Brief Background

- New York State hopes to enroll all Medicaid beneficiaries into some form of care management by June 2013.
- Enacted MRT recommendation authorizes OMH and OASAS to jointly contract with one or more regional Managed Behavioral Health Organizations.
- Implementation is divided into two phases:
  - Phase I – Currently in Phase One- the services to be provided are described in the June 24, 2011 Selection Process document instructions.
  - Phase 2 – Design to be shaped by MRT behavioral health subcommittee, this is currently underway.
  - Separate bid for risk bearing managed care entity for behavioral health.
BHO – Phase I

- Up to five regional contracts.
  - Conditional awards are being made now

- Goals
  - Monitor behavioral health inpatient length of stay;
  - Reduce unnecessary behavioral health inpatient hospital days;
  - Reduce behavioral health inpatient readmission rates;
  - Improve rates of engagement in outpatient treatment post discharge;
  - Better understanding of the clinical conditions of children diagnosed as having SED;
  - Profile provider performance; and
  - Test metrics of system performance
Phase 1 Population Focus

- No covered lives
- **Monitors inpatient and discharge planning for Fee for Service**
  - Admissions to OMH-licensed psychiatric units (**all ages**) in general hospitals (Article 28 hospitals);
  - Children and youth admitted to OMH licensed psychiatric hospitals (Article 31 hospitals);
  - Children and youth direct admissions (i.e., not transfers) to OMH State operated children’s psychiatric centers or children’s units of psychiatric centers;
  - OASAS certified hospital (Art 28/32) or freestanding (Article 32 only) Part 818 Chemical Dependence Inpatient Rehabilitation Services; and
  - OASAS Certified Part 816 Inpatient Detoxification Services (Article 28/32).
- Tracks children identified as SED by mental health outpatient clinics
- Excludes Medicare/Medicaid Duals in year 1
Additional Capabilities

- Capabilities
  - Define, engage and link cohorts of disengaged or high risk individuals to appropriate treatment
  - Review outpatient engagement for post discharge follow up care
  - Suicide prevention for high need/high risk populations discharged from inpatient settings.
  - Reducing costs for people with high cost physical and behavioral health conditions.
  - Behavioral health emergency diversion/inpatient diversion
Phase 1 BHO

4 of 5 Regional BHOs identified

- New York City Region: OptumHealth
- Hudson River Region: Community Care Behavioral Health
- Central Region: Magellan Behavioral Health
- Western Region: New York Care Coordination Program

A final determination has not yet been made in the Long Island Region.
Phase 2 BHO

- Behavioral Health Work Group (Co-Chairs Hogan and Gibbs) was charged by the MRT with helping to establish the parameters of the transformation to care management for New Yorkers with mental illnesses and substance use disorders.
  - Will consider various payment and delivery models that support the integration of substance abuse and mental health services, as well as the integration of these services with physical health.
  - Will examine opportunities for the co-location of services and also explore peer and managed addiction treatment services and their potential integration with Behavioral Health Organizations (BHO).
  - Will provide guidance about health homes and propose other innovations that lead to improved coordination of care between physical and mental health services.
Phase 2 BHO

- Ad hoc workgroup charged with developing set of recommendations specific to the unique needs of children and their families
**Children’s Workgroup Membership**

*Chair:* Gail B. Nayowith, Executive Director, SCO Family of Services

Euphemia S. Adams, Executive Director, Families on the Move NYC, Inc.

Scott Bloom, Dir of School MH Services, NYC DOE,NYCDOHMH

Lauri Cole, Executive Director, NYS Council Community Behavioral Healthcare

Carmen Collado, Dir of Public Policy and Government Relations, JBFCS

Kevin Connally, Executive Director, Hope House, Albany

John Coppola, Executive Director, Assn of Addiction Providers of NYS

Phil Endress, Commissioner of Mental Health, Erie County DMH

William Gettman, Executive Deputy Commissioner, OCFS

Steven Hanson, Acting Associate Commissioner, NYS OASAS

Adam Karpati, Executive Deputy Commissioner, NYC DOHMH

Danielle Laraque, M.D., Chair of Pediatrics, Maimonides

Brian Lombrowski, Youth Advisor, NYC Field Office, NYS OMH

Angel Mendoza, M.D., Asst Commissioner, ACS

Paige Pierce, Executive Director, Families Together in NYS

Jim Purcell, CEO, Council of Family and Child Caring Agencies

Kathy Riddle, Executive Director, Outreach Development LI and Queens

Kristin Riley, Deputy Commissioner, NYS OMH

Phil Saperia, Executive Director, The Coalition of Behavioral Health Agencies

Glenn Saxe, Chair, Child Psychiatry New York University

Andrea Smyth, Executive Director, NYS Coalition for Children’s MH Services

Phyllis Silver, President, Silver Health Strategies

Lauren Tobias, Assistant Director, Division of Financial Planning and Policy, DOH
While...our charge related specifically to children with Medicaid and their families.....

