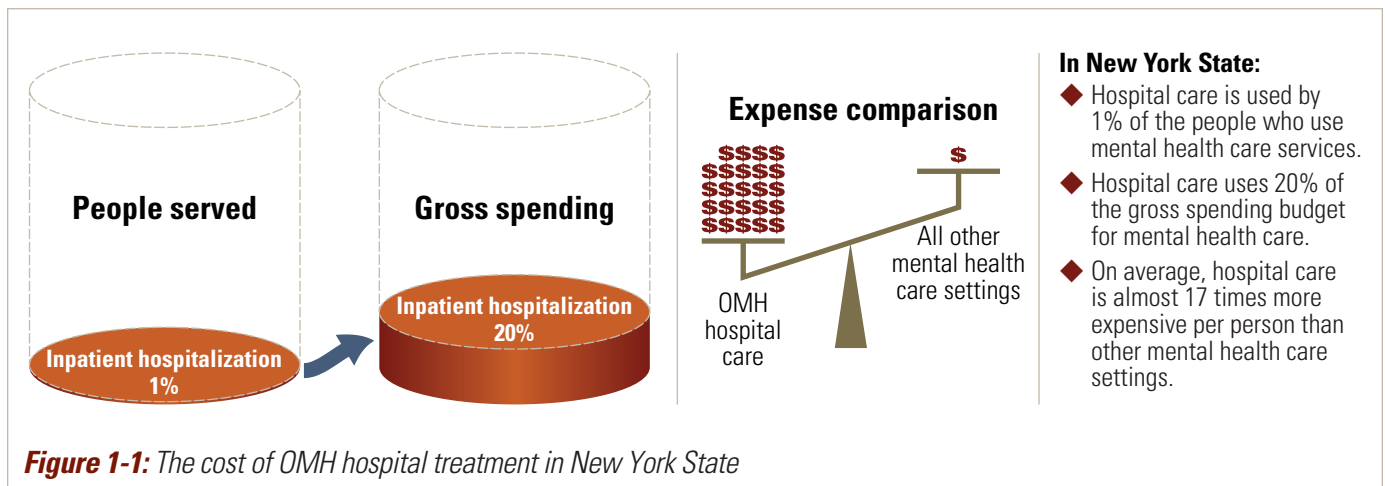
As shown in Figure 1-1, despite a significant emphasis on becoming more community- and recovery-oriented, OMH remains overly reliant on extended inpatient hospitalization for those with serious mental illnesses.

This reliance comes at a great cost. More than \$1.3 billion per year is spent on OMH hospital treatment and care for 10,000 individuals, while \$5.3 billion is spent on mental health care in the community for a population of more than 700,000 people. New York’s historical choice to operate and maintain 24 State psychiatric hospitals is no longer sustainable.

The undeniable forces of healthcare reform are substantial—the national Affordable Care Act, Medicaid Redesign and Medicaid managed care, mental health parity, the Americans with Disabilities Act, and continuing budget demands—have laid the groundwork for a more efficient and effective consumer-oriented model. The momentum of change cannot be halted and the moral force of recovery cannot be denied. The fast-changing environment serves as an impetus to equip the entire State mental health system for entry into the new world of healthcare delivery. The only other option would be to avoid change and fail to be a player in the new healthcare field.

In short, OMH resources must be realigned with medical best practices and what is known to promote accessible care, resiliency, and recovery for the majority of adults, children and their families. OMH must shift resources to improve the overall health of populations served, improve the outcomes of care and reduce the per-person costs of care. By doing so, OMH can better support the needs of the majority of people in the community—where they do, will, or should reside.

As providers throughout the public mental health system transform, OMH also must adapt to the changing environment. It must embrace new tenets of healthcare management, from accountability, to collaborative care, improved outcomes, and high return on investment for New Yorkers.



**Figure 1-1:** The cost of OMH hospital treatment in New York State

# A Path to a Progressive Behavioral Health Care System

Upon taking office in 2011, Governor Andrew Cuomo initiated a series of health care reforms aimed at reducing the cost of health care, increasing quality and efficiency, and improving individual health outcomes for New Yorkers. In many ways, these reforms serve as a guide for the types of reforms that remain necessary within the State public mental health system.

A progressive behavioral health care system commits to follow through on fundamental reforms already under way. They are necessary to bring about change and build upon four mainstays of superior behavioral care:

1. **Accountable care management** – getting care management right by relying upon best practices and continuous therapeutic relationships to engage people with serious mental illnesses and their families in obtaining the right services -at the right time - in the right amount; ensuring that accountability for care is affixed and that the outcomes of care enable people to work toward recovery with success.
2. **Early access to care across the lifespan** – investments early on in the trajectory of behavioral illnesses yield better health outcomes, reduce pain and distress, and bring value to taxpayer dollars invested in care; such investments include depression screening, expert care during first episodes of psychosis to reduce disability, and education of primary care providers who treat mental health problems.
3. **Access to affordable housing, education and employment** – success of behavioral health services is measured by the individuals who have access to safe and affordable housing, live productively in their

communities and stay engaged in work, school (especially for children with serious emotional disturbance who today have some of the worst educational outcomes) and social activities; when illness manifests or is exacerbated and hospitalization becomes necessary, adults and children return to their homes and communities with necessary treatment and supports.

4. **Excellence in treatment and community services** – is a mandate for all parts of the public mental health system, with a shift from a primary focus on inpatient services to positioning State-operated services so they provide the best services possible for the individuals served, preserve and acknowledge the expertise and experience of the OMH workforce through continuity of employment, and reflect attention to the expressed needs and recommendations of communities in which services are based.

Working toward a progressive behavioral health system advances a sustainable role for State-operated services. Such a system would be driven by the needs of the individuals served; enable health plans, particularly Medicaid managed care providers, to offer high return on investment; and take into account who is served and where, while building on the strengths of communities and the OMH workforce in adapting to the changing health care environment.

The following sections highlight some of the central initiatives to advance New York toward a more recovery- and resiliency-oriented, progressive behavioral health system. As an Interim Plan, this document will exhibit some of the most recent and ongoing developments to the state-operated and community-based service transformation, managed behavioral healthcare, and several other components of healthcare reform; all driving an ongoing process of stakeholder engagement, systems analysis, planning, and action.





## Chapter 2

# A Transformational Plan for a Progressive Behavioral Health Care System

The Office of Mental Health’s plan to transform and integrate State-operated services into the community takes into account our responsibility to maintain, strengthen, build and sustain the infrastructure necessary for the develop “best in nation” care through collaborative, person-centered regional networks across New York State. Currently, New York State surpasses the national average in State Psychiatric Center (PC) utilization rates, and exceeds all Mid-Atlantic and other urban states in State PC per capita census levels. The OMH transformational plan for the public mental health system reflects choices shaped by the forces of reform, a strong body of scientific evidence on recovery and client-centered approaches to care, and analysis of the current OMH State-operated system and regional health care systems.

State-operated services will be transformed by using the assets of our State workforce and savings associated with rebalancing our institutional footprint to develop and enhance community-based services in geographically distinct areas of each region. State and community-based services will be integrated and redesigned to diagnose and treat the most severe or complex forms of mental illness and offer expanded and improved ambulatory services. Strong university affiliations, based upon collaborations that promote research and result in the quick dissemination of evidence-based treatments will support these efforts.

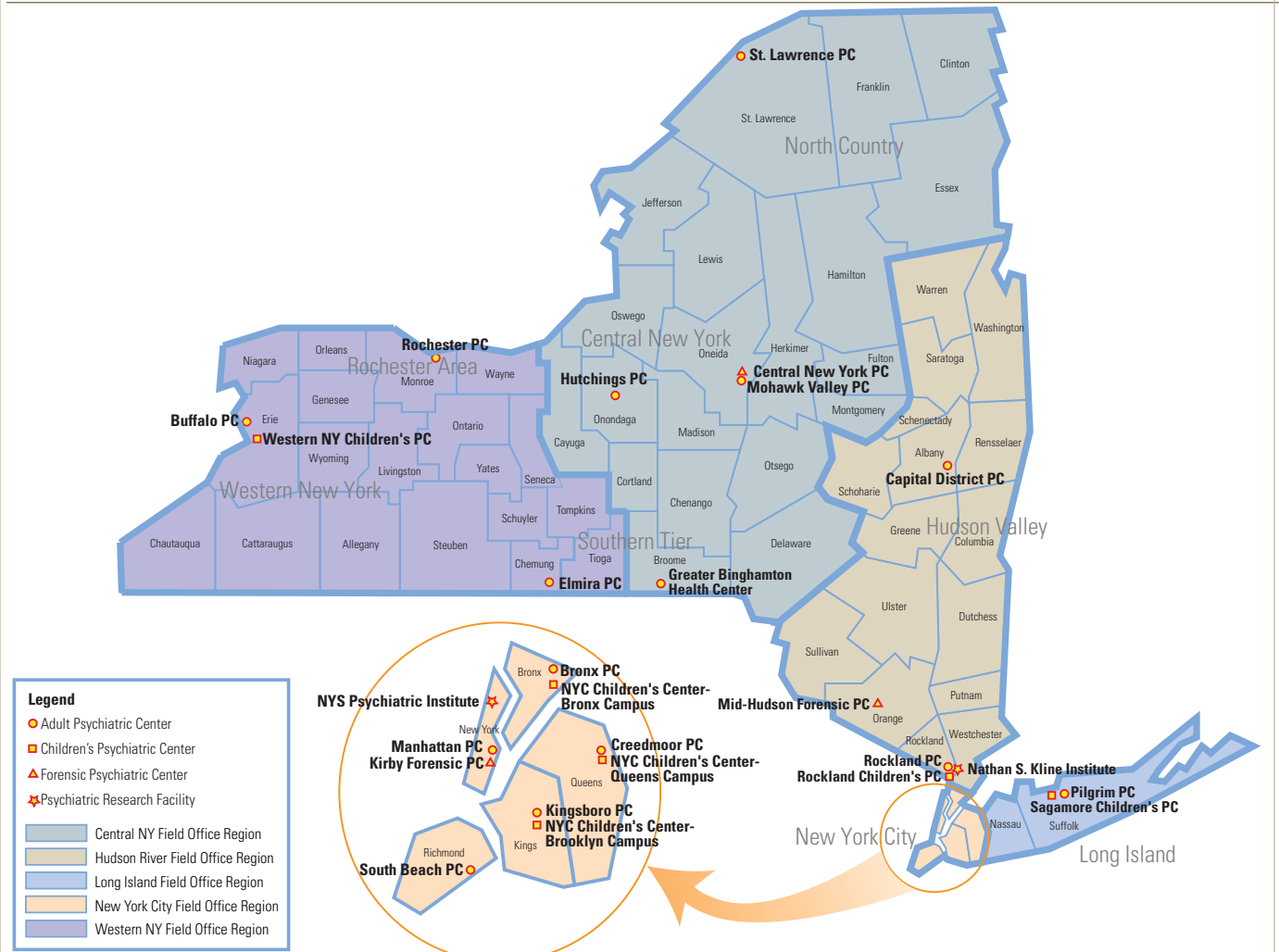
In the Fall of 2013, Regional Advisory Committees were convened in each OMH region of the State in order to identify those services and supports necessary to help reduce inpatient admissions and lengths of stay, and to optimize community living for adults with serious mental illness and children with serious emotional disturbance. Some of the commonly identified areas for each region were mobile intervention and community support teams, expanded housing opportunities, crisis/respite

beds, family and peer supports, mental health urgent care, home and community-based waiver expansion, transportation supports, and greater integration of peers and families into all service models.

