## EXECUTIVE SUMMARY

The New York Care Coordination Program (NYCCP) wishes to work with New York State to design and implement a specialized health home services program to coordinate physical health, behavioral health and social services for children with serious emotional disturbance and adults with serious mental illness.

NYCCP has implemented person-centered service planning and care coordination programs in diverse service environments in urban and rural counties, with a documented record of improving individual outcomes and reducing Medicaid and other government costs. (See Appendix B.) The proposal that we offer is based on our experience working with people with serious mental illness, and lessons learned from our own efforts to create the structural components of a health home model, described at pages 6 to 9.

People with serious mental illness often have complex, co-occurring physical health disorders. They are often not well understood or well served by primary care providers. But very few behavioral health agencies have the resources or expertise to deliver primary physical health services onsite. Widespread implementation of a comprehensive health home services program will require partnerships between independently operated behavioral health and primary care organizations, and the nature of those partnerships will vary.

This proposal suggests a flexible, functionally oriented, system to foster rapid development of the health home program, distributing responsibility for operation of the program between a specialized health home organization and direct care providers.

As described at pages 10 to 12, a specialized health home organization (such as NYCCP) would: (i) provide the infrastructure to support operation of the health home program (including case finding, complex case management, information technology, outcomes measurement, adoption of evidence based standards of practice, education and training); (ii) work with HMOs and County mental health departments to develop local networks of primary care and behavioral health home providers and coordinate payer case management efforts; (iii) contract with local providers for the delivery of health home services; (iv) monitor outcomes and provide continuous quality improvement; and (v) ensure regulatory compliance.

Direct care providers would (i) provide behavioral health, physical health and social assessment services; (ii) work with individuals to develop person-centered services plans; (iii) provide referrals to needed physical health, behavioral health and social services (directly, or in consultation with Complex Case Managers from the Health Home Agency); (iv) assist individuals in gaining access to service; (v) assist in arranging transitional care between inpatient and outpatient services and between child and adult systems of care; (vi) monitor the well-begin of participating individuals and revise services plans as appropriate; and (vii) be required to submit Continuity of Care Documents to the health home network, in standard electronic formats whenever possible.

Specialty health homes would be a critical structural support for any managed care program that serves children with serious emotional disturbance or adults with serious mental illness. Our suggested approach to development of the program could be replicated statewide, allowing the State to ramp up quickly and take advantage of 90% federal financial participation for the first two years of operation.

For more information about NYCCP or this proposal, please contact Adele Gorges, Executive Director, at 585-613-7656 or agorges@ccsi.org.

## INTRODUCTION

NYCCP is a collaborative undertaking by county governments, providers and consumers who share interests in promoting recovery and conserving resources for the support of children with serious emotional disturbance and adults with serious mental illness. Stakeholders from Erie, Monroe, Onondaga, Wyoming, Genesee, and Chautauqua counties have worked together since 2000. Westchester County joined the consortium in 2009. Stakeholders from each county actively participate in program planning, governance, working groups, and training programs. Our work is based upon a common belief in recovery, and a holistic, person-centered approach to planning and delivery of health, behavioral health, and social support services.

The counties, providers and consumers that participate in NYCCP have learned a great deal about operation of person-centered systems of care for children and adults diagnosed with serious mental illness. Our case finding, person-centered care coordination, complex case management, and outcomes monitoring have resulted in significant reductions in Medicaid and other government costs of service to high-risk children and adults. There have been fewer emergency room visits, fewer hospitalizations, and fewer arrests. Service recipients report improved quality of life, and a high level of satisfaction with the program.

NYCCP recognizes that New York State must control Medicaid costs, including the cost of behavioral health services to all populations and the cost of all Medicaid services to children with serious emotional disturbances and adults with serious mental illness or chemical dependency.

The cost of service to people with serious mental illness is particularly high. 20% of the users of Medicaid funded behavioral health services account for 80% of total Medicaid costs to all users of those services. In one recent analysis of an upstate County, Medicaid costs for the top 10% of users was $42,000/year, of which 41% was for physical health, 33% for mental health, 20% for pharmacy and 6% for substance abuse service. 75% of this high needs population were not receiving targeted case management or ACT services. A recent analysis for another large upstate county revealed a significant population of individuals with multiple mental health, physical health and chemical dependency inpatient admissions within a 90-day interval. The multiple admission population exhibited low use of mental health outpatient and case management services.