We found it **ESSENTIAL** to meld research, experience and collective children’s CONTEXT into universal statements for children and their families.

These should be New York State’s core expectations for all payers of behavioral health services for children.
The following identifies the building blocks that support a comprehensive operating framework:

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

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

- Peer and family support, self help and natural supports should be integrated with other behavioral health services to empower children and their families, offer choice in approach to care and reduce reliance on formal systems of care.
The following identifies the building blocks that support a comprehensive operating framework:

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

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

- Outcomes of behavioral health services for children and their families should be clearly articulated, measured, reported and used to inform policy, services, reimbursement and practice quality. Outcome measures should be reported at the child, provider, system and population levels.

- Accountability mechanisms should focus on achieving specific child outcomes.

- Accountability should occur at the BH provider level and occur across relevant child-serving systems. BH outcomes for children are often achieved by services that extend beyond the BH system.

- Outcome data should be used to improve the quality of services and be linked to performance incentives.
The following identifies the building blocks that support a comprehensive operating framework:

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

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

- Continuity of the child’s care and relationship with primary care and behavioral health providers should be maintained regardless of changes in health insurance coverage or managed care plan.
The following identifies the building blocks that support a comprehensive operating framework:

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

- **Financing mechanisms** should incentivize clinical outcomes and coordinated case planning. Entities receiving behavioral health financing must exercise the highest degree of fiscal integrity, transparent reporting and quality practice to create a high-performing, high-quality system of care.
The following identifies the building blocks that support a comprehensive operating framework:

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

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

(**Children relates to infants, children, adolescents and young adults from birth to 21 years**)
Recommendations Children’s Behavioral Health Managed Care

1. Identify the core elements of the benefit package and priorities for the basic Medicaid Managed Care, Child Health Plus, Family Health Plus and Commercial Insurance Plans.

2. Identify the enhanced elements of the benefit package and processes for a Special Behavioral Healthcare Managed Care Plan for children with special needs.

3. Develop outcome measurements and standards to review program performance.
Core behavioral health standards for children should be met by all public and private health insurance plans.

Access

Medical Necessity

Basic Behavioral Health Benefit

Provider Network

Fiscal

Outcomes
#2 Children with SED/SUD, Complex Symptoms and Behaviors Should Be Served in Specialty Behavioral Health Managed Care for Children with Medicaid.

- A specialty managed care program should be designed for children eligible for Medicaid who meet defined clinical criteria (DSM diagnosis of serious emotional disturbance or substance use disorder) or who display complex symptoms and behaviors AND meet a risk assessment threshold. Children meeting the clinical criteria above and who also have an individualized educational plan (IEP) or are served in the child welfare or juvenile justice systems would have presumptive eligibility.
Children with SED/SUD, Complex Symptoms and Behaviors Should Be Served in Specialty Behavioral Health Managed Care for Children with Medicaid.

- Access
- Medical Necessity
- Basic Behavioral Health Benefit
- Provider Network
- Fiscal
- Outcomes
- Identify what services would be included in an enhanced benefit
#3 Behavioral Health Outcomes to be used by All Plans and Payers

- Overall outcomes should be specific and relevant to children and:
  - Meaningful: they are indicators that capture what we are trying to achieve through BH interventions including: symptom reduction, risk reduction, improved functioning and well-being
  - Easy to measure: they are indicators that will be used universally by all plans and must not be too burdensome to implement
  - Validated and readily available: they are indicators that are based on established measurement tools with established validity, reliability and are available in the public domain (don’t require purchase)
  - Easy to use: they are indicators that can be used relatively easily to improve quality
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#3 Behavioral Health Outcomes to be used by All Plans and Payers

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

- The public should have open access to regular performance reports for the BHO and for behavioral health services in basic plans.
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#3 Outcome Areas:

- Improvement in psychiatric symptoms for which treatment is sought
- Improvement in functional status (e.g. social, school function)
- Consumer Satisfaction/Involvement
- Critical incidents
- Success/failure at transition to less intensive level of care
- Access to services
- Medication Management
- Cross Systems Communication/Case Planning
- Network Adequacy
Next Steps:

- MRT BHO workgroup report to be finalized by mid November and presented to Governor
- Children’s workgroup to begin task of developing alternative health home model/care coordination approach for children with serious behavioral disorders by December 31, 2011.