In December 2013, the statewide Steering Committee comprised of the co-chairs of the five Advisory Committees and several key statewide stakeholders met to review the recommendations of the Committees, and to advise the Commissioner of OMH on some of the top priorities for new and enhanced community supports and services to support this transformation. This advisory process subsequently and directly informed the development of the Governor’s Executive Budget proposal for the Office of Mental Health released on January 21, 2014, and which included \$25 million (annualizing to \$44 million) in “pre-investment” funds for many of the services and supports identified through the advisory process. The enacted Budget for 2014-15 includes the \$25 million in pre-investments funds, and will continue funding for nearly 3,000 civil adult and children’s inpatient Psychiatric Center beds, maintaining nearly 90% of the existing civil bed capacity at the end of the fiscal year. Through the budget process, OMH has committed that new community investments resulting from these new appropriations will begin prior to any significant reduction of capacity in State Psychiatric Centers.

### **Transformation Efforts as Reflected in the 2014-15 Enacted Budget**

This section provides an overview of reforms planned for State fiscal year 2014-15, followed by an outline of some of the community service enhancements planned to reduce the need for inpatient admissions, reduce length of stay, and optimize community living. These services were based on the recommendations developed throughout the regional advisory process in 2013, and will



**Figure 2.1: Regional Reinvestment Areas**

*Service expansions in this section are described in general terms of facility service areas; the specific locations and geographic range of such services are still under development.*

be further developed with the advice and consultation of local governmental units and other stakeholders. Please note that while service expansions in this section are described in general terms of facility service areas, the specific locations and geographic range of such services are still under development.

**Western New York**

The 2014-2015 enacted State Budget reflects the continued operation of Western New York Children’s Psychiatric Center in West Seneca, New York in Fiscal Year 2014-2015. Additionally, the enacted Budget provides \$4 million in new funds for the creation and expansion of community-based mental health services in the Western New York region served by Western New York Children’s Psychiatric Center and Buffalo Psychiatric Center.

The 2014-2015 State Budget makes historic investments into services designed to bring quality community based

care to the region that will reduce the need for and length of costly psychiatric hospitalizations. The Western New York region will receive this funding out of an overall \$44 million statewide investment for community based mental health services focused primarily on decreasing avoidable hospital admissions and readmissions. The creation and expansion of community-based services in the Western New York region will allow over 250 additional residents to receive community mental health services at full program implementation.

These innovative community-based services funded through the enacted Budget were developed through community input with strong representation from the Western New York region. Regional Advisory Committees were convened across the State over the past year to identify those services and supports that most effectively reduce psychiatric hospitalizations and lengths of stay,

and to optimize community living for adults with serious mental illness and children with serious emotional disturbance.

The following services may be developed in Western New York as a result of Regional Advisory Committee recommendations, which directly informed the 2014-2015 Budget agreement, and will be further refined through ongoing community outreach and planning. These services are designed to enhance the existing system of care.

- ◆ **50 new Supported Housing units.** These apartments, with related supports and services, are the cornerstone of recovery and resiliency and are integrated into local communities for individuals leaving inpatient and other group living situations. This resource will provide opportunities for more people to live productive and satisfying lives in the community.
- ◆ **24 new Home and Community Based Services (HCBS) Waiver slots** for children will be established. Participation in this program enables children and their families to receive a multitude of services designed to prevent psychiatric hospitalization. This will be accomplished through intensive services in the home and community, which include: respite services providing family caregivers with a needed rest or time to care for themselves, skill building for children and families, crisis response, family support, intensive in-home supports and care coordination.
- ◆ **Mobile Integration Team for Youth and Families.** Such a team would respond to calls from schools, families and pediatric services to provide on-site crisis assessment and intervention. It would also provide in-home treatment, in-school behavioral support and consultation as needed. This team would provide “Community Respite” services, which are services provided to a family in their natural environment, providing family caregivers with a needed rest or time to care for themselves.
- ◆ **Children and Youth Clinic Services** expansion will allow for enhanced clinic access, provide services in schools, and facilitate partnerships with local pediatricians. Early access and early intervention help ensure that youth are able to stay at home and in their communities.
- ◆ **Mobile Mental Health Juvenile Justice Team** will expand capacity to provide specialized assessments for probation and the courts.

Other services identified through the Regional Advisory Committee process and in consultation with local gov-

ernmental units, supported through additional reinvestment funding, may include:

- ◆ **School and BOCES-based clinic satellite programs,** supporting children in accessible and integrated educational settings.
- ◆ **Forensic intervention and training programs,** diverting individuals with serious mental illness from the criminal justice system to treatment.
- ◆ **Family supports,** including parent training and support network creation.
- ◆ **Expansion of recovery services** that foster vocational, educational, and social growth.
- ◆ **First Episode Psychosis** programs and other early identification/intervention strategies to mitigate the onset of psychotic disorders.
- ◆ **“Bridger” staff** to personally guide individuals through transitions from inpatient institutions into integrated and clinically-supported community living.

The Office of Mental Health is committed to continue to work with county and local government officials in the development and review of community-based service investments to best support the children, adults and families of Western New York.

### Rochester Area

The enacted State Budget provides \$5.9 million in new funds for the creation and expansion of community-based mental health services in the area served by the Rochester Psychiatric Center.

The 2014-2015 State Budget makes historic investments into services designed to bring high quality community-based care to the region that will reduce the need for and length of costly psychiatric hospitalizations. The Rochester PC service region will receive this funding out of an overall \$44 million statewide investment for community-based mental health services focused primarily on decreasing avoidable hospital admissions and readmissions. The creation and expansion of community-based services in Western New York will allow over 400 additional residents to receive community mental health services, at full program implementation.

These innovative community-based services funded through the Budget were developed through community input with strong representation from Western New York. Regional Advisory Committees were convened across the State over the past year to identify those services and supports that most effectively reduce psychiatric hospital-

izations and lengths of stay, and to optimize community living for adults with serious mental illness and children with serious emotional disturbance.

The following services may be developed as a result of Regional Advisory Committee recommendations, which directly informed the 2014-2015 Budget agreement, and will be further refined through ongoing community outreach and planning.

- ◆ **116 new Supported Housing units.** These apartments, with related supports and services, are the cornerstone of recovery and resiliency and are integrated into local communities for individuals leaving inpatient and other group living situations. This resource will provide opportunities for more people to live productive and satisfying lives in the community.
- ◆ **Forensic intervention and training programs,** diverting individuals with serious mental illness from the criminal justice system to treatment.
- ◆ **Expansion of recovery services** that foster vocational, educational, and social growth.
- ◆ **First Episode Psychosis** programs and other early identification/intervention strategies to mitigate the onset of psychotic disorders.
- ◆ **“Bridger” staff** to personally guide individuals through transitions from inpatient institutions into integrated and clinically-supported community living.

The Office of Mental Health will continue to work with county and local government officials in the development and review of community-based service investments to best support the children, adults and families in the Rochester area.

### Southern Tier

The 2014-2015 enacted State Budget reflects the continued operation of both Greater Binghamton Health Center and Elmira Psychiatric Center in Fiscal Year 2014-2015. Additionally, the enacted Budget provides \$8.1 million in new funds, \$4.3 million for the region served by Greater Binghamton Health Center (GBHC) and \$3.8 million for the region served by Elmira Psychiatric Center (EPC), for the provision of community-based mental health services.

The 2014-2015 State Budget makes historic investments into services designed to bring high quality community-based care to the region that will reduce the need for and length of costly psychiatric hospitalizations. The Southern Tier region will receive this funding out of an overall \$44 million statewide investment for community-

based mental health services focused primarily on decreasing avoidable hospital admissions and readmissions. The creation and expansion of community-based services in the Southern Tier will allow over 550 additional residents to receive community mental health services at full program implementation.

These innovative community-based services funded through the enacted Budget were developed through community input with strong representation from the Southern Tier. Regional Advisory Committees were convened across the State over the past year to identify those services and supports that most effectively reduce psychiatric hospitalizations and lengths of stay, and to optimize community living for adults with serious mental illness and children with serious emotional disturbance.

The following services may be developed in the Southern Tier as a result of Regional Advisory Committee recommendations, which directly informed the 2014-2015 Budget and will be further refined through ongoing community outreach and planning. These services are designed to enhance the existing system of care.

- ◆ **108 new Supported Housing units (60 in the GBHC service area and 48 in the EPC service area) including supported housing and family care beds.** These apartments, with related supports and services, are the cornerstone of recovery and resiliency and are integrated into local communities for individuals leaving inpatient and other group living situations. This resource will provide opportunities for more people to live productive and satisfying lives in the community.
- ◆ **The conversion of up to 16 Crisis and Respite Beds (8 at GBHC and 8 at EPC)** will provide a short term (1-21 days), non-hospital trauma sensitive, therapeutic living environment for children and youth in crisis that will enable intensive work with families to support their return to home with ongoing support.
- ◆ **24 new Home and Community Based Services (HCBS) Waiver slots (12 in the GBHC service area and 12 in the EPC service area)** for children will be established. Participation in this program enables children and their families to receive a multitude of services designed to prevent psychiatric hospitalization. This will be accomplished through intensive services in the home and community, which include: respite services providing family caregivers with a needed rest or time to care for themselves, skill building for children and families, crisis response, family support, intensive in-home supports and care coordination.