NYCCP believes that one way to control Medicaid costs is for the State to take advantage of section 2703 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), which allows States to amend their State Medicaid Plans to provide "Health Homes" to enrollees with chronic conditions, including mental health conditions, substance abuse disorders, asthma, diabetes, heart disease and being overweight (BMT > 25). Planning grants are available to States to support development of required State Plan amendments. For the first two years after approval of the State Plan amendment, federal financial participation will be 90% of the Medicaid costs for health homes for people with chronic conditions.

The Centers for Medicare and Medicaid Services (CMS) is encouraging States to take advantage of this opportunity, emphasizing the importance of taking a "whole-person" approach to planning and coordination of physical health, behavioral health and social support services to people with chronic conditions. On November 16, 2010, the Centers for Medicare and Medicaid Services (CMS) sent a letter to State Medicaid Directors and State Health Officials with preliminary guidance regarding implementation of health homes.

As stated by CMS…

> *The health home provision authorized by the Affordable Care Act provides an opportunity to build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for State Medicaid programs. This provision supports CMS's overarching approach to improving health care through the simultaneous pursuit of three goals: improving the experience of care; improving the health of populations; and reducing per capita costs of health care (without any harm whatsoever to individuals, families, or communities).*
>
> *The health home service delivery model is an important option for providing a cost-effective, longitudinal "home" to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. While there is still much to learn, we expect that use of the health home service delivery model will result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual.*
>
> *Health homes can play a particularly pivotal role in improving the health care delivery system for individuals with chronic conditions. Consistent with the intent of the statute, we expect States that provide this optional benefit, and the health home providers with which the State collaborates, to operate under a "whole-person" philosophy – caring not just for an individual's physical condition, but providing linkages to long-term community care services and supports, social services, and family services. The integration of primary care and behavioral health services is critical to the achievement of enhanced outcomes.*

Health home services include comprehensive care management, care coordination and health promotion, comprehensive transitional care, including appropriate follow-up, from inpatient to other settings, patient and family support, referral to community and social support services, and use of health information technology to link services, as feasible and appropriate.[1] All of these are services currently provided by NYCCP stakeholders.

People with serious and persistent mental illnesses such as schizophrenia and bipolar disorder are often in poor physical health - the result of poverty, poor diet, and side effects of anti-psychotic medications. There is a high incidence of smoking, obesity, and co-occurring diabetes, cardio-pulmonary disease, and substance abuse disorders. But the quality of physical health services to people with serious mental illness if often poor. A recent article in *Health Affairs* documents this problem.[2]

> *A health assessment of a sample of patients with schizophrenia found that 88 percent of those with elevated cholesterol and 62 percent of those who met criteria for hypertension were not receiving appropriate medications. Furthermore, recent evidence indicates that people with severe and persistent mental disorders who do receive medical care are less likely to receive care that meets clinical guidelines, compared to the rest of the population.*

Integration of primary care and behavioral health services is indeed critical to achievement of enhanced outcomes and reduced medical costs. Yet a primary care setting may not be the right venue for a health home for many people with serious mental illness. Many people with SMI have established, trusting relationships with behavioral health providers who serve as their primary point of contact with the health system. And many primary care practitioners lack experience in treatment of people with serious mental

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[1] Social Security Act § 1945

[2] Specialty Care Medical Homes For People With Severe, Persistent Mental Disorders ~ Alakeson et al. 29 (5): 867 ~ Health Affairs, 2010

illness, or the time required to fully assess an individual's physical health, mental health and social support needs and develop a holistic plan of care.

Only a few providers offer a complete range of physical and behavioral health services for people with serious mental illness at one location, creating the ideal setting for a health home for their patients. (The Strong Ties program in Rochester, NY is an example.) With those few exceptions, any effort to establish health homes for people with serious mental illness will require the creation of effective working partnerships between independently operated behavioral health and primary care providers. The optimal approach to creation of those partnerships will vary based on local resources.

For example, a federally qualified health center or primary care practice might place a nurse practitioner within a community mental health center to provide screening, monitoring, and treatment of common physical health conditions. The primary care organization would supervise the nurse practitioner, and secure referrals to specialty medical services. (This is similar to the relationship between the University of Buffalo Family Medicine practice and Lake Shore Behavioral Health). Or the primary care organization might place a nurse care manager within the behavioral health setting to facilitate access to primary care services off site. The nurse care manager would not provide direct care but, rather, act as a source of information for patients and behavioral health care coordinators and as a broker between patients and medical care providers. (This approach has been used successfully in Wyoming County.) In these examples, the behavioral health provider would serve as the health home. Alternatively, a federally qualified health center might serve as the health home, with consultation regarding development of a holistic person-centered plan of care and ongoing monitoring of an individual's well being provided by a behavioral health worker placed on site by a community mental health center. (This approach is being explored in Westchester County.)