◆ **Mobile Integration Team for Youth and Families.** Such a team would respond to calls from schools, families and pediatric services to provide on-site crisis assessment and intervention. It would also provide in-home treatment, in-school behavioral support and consultation as needed. This team would provide “Community Respite” services, which are services provided to a family in their natural environment, providing family caregivers with a needed rest or time to care for themselves.

◆ **Expansion of Tele-Psychiatry** will improve access to quality evaluations and treatment in rural settings and emergency departments that do not have on-site child psychiatric services. Tele-psychiatry allows access to skilled and experienced psychiatrists by means of audio/video conferencing technology on computers or other dedicated equipment.

◆ **Mobile Crisis and Support Team for Adults** would work with adults of all ages and their families and include peers who have experienced and recovered from a mental illness. A Mobile Crisis and Support Team provide on-site assessment, supportive care and treatment to individuals, thus avoiding unnecessary police calls, emergency room visits, and hospitalizations. This team would also provide support to people who have recently begun to live in the community, helping them to maintain their residence and social and vocational progress. The goal is to help people be successful in leading full and productive lives.

Other services identified through the Regional Advisory Committee process and in consultation with local governmental units, supported through additional reinvestment funding, may include:

◆ **School and BOCES-based clinic satellite programs,** supporting children in accessible and integrated educational settings.

◆ **Forensic intervention and training programs,** diverting individuals with serious mental illness from the criminal justice system to treatment.

◆ **Family supports,** including parent training and support network creation.

◆ **Expansion of recovery services** that foster vocational, educational, and social growth.

◆ **First Episode Psychosis** programs and other early identification/intervention strategies to mitigate the onset of psychotic disorders.

◆ **“Bridger” staff** to personally guide individuals through transitions from inpatient institutions into integrated and clinically-supported community living.

The Office of Mental Health is committed to continue to work with county and local government officials in the development and review of community-based service investments to best support the children, adults and families of the Southern Tier.

### **Central New York**

The 2014-15 enacted State Budget provides \$1.7 million in new funds for the creation and expansion of community-based mental health services in the Central New York region served by Hutchings and Mohawk Valley Psychiatric Centers.

The 2014-2015 State Budget makes historic investments into services designed to bring high quality community-based care to the region that will reduce the need for and length of costly psychiatric hospitalizations. The Central New York region will receive this funding out of an overall \$44 million statewide investment for community-based mental health services focused primarily on decreasing avoidable hospital admissions and readmissions. The creation and expansion of community-based services in Central New York will allow over 120 additional residents to receive community mental health services, at full program implementation.

These innovative community-based services funded through the Budget were developed through community input with strong representation from Central New York. Regional Advisory Committees were convened across the State over the past year to identify those services and supports that most effectively reduce psychiatric hospitalizations and lengths of stay, and to optimize community living for adults with serious mental illness and children with serious emotional disturbance.

The following services may be developed as a result of Regional Advisory Committee recommendations, which directly informed the 2014-2015 Budget agreement, and will be further refined through ongoing community outreach and planning.

◆ **18 new Home and Community Based Services (HCBS) Waiver slots** for children will be established. Participation in this program enables children and their families to receive a multitude of services designed to prevent psychiatric hospitalization. This will be accomplished through intensive services in the home and community, which include: respite services providing family caregivers with a needed rest or time



to care for themselves, skill building for children and families, crisis response, family support, intensive in-home supports and care coordination.

- ◆ The creation of up to **6 Crisis and Respite Beds** will provide a short term (1-21 days), non-hospital trauma sensitive, therapeutic living environment for children and youth in crisis that will enable intensive work with families to support their return to home with ongoing support.
- ◆ **Expansion of Tele-Psychiatry** to improve access to quality evaluations and treatment in rural settings, in emergency departments that do not have on site child psychiatric services, and to pediatricians in need of consultation. Tele-psychiatry allows access to skilled and experienced psychiatrists by means of audio/video conferencing technology on computers or other dedicated equipment.

Other services identified through the Regional Advisory Committee process and consultation with local governmental units, supported through additional reinvestment funding, may include:

- ◆ **School and BOCES-based clinic satellite programs**, supporting children in accessible and integrated educational settings.
- ◆ **Forensic intervention and training programs**, diverting individuals with serious mental illness from the criminal justice system to treatment.
- ◆ **Family supports**, including parent training and support network creation.
- ◆ **Expansion of recovery services** that foster vocational, educational, and social growth.
- ◆ **First Episode Psychosis** programs and other early identification/intervention strategies to mitigate the onset of psychotic disorders.
- ◆ **“Bridger” staff** to personally guide individuals through transitions from inpatient institutions into integrated and clinically-supported community living.

The Office of Mental Health will continue to work with county and local government officials in the development and review of community-based service investments to best support the children, adults and families of Central New York.

## North Country

The 2014-15 enacted State Budget reflects continued operation of the St. Lawrence Psychiatric Center in Ogdensburg, New York in Fiscal Year 2014-2015. Additionally, the enacted Budget provides \$3.85 million in new funds for the creation and expansion of community-based mental health services in the North Country region served by St. Lawrence Psychiatric Center.

The 2014-2015 State Budget makes historic investments into services designed to bring high quality community-based care to the region that will reduce the need for and length of costly psychiatric hospitalizations. The North Country region will receive this funding out of an overall \$44 million statewide investment for community-based mental health services focused primarily on decreasing avoidable hospital admissions and readmissions. The creation and expansion of community-based services in the North Country will allow over 270 additional residents to receive community mental health services, at full program implementation.

These innovative community-based services funded through the Budget were developed through community input with strong representation from the North Country. Regional Advisory Committees were convened across the State over the past year to identify those services and supports that most effectively reduce psychiatric hospitalizations and lengths of stay, and to optimize community living for adults with serious mental illness and children with serious emotional disturbance.

The following services may be developed in the North Country as a result of Regional Advisory Committee recommendations, which directly informed the 2014-2015 Budget agreement, and will be further refined through ongoing community outreach and planning.

- ◆ **50 new Supported Housing units.** These apartments, with related supports and services, are the cornerstone of recovery and resiliency and are integrated into local communities for individuals leaving inpatient and other group living situations. This resource will provide opportunities for more people to live productive and satisfying lives in the community.
- ◆ The creation of up to **8 Crisis and Respite Beds** will provide a short term (1-21 days), non-hospital trauma sensitive, therapeutic living environment for children and youth in crisis that will enable intensive work with families to support their return to home with ongoing support.

- ◆ **12 new Home and Community Based Services (HCBS) Waiver slots** for children will be established. Participation in this program enables children and their families to receive a multitude of services designed to prevent psychiatric hospitalization. This will be accomplished through intensive services in the home and community, which include: respite services providing family caregivers with a needed rest or time to care for themselves, skill building for children and families, crisis response, family support, intensive in-home supports and care coordination.
- ◆ **Mobile Integration Team for Youth and Families.** Such a team would respond to calls from schools, families and pediatric services to provide on-site crisis assessment and intervention. It would also provide in-home treatment, in-school behavioral support and consultation as needed. This team would provide “Community Respite” services, which are services provided to a family in their natural environment, providing family caregivers with a needed rest or time to care for themselves.
- ◆ **Expansion of Tele-Psychiatry** to improve access to quality evaluations and treatment in rural settings, in emergency departments that do not have on site child psychiatric services, and to pediatricians in need of consultation. Tele-psychiatry allows access to skilled and experienced psychiatrists by means of audio/ video conferencing technology on computers or other dedicated equipment.
- ◆ **Mobile Crisis and Support Team.** Such a team would work with adults of all ages and their families and will include peers who have experienced and recovered from a mental illness. A Mobile Crisis and Support Team would provide on-site assessment, supportive care and treatment to individuals in crisis, thus avoiding unnecessary police calls, emergency room visits, and hospitalizations. It would also provide support to people who have recently begun to live in the community, helping them to maintain their residence and social and vocational progress. The goal is to help people be successful in leading full and productive lives.
- ◆ **Increase clinic capacity** and access in targeted counties.
- ◆ **Community Mental Health Forensic Program** to develop and manage pretrial release plans for seriously mentally ill persons entering jails in the North Country.

Other services identified through the Regional Advisory Committee process and consultation with local governmental units, supported through additional reinvestment funding, may include:

- ◆ **School and BOCES-based clinic satellite programs,** supporting children in accessible and integrated educational settings.
- ◆ **Forensic intervention and training programs,** diverting individuals with serious mental illness from the criminal justice system to treatment.
- ◆ **Family supports,** including parent training and support network creation.
- ◆ **Expansion of recovery services** that foster vocational, educational, and social growth.
- ◆ **First Episode Psychosis** programs and other early identification/intervention strategies to mitigate the onset of psychotic disorders.
- ◆ **“Bridger” staff** to personally guide individuals through transitions from inpatient institutions into integrated and clinically-supported community living.

The Office of Mental Health will continue to work with county and local government officials in the development and review of community-based service investments to best support the children, adults and families of the North Country.

### **Hudson Valley**

The enacted 2014-15 State Budget provides \$3.2 million in new funds for the creation and expansion of community-based mental health services in the Hudson Valley region served by the Rockland Adult and Children’s Psychiatric Centers and the Capital District Psychiatric Center.

The 2014-2015 State Budget makes historic investments into services designed to bring high quality community-based care to the region that will reduce the need for and length of costly psychiatric hospitalizations. The Hudson Valley region will receive this funding out of an overall \$44 million statewide investment for community-based mental health services focused primarily on decreasing avoidable hospital admissions and readmissions. The creation and expansion of community-based services in the Hudson Valley will allow over 200 additional residents to receive community mental health services, at full program implementation.

These innovative community-based services funded through the Budget were developed through community

input with strong representation from Hudson Valley. Regional Advisory Committees were convened across the State over the past year to identify those services and supports that most effectively reduce psychiatric hospitalizations and lengths of stay, and to optimize community living for adults with serious mental illness and children with serious emotional disturbance.

The following services may be developed as a result of Regional Advisory Committee recommendations, which directly informed the 2014-2015 Budget agreement, and will be further refined through ongoing community outreach and planning.

- ◆ **50 new Supported Housing units.** These apartments, with related supports and services, are the cornerstone of recovery and resiliency and are integrated into local communities for individuals leaving inpatient and other group living situations. This resource will provide opportunities for more people to live productive and satisfying lives in the community.
- ◆ **12 new Home and Community Based Services (HCBS) Waiver slots** for children will be established. Participation in this program enables children and their families to receive a multitude of services designed to prevent psychiatric hospitalization. This will be accomplished through intensive services in the home and community, which include: respite services providing family caregivers with a needed rest or time to care for themselves, skill building for children and families, crisis response, family support, intensive in-home supports and care coordination.

Other services identified through the Regional Advisory Committee process and consultation with local governmental units, supported through additional reinvestment funding, may include:

- ◆ **Mobile Crisis and Support Team.** Such a team would work with individuals of all ages and their families and will include peers who have experienced and recovered from a mental illness. A Mobile Crisis and Support Team would provide on-site assessment, supportive care and treatment to individuals in crisis, thus avoiding unnecessary police calls, emergency room visits, and hospitalizations. It would also provide support to people who have recently begun to live in the community, helping them to maintain their residence and social and vocational progress. For children and youth, these mobile intervention services could provide respite functions providing family caregivers with a needed rest or time to care for themselves. The goal is to help people be successful in leading full and productive lives.

- ◆ **Forensic intervention and training programs,** diverting individuals with serious mental illness from the criminal justice system to treatment.
- ◆ **Expansion of recovery services** that foster vocational, educational, and social growth.
- ◆ **First Episode Psychosis** programs and other early identification/intervention strategies to mitigate the onset of psychotic disorders.
- ◆ **“Bridger” staff** to personally guide individuals through transitions from inpatient institutions into integrated and clinically-supported community living.

The Office of Mental Health will continue to work with county and local government officials in the development and review of community-based service investments to best support the children, adults and families of the Hudson Valley.

### **New York City**

The 2014-15 enacted State Budget provides \$7.3 million in new funds for the creation and expansion of community-based mental health services in New York City.

The 2014-2015 State Budget makes historic investments into services designed to bring high Coquality community-based care to the region that will reduce the need for and length of costly psychiatric hospitalizations. New York City will receive this funding out of an overall \$44 million statewide investment for community-based mental health services focused primarily on decreasing avoidable hospital admissions and readmissions. The creation and expansion of community-based services in New York City will allow over 500 additional residents to receive community mental health services, at full program implementation.

These innovative community-based services funded through the Budget were developed through community input with strong representation from New York City. Regional Advisory Committees were convened across the State over the past year to identify those services and supports that most effectively reduce psychiatric hospitalizations and lengths of stay, and to optimize community living for adults with serious mental illness and children with serious emotional disturbance.

The following services may be developed as a result of Regional Advisory Committee recommendations, which directly informed the 2014-2015 Budget agreement, and will be further refined through ongoing community outreach and planning.



- ◆ **154 new Supported Housing units (50 in the Bronx service area and 104 in other boroughs).** These apartments, with related supports and services, are the cornerstone of recovery and resiliency and are integrated into local communities for individuals leaving inpatient and other group living situations. This resource will provide opportunities for more people to live productive and satisfying lives in the community.
- ◆ **24 new Home and Community Based Services (HCBS) Waiver slots (12 in the Bronx service area and 12 in other boroughs)** for children will be established. Participation in this program enables children and their families to receive a multitude of services designed to prevent psychiatric hospitalization. This will be accomplished through intensive services in the home and community, which include: respite services providing family caregivers with a needed rest or time to care for themselves, skill building for children and families, crisis response, family support, intensive in-home supports and care coordination.

Other services identified through the Regional Advisory Committee process and consultation with local governmental units, supported through additional reinvestment funding, may include:

- ◆ **Mobile Crisis and Support Team.** Such a team would work with adults of all ages and their families and will include peers who have experienced and recovered from a mental illness. A Mobile Crisis and Support team would provide on-site assessment, supportive care and treatment to individuals in crisis, thus avoiding unnecessary police calls, emergency room visits and hospitalizations. It would also provide support to people who have recently begun to live in the community, helping them to maintain their residence and social and vocational progress. The goal is to help people be successful in leading full and productive lives
- ◆ **Mobile Integration Team for Youth and Families.** Such a team would respond to calls from schools, families and pediatric services to provide on-site crisis assessment and intervention. It would also provide in-home treatment, in-school behavioral support and consultation as needed. This team would provide “Community Respite” services, which are services provided to a family in their natural environment, providing family caregivers with a needed rest or time to care for themselves.
- ◆ **Expand respite and in-home services to assist transition age youth.** Respite services are services provided to a family in their natural environment, providing

family caregivers with a needed rest or time to care for themselves.

- ◆ **Develop Crisis Respite Centers** that offer an alternative to hospitalization that serve people anticipating or experiencing acute symptoms of psychosis for stays of one night to two weeks. The Crisis Respite Centers provide an innovative and unique complementary service to traditional emergency room and inpatient care.
- ◆ **Forensic intervention and training programs,** diverting individuals with serious mental illness from the criminal justice system.
- ◆ **Expansion of recovery services** that foster vocational, educational, and social growth.
- ◆ **First Episode Psychosis** programs and other early identification/intervention strategies to mitigate the onset of psychotic disorders.
- ◆ **“Bridger” staff** to personally guide individuals through transitions from inpatient institutions into integrated and clinically-supported community living.
- ◆ **Develop training and resource materials,** for providers, children and families, listing appropriate community-based services that support recovery for children, adolescents, and youth in transition.
- ◆ **Development of additional supportive employment models** for individuals with mental illness.
- ◆ **Expansion of youth, family and peer support services.**

The Office of Mental Health will continue to work with New York City Department of Health and Mental Hygiene officials in the development and review of community-based service investments to best support the children, adults and families of New York City.

### Long Island

The 2014-15 enacted State Budget reflects the continued operation of Sagamore Children’s Psychiatric Center in Fiscal Year 2014-2015. Additionally, the enacted Budget provides \$8.4 million in new funds, \$4.4 million for Sagamore Children’s Psychiatric Center (SCPC) and \$4 million for Pilgrim Psychiatric Center (PPC), for the provision of community-based mental health services on Long Island.

The 2014-2015 State Budget makes historic investments into services designed to bring quality community based care to the region that will reduce the need for and length of costly psychiatric hospitalizations. Long Island will re-

ceive this funding out of an overall \$44 million statewide investment for community-based mental health services focused primarily on decreasing avoidable hospital admissions and readmissions. The creation and expansion of community-based services in Long Island will allow over 550 additional residents to receive community mental health services, at full program implementation.

These innovative community-based services funded through the Budget were developed through community input with strong representation from Long Island. Regional Advisory Committees were convened across the State over the past year to identify those services and supports that most effectively reduce psychiatric hospitalizations and lengths of stay, and to optimize community living for adults with serious mental illness and children with serious emotional disturbance.

The following services may be developed in Long Island as a result of Regional Advisory Committee recommendations, which directly informed the 2014-2015 Budget agreement, and will be further refined through ongoing community outreach and planning.

- ◆ **100 new Supported Housing units.** These apartments, with related supports and services, are the cornerstone of recovery and resiliency and are integrated into local communities for individuals leaving inpatient and other group living situations. This resource will provide opportunities for more people to live productive and satisfying lives in the community.
- ◆ **54 new Home and Community Based Services (HCBS) Waiver slots** will be established. Participation in this program enables children and their families to receive a multitude of services designed to prevent psychiatric hospitalization. This will be accomplished through intensive services in the home and community, which include: respite services providing family caregivers with a needed rest or time to care for themselves, skill building for children and families, crisis response, family support, intensive in-home supports and care coordination.
- ◆ The creation of up to **8 Crisis and Respite Beds** will provide a short term (1-21 days), non-hospital trauma sensitive, therapeutic living environment for children and youth in crisis that will enable intensive work with families to support their return to home with ongoing support.
- ◆ **Mobile Integration Team for Youth and Families.** Such a team would respond to calls from schools, families and pediatric services to provide on-site crisis assessment and intervention. It would also provide in-home treatment, in-school behavioral support and

consultation as needed. This team would provide “Community Respite” services, which are services provided to a family in their natural environment, providing family caregivers with a needed rest or time to care for themselves.

- ◆ **Enhancement of the Family Court Evaluation Team** to reduce the number of youth remanded by the local courts and reduce the length of stay for those who are admitted for inpatient evaluation. This team would seek to reduce the current two week evaluation process, identify youth who can have assessments completed in the community, and ensure that youth are appropriately engaged in outpatient services to address the issues that are causing them to present to Family Court.

Other services identified through the Regional Advisory Committee process and consultation with local governmental units, supported through additional reinvestment funding, may include:

- ◆ **School and BOCES-based clinic satellite programs,** supporting children in accessible and integrated educational settings.
- ◆ **Forensic intervention and training programs,** diverting individuals with serious mental illness from the criminal justice system to treatment.
- ◆ **Family supports,** including parent training and support network creation.
- ◆ **Expansion of recovery services** that foster vocational, educational, and social growth.
- ◆ **First Episode Psychosis** programs and other early identification/intervention strategies to mitigate the onset of psychotic disorders.
- ◆ **“Bridger” staff** to personally guide individuals through transitions from inpatient institutions into integrated and clinically-supported community living.

The Office of Mental Health will continue to work with county and local government officials in the development and review of community-based service investments to best support the children, adults and families of Long Island.

## Chapter 3

# The Integration of Behavioral and Physical Health Care: Medicaid Managed Care Approaches

Physical health and mental health are inextricably linked. Data from the 2003 National Co-morbidity Survey Replication show that nearly 7 out of 10 adults with a mental disorder have one or more medical conditions, while 3 out of 10 adults with medical disorders experience at least one mental health condition.<sup>1</sup> Moreover, an estimated 70% of primary care visits have been attributed to psychosocial issues, suggesting that office visits by people with physical health ailments may often be prompted by underlying behavioral health issues.<sup>2</sup> The relationship between physical and mental health is further complicated by our knowledge that barriers to primary healthcare services—coupled with challenges in navigating intricate healthcare systems—represent a major obstacle to effective care for people with physical and behavioral health conditions.

In response to these data and emerging evidence about the importance of integrated healthcare, health organizations are striving to shift resources from systems in which care often has been poorly coordinated to ones where the delivery of physical and behavioral healthcare is systematic, well-coordinated and integrated. In New York State, the Office of Mental Health's State and community-based service transformation plan is just one example of an effort aimed at addressing the fragmentation of healthcare, improving outcomes, and holding down the costs of care. Nationally, such efforts have been spurred in part by the passage of the federal Affordable Care Act, which is providing incentives and support for the integration of mental health, substance abuse and primary care services for millions of Americans, as well as such forces as mental health parity, state and federal fiscal challenges, and scientific evidence confirming that recovery from mental illnesses and substance use disorders is possible and does occur.

In NYS, the Medicaid Redesign Team (MRT) has been at the forefront of leading change and advancing

the State toward the seamless integration of health and mental healthcare for beneficiaries of Medicaid. A cornerstone of healthcare transformation in the State public mental health system, Medicaid Redesign aligns with findings from research demonstrating that outcomes improve and priceless healthcare dollars are saved when integrated care approaches are implemented effectively,<sup>3,4,5,6,7</sup> whether in primary care settings, behavioral health settings or health homes.

The charge of the MRT Behavioral Health Reform Workgroup has been to help establish the parameters of the transformation to care management for New Yorkers with mental illnesses and substance use disorders. Its final report issued in October 2011 focused on facets of the charge, including consideration of delivery and payment mechanisms for the integration of substance abuse and mental health services, as well as their integration with physical healthcare services; examination of opportunities for the co-location of services and peer and managed addiction treatment services and their potential integration with behavioral health organizations (BHOs); and the provision of guidance about health homes and proposals of other innovations that lead to improved coordination of care between physical and mental health services.

When begun, the MRT process reflected the recognition that the State's behavioral health system (which is the system providing specialty treatment and care for individuals diagnosed with mental illnesses and substance use disorders) was large and fragmented, with then more than 700,000 people with mental illness being served at an estimated annual cost of \$6.6 billion.<sup>8</sup> Approximately one-half the spending, the Behavioral Health Reform Workgroup noted, goes to inpatient care. For substance use disorders, the publicly funded system serves more than 250,000 individuals and accounts for about \$1.7 billion in expenditures annually. Despite the

significant spending on behavioral healthcare, however, comprehensive care coordination for individuals receiving services, particularly those with the most intensive needs, has been lacking and accountability for outcomes and quality care have been insufficient.

The MRT report also documented the lack of clinical, regulatory and fiscal integration and effective care coordination for behavioral health and physical healthcare. While behavioral health is funded primarily through fee-for-service Medicaid funding, a substantial portion of physical healthcare for people diagnosed with mental illnesses and/or substance use disorders is financed and arranged through Medicaid managed care plans. The result of these funding arrangements is that they inadvertently contributed to fragmented care and a lack of accountability for care. Moreover, this fragmentation and lack of accountability extend well beyond physical healthcare into the education, child welfare, and juvenile justice systems for children and youth under the age of 21, as well as adults who are homeless or involved in the criminal justice system.

When care is not well coordinated, there is greater risk that behavioral health needs will not be identified and people will receive suboptimal behavioral healthcare in primary care settings. Untreated or suboptimal treatment of behavioral health conditions is associated with lower adherence to prescribed medical treatment, higher medical costs, and poorer health outcomes. In particular, adults with mental disorders have a “two-fold to fourfold elevated risk of premature mortality,” largely due to poorer physical health status, as well as accidents or suicides.<sup>9</sup> Given the high prevalence of mental illnesses and co-occurring mental illnesses and substance use disorders among Medicaid beneficiaries,<sup>10</sup> the opportunity for improved clinical and financial outcomes through improved coordination of behavioral and physical health services is strong. The integration of behavioral and physical healthcare via managed care for individuals with substance use disorders, with or without serious mental illnesses is associated with improved access, better monitoring of quality outcomes and a better distribution of services across the entire care continuum.<sup>11,12,13,14,15</sup>

The final report produced by the MRT Team has provided NYS with a blueprint and action plan for reforming Medicaid services and optimizing health system performance through alignment with what the Institute of Healthcare Improvement calls the triple aim: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per person cost of healthcare.<sup>16</sup> Overall, the design and operational components of the newly configured behavioral health system for

### **Behavioral Health Benefits Should...**

- ◆ Promote person-centered care management
- ◆ Foster the integration of physical and behavioral health services
- ◆ Root services in a recovery and resiliency orientation
- ◆ Engage individuals in decision making and choice
- ◆ Address the cultural and other unique needs of children, families and older adults
- ◆ Ensure adequate and comprehensive service networks
- ◆ Tie payment to outcomes of care
- ◆ Track physical and behavioral health spending separately
- ◆ Reinvest savings to improve services for the population of individuals with behavioral health conditions

Medicaid beneficiaries address the State’s advancement of the MRT vision and goals, including:

- ◆ Improved access to appropriate behavioral and physical healthcare services for individuals with mental illnesses and/or substance use disorders
- ◆ Better management of total medical costs for individuals diagnosed with co-occurring behavioral and physical health conditions
- ◆ Improved health outcomes and increased satisfaction among individuals engaged in care
- ◆ Transformation of the behavioral health system from one dominated by inpatient care to one based in ambulatory and community care
- ◆ Enhanced service delivery system that supports employment, success in school, housing stability and social integration

Specifically, the design of the State’s behavioral health Medicaid program is marked by four key operational components:

- ◆ Development of managed behavioral health organizations regionally, by entities with demonstrated expertise in managing behavioral health services for individuals with substance use disorders and serious mental illnesses<sup>17</sup> as well as networks of health homes statewide that are qualified to serve enrollees with behavioral health and/or chronic medical conditions (these health homes



### Care Management in New York State— The Health Home

A health home is a care management service model where all of the professionals involved in a member's care communicate with one another so that the member's medical, behavioral health and social service needs are addressed comprehensively. The coordination of each member's care is carried out by a dedicated care manager who oversees and manages access to all of the services a member requires to sustain optimal health. For Medicaid managed care members, health home services are provided contractually through partnerships between members' managed care plans and assigned health homes.

are not tailored for meeting the needs of people with developmental disabilities and long term care needs).<sup>18</sup>

- ◆ Integration of Medicaid behavioral health benefits with the physical health benefit already under managed care, beginning with adults in New York City on January 1, 2015; with adults in the remainder of the State on July 1, 2015; and with children statewide on January 1, 2016.
- ◆ Qualification of managed care organizations (MCOs) and Health and Recovery Plans (HARPs) prior to the implementation, thereby ensuring adequate capabilities to manage behavioral health services and supports. Qualification includes verifying the program and financial management structures to support the transition to, and ongoing operation of, the newly integrated behavioral and physical health system and ensuring member continuity of care requirements from fee-for-service to managed care.
- ◆ Integration of the behavioral/physical health premium and minimum medical loss ratio (MLR) for HARPs and a behavioral health MLR for qualifying MCOs.<sup>19</sup> All behavioral health capitation rates and health home reimbursement will flow through the Plans. Plans will be required to separately report behavioral health expenditures to ensure access to new behavioral health services and to work with health homes to ensure coordinated plans of care.

The Medicaid managed care program design takes a multi-pronged approach to raise expectations and improve the behavioral and physical healthcare outcomes for all members. Key elements of the design include:

- ◆ Providing all Medicaid State Plan services for physical health, behavioral health, pharmacy, and long-term care

- ◆ Expanding and enhancing network capacity and the array of evidence-based treatment and support services accessible in the community so they facilitate recovery for adults and resiliency for children
- ◆ Clearly specifying the expectation that the behavioral health benefit will result in high-quality care that has a positive impact on member outcomes
- ◆ Requiring routine screening of members in primary care settings to identify unmet behavioral health needs and expedited, effectively made referrals to behavioral health services
- ◆ Requiring routine screening of members in behavioral health settings to identify unmet medical needs and expedited, effectively made referrals to appropriate physical services
- ◆ Stipulating data integration and predictive modeling approaches to identify individuals who are at high risk for, or have intensive and costly service needs, and facilitating program evaluation across systems
- ◆ Instituting utilization management, medical management, and quality management protocols and other administrative methods to ensure that behavioral health service delivery, and associated financial and clinical outcomes, are appropriately managed
- ◆ The NYS Department of Health, in conjunction with OMH and the Office of Alcoholism and Substance Abuse Services (OASAS), will pre-approve MCO behavioral health services criteria and practice guidelines for utilization review, prior authorization, and levels of care.
- ◆ Each MCO will be required to use an OASAS-approved substance use disorder level-of-care tool for all substance use disorder level-of-care decisions (to include, but may not be limited to, the agency's placement criteria system known as the Level of Care for Alcohol and Drug Treatment Referral [LOCADTR]).
- ◆ Utilizing specialized case management and care coordination protocols to improve the engagement of each person in care, promote self-care, and enhance cross-system coordination—including participation in health home innovations—for people at risk for or experiencing intensive and costly service needs
- ◆ Facilitating system transformation through the provision of comprehensive and ongoing education, training and technical assistance programs for members, behavioral and physical health providers, and MCO staff
- ◆ Developing a transition plan that delineates key milestones and time lines for transitioning behavioral services from fee-for-service to MCOs and implementing other key program components

Because some MCOs may not have the expertise to manage specialty behavioral benefits, MCOs must

demonstrate their qualifications, subcontract with a BHO, or partner with vendors and providers who demonstrate experience in serving the population.

The Behavioral Health Reform Workgroup recommendations adopted by the MRT have informed the State's submission for December 2013 of an amendment to its current federal 1115 demonstration<sup>20</sup> to enable qualified MCOs statewide to comprehensively meet the needs of participants with behavioral health needs, either by meeting rigorous standards (perhaps through a partnership with a BHO, as noted above) or under HARPs for those individuals with significant behavioral health needs. As proposed, specific features of Medicaid managed care would include:

- ◆ Mainstream or conventional MCOs having responsibility for the integration of Medicaid-covered mental illnesses, substance use disorders, and physical health services for adult Medicaid beneficiaries and the use of performance measures specific to behavioral health.
- ◆ HARPs having responsibility for providing specialized services for adult Medicaid beneficiaries with significant behavioral health needs based on clinical/functional impairment eligibility requirements. The HARP benefits package will include rehabilitation, crisis intervention, educational and employment support, case management/care coordination, peer and self-directed services modeled after the federal Section 1915(i) home and community-based services (HCBS).<sup>21</sup> These services will be available to beneficiaries based on a full functional assessment and their detailed plan of care. Qualified HARPs will rely upon specialized medical and social necessity/utilization review approaches and provide care

management, including the 1915(i)-like services,<sup>22</sup> pending approval from the Centers for Medicare and Medicaid Services, in compliance with home and community-based standards and assurances.

- ◆ Children in mainstream MCOs: Children's behavioral health services, including all HCBS waivers operated by OMH and the Office of Children and Family Services (OCFS), will be included in the mainstream MCOs. As policy and design options are being considered, the children's managed care transition program work plan now reflects the January 2016 implementation target date.

Overall, the goals of the various managed care models and qualification process aim to improve clinical and recovery outcomes for Medicaid beneficiaries diagnosed with serious mental illnesses and substance use disorders; reduce the growth in costs through a reduction in unnecessary emergency and inpatient care; and increase network capacity to deliver community-based, recovery-oriented services and supports. Transformation activities beginning in 2013 and planned for the next three years are highlighted in Figure 3-1.

From September through December of 2013, OMH distributed the MCO Data Book, containing information on eligibility data, managed care encounters, and fee-for-service claims. The Book displays data summaries by region and premium group, provides a separate premium group for individuals eligible for participation in HARPs, delineates separate behavioral health and physical health components of the HARP integrated premium, and shows utilization and dollars based on managed care encounters and on utilization and dollars from fee-for-service claims.

## Qualified Behavioral Health Plan and Health and Recovery Plan Elements

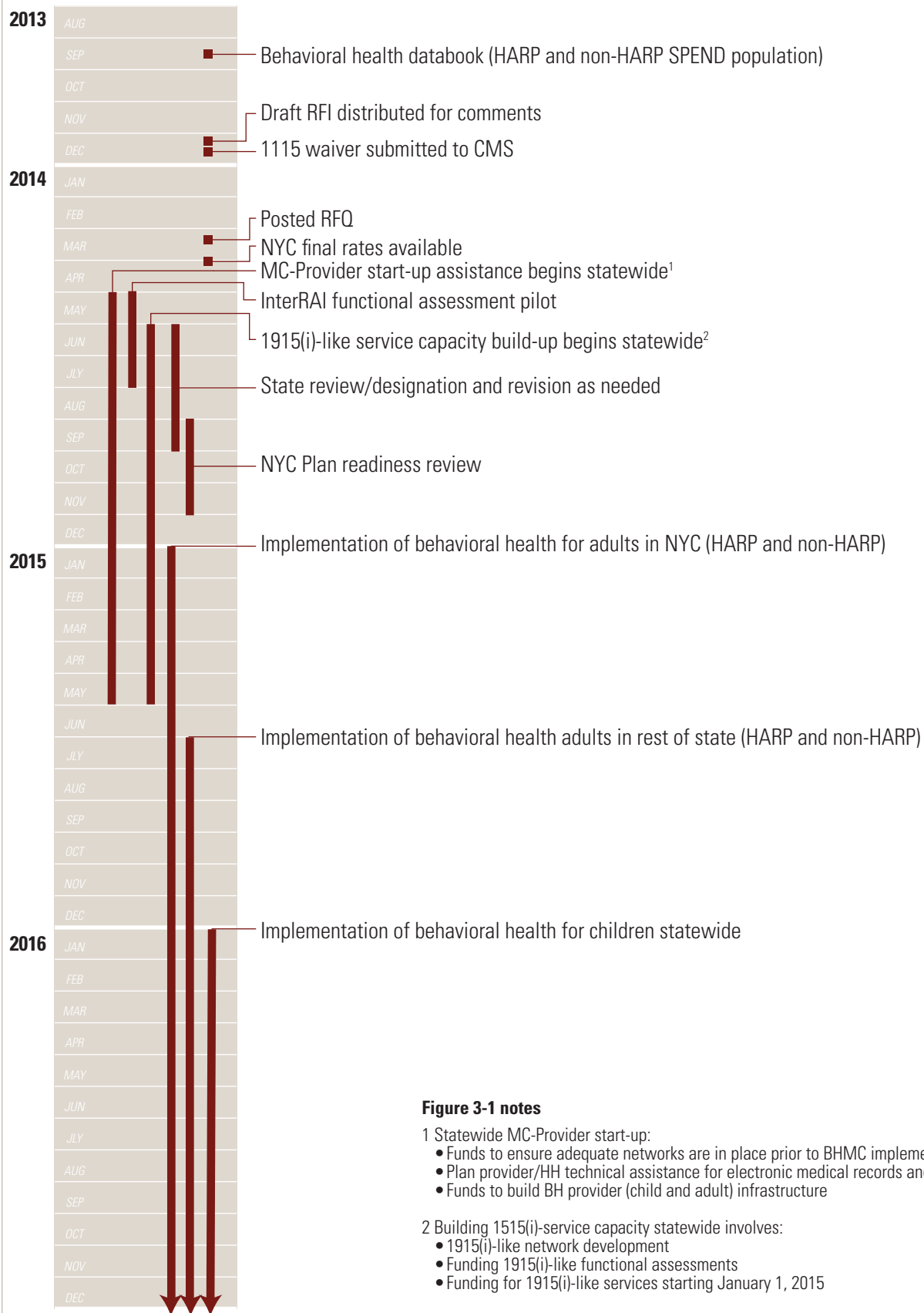
### Behavioral Health Plan

- ◆ Open to people eligible for Medicaid
- ◆ Benefit includes all current services
- ◆ Benefit management specific to public benefit population social needs
- ◆ Organized as benefit within Medicaid managed care—enhanced staffing for behavioral health benefit management coordinated with physical health benefit management
- ◆ Performance metrics specific to behavioral health outcomes and plan management of Medicaid population and behavioral health and social needs

### Health and Recovery Plan (HARP)

- ◆ Eligibility based on targeting criteria and identified risk factors
- ◆ Benefits include all current and new 1915(i)-like services
- ◆ Benefit management built around expectations of more intensive needs of individuals served by HARP
- ◆ Organized as a separate product line with a separate behavioral health director
- ◆ Performance metrics specific to specialized services, higher need population social and medical needs

**Figure 3-1: NYS Medicaid behavioral health transformation implementation time line**



**Figure 3-1 notes**

- 1 Statewide MC-Provider start-up:
  - Funds to ensure adequate networks are in place prior to BHMC implementation
  - Plan provider/HH technical assistance for electronic medical records and billing
  - Funds to build BH provider (child and adult) infrastructure
- 2 Building 1515(i)-service capacity statewide involves:
  - 1915(i)-like network development
  - Funding 1915(i)-like functional assessments
  - Funding for 1915(i)-like services starting January 1, 2015

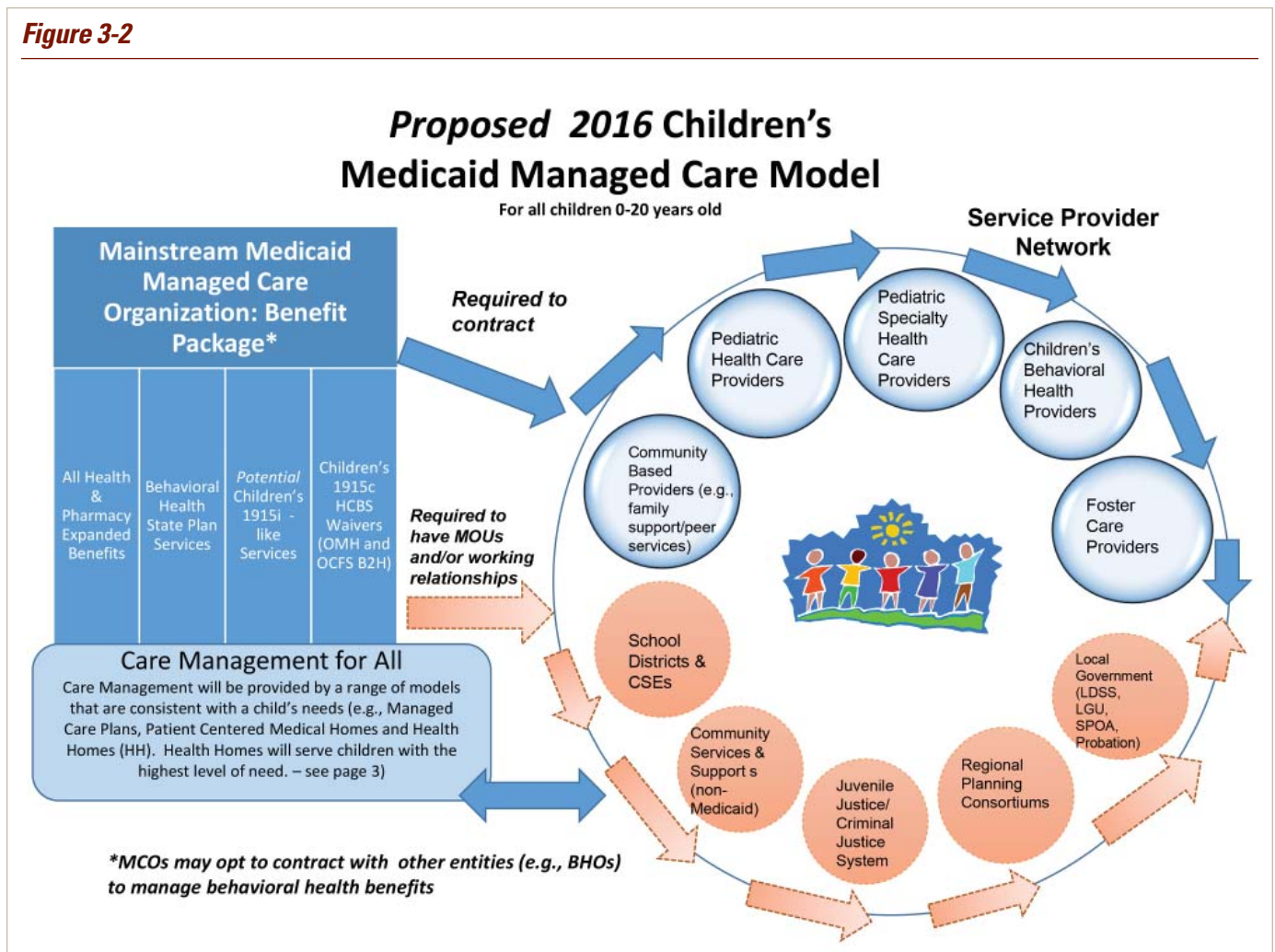
In December 2013, New York State released a Request for Information (RFI) regarding “New York’s Request for Qualifications (RFQ) for Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans.” This RFI solicited input concerning New York’s draft proposal to manage Medicaid substance use and mental health benefits for adults. The RFI addresses planning and systems oversight under the concept of “Regional Planning Consortia,” which would consist of LGUs and other important stakeholders, and require collaboration between MCOs/HARPs and these regional entities. Comments in response to the RFI submitted through January 17, 2014 have been reviewed, and the State released the final RFQ in March 2014.

During the summer of 2014, work will intensify to provide technical assistance, particularly to the New York City region, which responded to the RFQ, and after which Plan designations will be made and readiness reviews will take place. Contingent upon federal approval, the starting date for the full implementation in New York City of behavioral HARPs and non-HARPs for adults is set for January 1, 2015, and for July 1, 2015, for the adult population in the remainder of the State.

With the submission in December of the 1115 waiver amendment to the Centers for Medicare and Medicaid Services, OMH, the Department of Health (DOH), and OASAS will continue to work with the federal government to refine the waiver submission and gain approval from the federal government to implement integrated behavioral and physical healthcare across the State.

The Children’s Behavioral Health Team continues its work and seeks stakeholder feedback on the design of the children’s integrated health and physical health planning. The leadership of the group, which is shared between OMH, OASAS, the Office of Children and Family Services (OCFS), and DOH, has approved a preliminary model to guide design. As illustrated in Figure 3-2, the model takes into consideration the unique specialty behavioral healthcare service needs of children with serious emotional disturbance and their families. The model clearly indicates the importance of early intervention; high-fidelity, evidence-based practices;

**Figure 3-2**





team-based, family-centered approaches; and family advocacy.

More information on the progress of the Children’s Behavioral Team is available on the OMH website under “Children and Family Medicaid Redesign Team (MRT) Working Team” on the left side of the page (see <http://www.omh.ny.gov/omhweb/Childservice/>). Additionally, to receive postings on the Team’s work, you can do so by subscribing to the listserv by going to <http://www.omh.ny.gov/omhweb/Childservice/LISTSERV/listserv.asp>.

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- 15 World Health Organization. (2003). *Organization of services for mental health*. Geneva: Author.
- 16 Berwick DM, Nolan TW, & Whittington J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, 27, 759–769.
- 17 The first phase of development created five regional BHOs to monitor inpatient behavioral health services for Medicaid beneficiaries whose inpatient behavioral health services are not covered by a Medicaid managed care plan and who also are not enrolled in Medicare. The phase one BHOs became operational in 2012 and were phased out in April 2014, while the lessons learned and process improvement achieved by these entities will help inform the integrated management of behavioral and physical health benefits for Medicaid beneficiaries.
- 18 New York State Department of Health. (nd). NYS health home provider qualification standards for chronic medical and behavioral health patient populations. Available online at [http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/provider\\_qualification\\_standards.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm).
- 19 The Affordable Care Act requires health insurers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). It also requires health insurers to issue rebates to enrollees if this percentage does not meet minimum standards. MLR requires insurance companies to spend at least 80% or 85% of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases.
- 20 Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children’s Health Insurance Program (CHIP). The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible; providing services not typically covered by Medicaid; and using innovative service delivery systems that improve care, increase efficiency, and reduce costs.
- 21 Under the Affordable Care Act, revised and new 1915(i) provisions were instituted in 2010 for removing barriers to offering home and community-based services through the Medicaid State plan. As revised, Section 1915(i) gives States an opportunity to provide services and supports before individuals need institutional care; importantly, it allows the provision by State plans of HCBS to individuals with mental health and substance use disorders.
- 22 If access to a health home is not available, then targeted case management (TCM) will be utilized for individuals who qualify for TCM so they receive case management services until such time as sufficient health home access exists and TCM is phased out.



## Chapter 4

# Other Environmental Factors

The transformational efforts described in Chapters 2 and 3 are taking place at the same time as multiple other redesign efforts that are driven by the federal Affordable Care Act and the NYS Medicaid Redesign Team; a few of these should be noted as they most directly impact the systems redesign and planning efforts underway at OMH. This section will briefly review three additional drivers of systems reform that will converge as planning for 2014 continues: Article 28/31 hospital reinvestment and the Vital Access Provider (VAP) program, the Delivery System Reform Incentive Program (DSRIP) waiver, and the Balancing Incentive Program (BIP).

### Reinvestment of Article 28/31 Savings and the Vital Access Provider Program

Over the past several years, there have been a number of closures of Article 28 and Article 31 inpatient and ambulatory programs, due to both programmatic and fiscal issues with the operation of the unit, or the overall fiscal viability of the institution. These actions could leave gaps in the service delivery system in certain areas of the State.

OMH is currently working with the Department of Health (DOH) to develop reinvestment plans to address the loss of psychiatric services in institutions that have closed, or will be closing in the near future. These plans are funded through the Medicaid state-share savings resulting from reductions in behavioral health capacity. The primary program focus areas of these plans involve crisis assessment and admission diversion programs, respite services, and other alternatives to inpatient admission.

In addition, OMH is working prospectively with DOH to implement a targeted investment strategy to ensure

critical access to behavioral health care in areas across New York State, through the Vital Access Provider program. VAP funds are currently available to Article 28 inpatient and ambulatory providers, including inpatient psychiatric units, to support providers identified as providing a critical role to specific populations or geographic areas. Among the factors that will go into the decisions made jointly by OMH and DOH in determining VAP eligibility will be current geographic capacity, provider occupancy levels within the geographic area, overall financial viability of the institution, proximity to actions planned for State Psychiatric Centers, and program need of the inpatient psychiatric unit. VAP funds will be used to enhance community care and to help providers achieve “defined financial, operational, and quality improvement goals related to integration or reconfiguration of services offered by the facility.”<sup>1</sup> While final VAP criteria for funding in the 2014-15 State fiscal year are still under development, the overall goal is consistent with the OMH goal to reduce the need for inpatient admissions and lengths of stay in State Psychiatric Centers.

### Delivery System Reform Incentive Program

With the implementation of dozens of Medicaid Redesign Team initiatives since its inception in 2011, New York State has saved approximately \$17 billion in federal share Medicaid funds, and set the State on a more sustainable path for health and behavioral healthcare spending in the future. The Delivery System Reform Incentive Program (DSRIP) is one of the central components of an \$8 billion, five-year federal waiver. DSRIP represents a broad effort to stabilize New York State’s health care safety net by reducing inpatient utilization through development of hospital and provider networks that will collaborate to redesign local and regional healthcare systems around common program goals.

DSRIP funding will be tied to certain process and outcome metrics, with the overriding goal of the initiative to reduce hospital and emergency department admissions by 25% over five years. DSRIP applications will be filed by a lead applicant and will require a broad provider and stakeholder network to support the application. The Department of Health has emphasized the importance of behavioral health providers and stakeholders being part of DSRIP applications to ensure an integrated approach to individuals in any DSRIP coverage area, and therefore OMH will be supporting and encouraging our stakeholders' involvement in network development as this initiative is implemented.

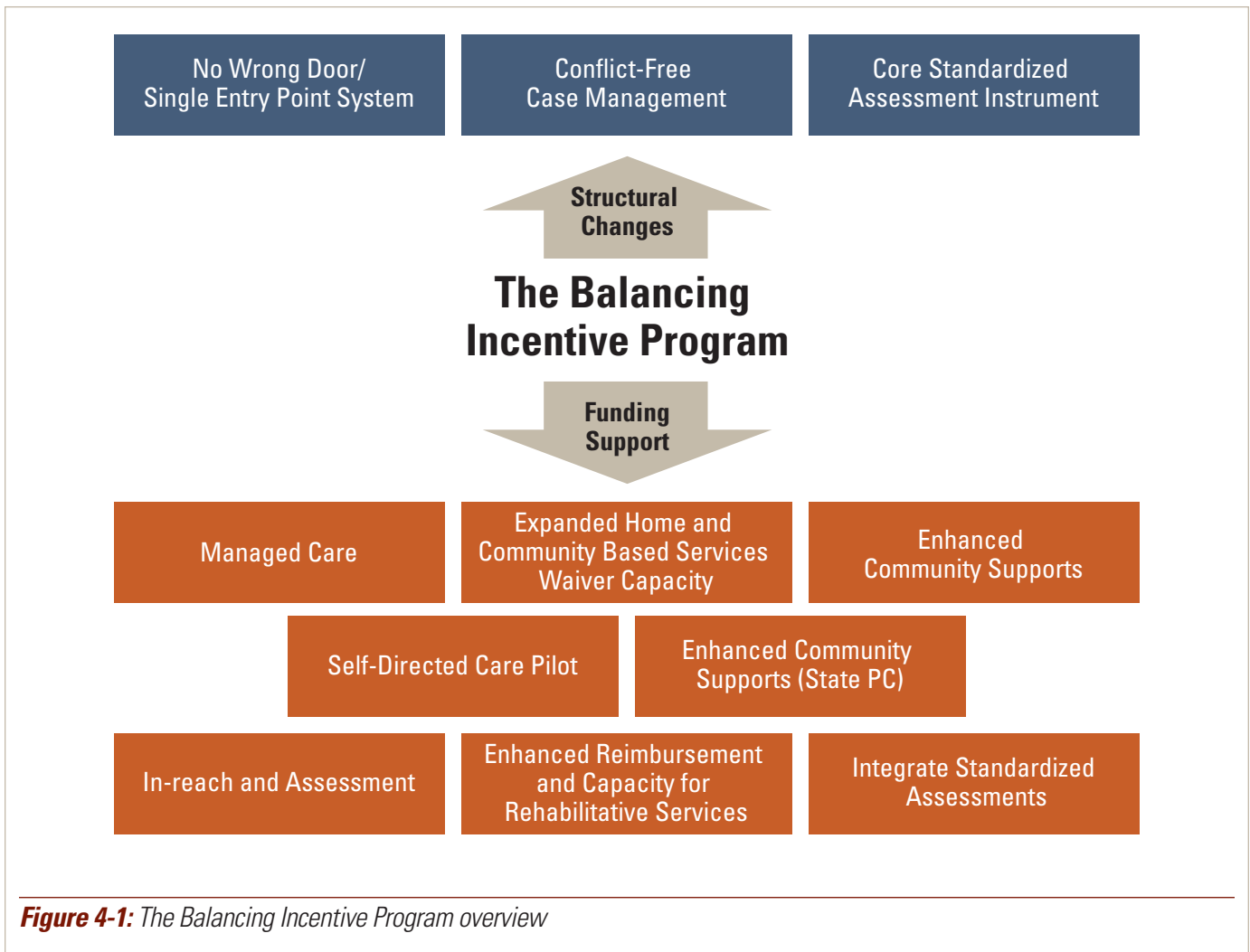
The Department of Health has set up a DSRIP website with information that will be updated as the program develops: [http://www.health.ny.gov/health\\_care/medicaid/redesign/delivery\\_system\\_reform\\_incentive\\_payment\\_program.htm](http://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm).

## The Balancing Incentive Program

The Balancing Incentive Program (BIP) was created in the Affordable Care Act to encourage states to rebalance long term services and supports (LTSS) by expanding access to community services as alternatives to institutional care. The program provides an additional 2% federal Medicaid participation for participating states. The BIP period is April 1, 2013 – September 30, 2015. When BIP ends, the State must show an increase in the percentage of LTSS provided in community based settings, compared to the baseline percentage.

Participating states are required to implement fundamental structural changes, and to meet expenditure targets for long term services and supports (See Figure 4-1). BIP's purpose is to rebalance the long term services and supports delivery system towards community based care; to strengthen individual choice; to standardize information for eligibility and enrollment; and to improve access and provide services in the least restrictive setting. Three structural changes that must be in place by September 15, 2015 include:

- ◆ **A “No Wrong Door/Single Entry Point System” (NWD/SEP):** To provide information on long term services and supports, determine eligibility, and help people enroll in appropriate services.
  - ◆ **Conflict-Free Case Management (CFCM):** States must develop an approach to Medicaid case management that ensures a separation between case management and providing direct services, and from eligibility determinations. Individuals' service funding cannot be established by case managers, and evaluators may not be related by blood or marriage to the individual.
  - ◆ **A Core Standardized Assessment Instrument:** States must develop and implement “core standardized assessment instruments” and a uniform process for making eligibility determinations using an assessment to identify what supports individuals need for Medicaid-funded LTSS, and for developing individuals' plans of care based on information from the assessment.
- The Office of Mental Health will use BIP funding to support the following:
- ◆ **Managed Care:** OMH will expand services for individuals being discharged from State Psychiatric Centers (PCs) and fund start-up to expand capacity for 1915(i)-like services in the Health and Recovery Plans.
  - ◆ **Expanded Home and Community Based Services Waiver Capacity:** OMH will transition capacity for children from institutional settings into the community by expanding the Home and Community Based Services waiver program to facilitate State inpatient bed reductions.
  - ◆ **Enhanced Community Supports:** OMH will transition individuals out of Adult Homes and Nursing Homes into community settings with funds to support the costs of enhanced services including rehabilitation services in Personalized Recovery Oriented Services (PROS) programs.
  - ◆ **Self-Directed Care Pilot:** OMH will develop and implement a self-directed care pilot for individuals transitioning from Adult Homes and Nursing Homes into the community.
  - ◆ **Enhanced Community Supports (State PC):** OMH will transition individuals residing in State Psychiatric Centers who would be better served in community settings. The funds will be used to support the costs of enhanced services including mobile community support services, a crisis stabilization team and training for State workforce to facilitate the transitions.
  - ◆ **In-reach and Assessment:** Funds to facilitate in-reach by community providers to support the transition from State PCs to the community.
  - ◆ **Enhanced Reimbursement and Capacity for Rehabilitative Services:** Enhanced reimbursement and capacity for rehabilitative services in community residences and apartment treatment for individuals discharged from OMH State PCs and Nursing Homes.
  - ◆ **Integrate Standardized Assessments:** Funds to integrate and automate OMH assessment tools with DOH and OPWDD assessments in the Uniform Assessment System for New York (UAS-NY).



**Figure 4-1:** The Balancing Incentive Program overview

### Chapter 4 Endnotes

- 1 Governor Cuomo Announces \$46 Million in Vital Access/Safety Net Provider Program Awards to Improve Community Care. Press Release, 12/3/13. <http://www.governor.ny.gov/press/12032013-vital-access-safety-net-provider-program>



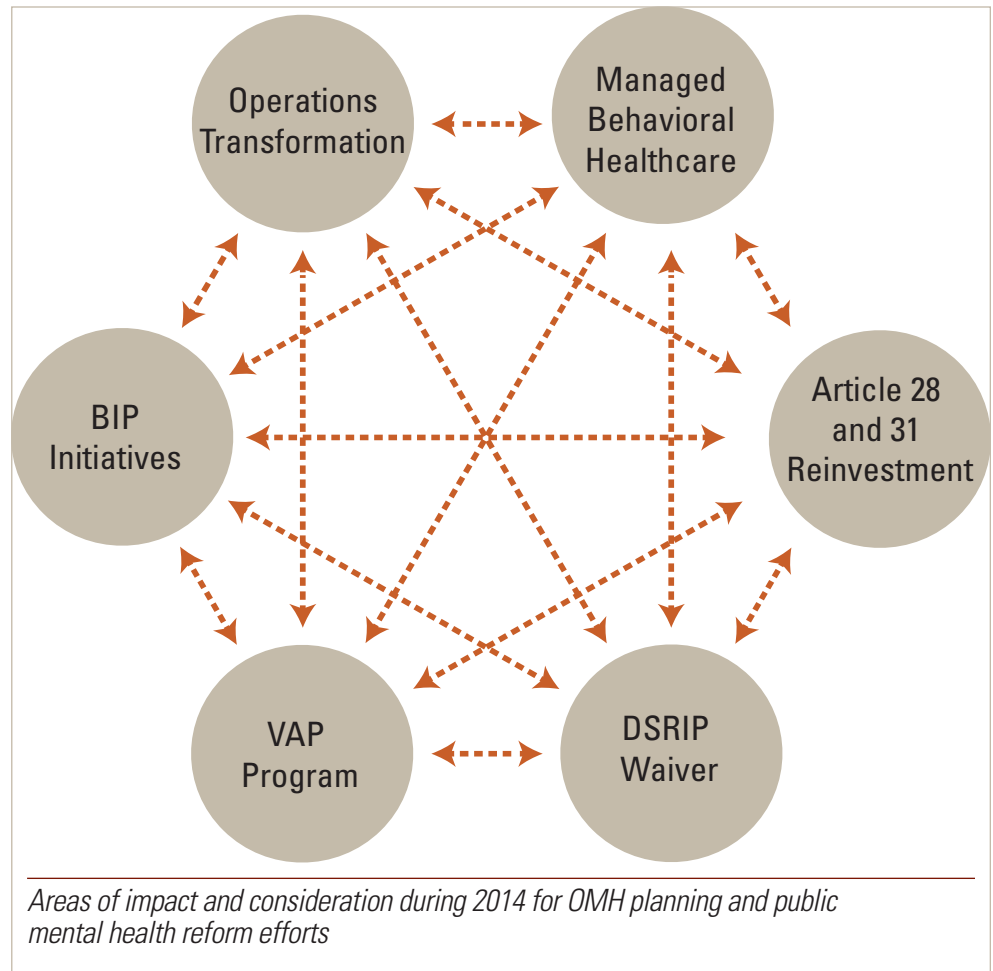
Chapter 5

# Concluding Notes

While operations transformation and managed behavioral healthcare are the two predominant policy trends driving state and local planning during 2014, there are additional areas with significant impacts for planning and public mental health reform that OMH is incorporating into its strategic planning for this year, in order to ensure that all stakeholders in the public mental health system are working in concert to better serve individuals with mental illness across the State. The DSRIP waiver, Article 28 and 31 reinvestment, the VAP program, and BIP initiatives are all interrelated and focused on institutional transformation and restructuring, at the same time maintaining stability of and access to health and behavioral health services across New York.

It is critical that as we move forward, that the foregoing initiatives are developed in coordination, with continuous stakeholder consultation, to ensure our commitment to promoting the mental health of all New Yorkers with a particular focus on facilitating hope and recovery for adults with serious mental illness and children with serious emotional disturbances. In the coming months of 2014, OMH will continue to strengthen its engagement with local stakeholders as the forces of change cause us to reassess

how to achieve our collective goals. The efforts under this transformation will be challenging, but the results will set a more accessible, rational, and sustainable course for the public health and behavioral health system for the people of the State of New York.







## Appendix 1

## 2014-15 Potential OMH Census Changes

Children's Facility	2013-14 Funded Beds	Change	2014-15 Funded Beds	New Children's Crisis/Respite Beds*
Elmira	18	(8)	10	8
Greater Binghamton	16	(8)	8	8
Hutchings	30	(15)	15	6
Mohawk Valley	30	-	30	
NYC Children's Center	172	-	172	
Rockland	54	(9)	45	
Sagamore	54	(27)	27	8
South Beach	12	-	12	
St. Lawrence	28	(8)	20	8
Western NY	46	(10)	36	
<b>Children's Total</b>	<b>460</b>	<b>(85)</b>	<b>375</b>	<b>38</b>

Adult Facility	2013-14 Funded Beds	Change	2014-15 Funded Beds
Bronx	181	(25)	156
Buffalo	183	(25)	158
Capital District	136	-	136
Creedmoor	344	-	344
Elmira	72	(24)	48
Greater Binghamton	90	(30)	60
Hutchings	119	-	119
Kingsboro	165	-	165
Manhattan	230	(52)	178
Pilgrim	385	(50)	335
Rochester	145	(58)	87
Rockland	430	(25)	405
South Beach	300	-	300
St. Lawrence	65	(25)	40
Washington Heights	21	-	21
<b>Adult Total</b>	<b>2,866</b>	<b>(314)</b>	<b>2,552</b>
<b>TOTAL</b>	<b>3,326</b>	<b>(399)</b>	<b>2,927</b>

\* 38 children's beds will be converted to crisis/respice beds as an offset to the 85 children's bed reduction; totaling to a net reduction of 47 facility-based children's beds. Also 168 Home and Community Based Service waiver slots will be available to provide alternatives to an inpatient admission and provide quality focused care with a child and their family in their home.