Fortunately, the statutory definitions of a "designated provider", "team of health care professionals", or "health team" that may provide health home services are extremely flexible.[3] The CMS letter to State Medicaid Directors emphasizes that the States have flexibility in their State Plan Amendments in their description of the entities that may operate a health home program. For example, it notes that a "*designated provider*" may include entities other than those listed in the statute[4], including "*agencies that offer behavioral health services*", and that "*teams of health care professionals" may operate in a variety of ways, such as free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary*.

Regardless of the provider arrangement(s) a State may offer, CMS expects States to require health home providers to meet CMS standards for operation of a health home.

States are also expected to describe the infrastructure in place to provide timely, comprehensive, high-quality health home services. The CMS letter says:

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[3] Social Security Act §§ 1945(a), 1945(h)(5), 1945(h)(6), 1945(h)(7)

[4] Section 1945(h)(5) of the Act includes examples of providers that may qualify as a "designated provider," such as physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined appropriate by the State and approved by the Secretary.

*The State must describe in its SPA the methods by which it will support providers of health home services in addressing the following components:*

- *Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;*
- *Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;*
- *Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;*
- *Coordinate and provide access to mental health and substance abuse services;*
- *Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;*
- *Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;*
- *Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;*
- *Coordinate and provide access to long-term care supports and services;*
- *Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;*
- *Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and*
- *Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.*

NYCCP offers much of this infrastructure, as described in the Proposal that follows.

(Continued on following page)

## PROPOSAL

NYCCP can help New York State to develop and implement health homes for people with serious mental illness by (1) providing a structure to support operation of health home programs, and (2) serving as a catalyst for development of local networks of specialized health homes.

### 1. **Support Structure**.

The New York Care Coordination Program has many of the capabilities required to help New York State implement a health home program for people with serious mental illness. These capabilities include:

a. Case Finding

NYCCP currently has access to Medicaid claims data for six of the seven NYCCP participating counties. Through our association with Coordinated Care Services, Inc. we have the capability to receive, process, and analyze Medicaid data to identify individuals with serious mental illness and co-occurring disorders who are underserved and who might benefit from participation in the health home program. We currently use this capability to identify high-need high-risk individuals who might benefit from our Complex Care Management program (described below).

b. Person Centered Services Planning

NYCCP has established state of the art practices for Person Centered Services Planning for people with serious mental illness. Working with nationally recognized experts, we have developed and conducted person centered planning training programs for behavioral providers throughout the NYCCP service area. We have developed online programs to enable practitioners to develop their skills in person centered planning. This work has resulted in a significant shift in philosophy and practice by providers, improved outcomes, and decreased Medicaid costs.

c. Coordination and Access to Community, Social Support and Recovery Services.

The participation of County governments is critical to efforts to identify children and adults with chronic conditions, manage the transition from child to adult systems of care, arrange social services, and manage access to housing programs. All of the activities are essential to operation of a health home program.

The County Departments of Mental Health that participate in the NYCCP program operate "Single Points of Access" to evaluate the needs of individuals with serious mental illness, arrange placement in targeted case management and/or residential programs, arrange for social support services, and interface with school systems and criminal justice systems as appropriate. NYCCP supports County operations through an online SPOA application, education and training programs, and the Complex Care Management program.

The State's non-Medicaid local assistance to County behavioral health departments is essential to the management of local systems of care, to the provision of "wrap-around" services that help high risk people live in the community, and to the provision of clinical services to people who are not Medicaid eligible

Recovery is a fundamental value of the Care Coordination Program. We support this through person-centered planning, active involvement of consumers in program operations, measurement of outcomes, and pay for performance programs.

d. Coordination and Access to Mental Health and Substance Abuse Services.

It is a core responsibility of all behavioral health providers to evaluate the needs of individuals and arrange access to appropriate mental health and substance abuse services. Targeted case management programs have an ongoing responsibility to monitor individual behavioral health, revise service plans as appropriate, and arrange access to services. As discussed below, NYCCP has endeavored to enhance this function through its complex care management program.

e. Complex Care Management

Working with Beacon Health Strategies, NYCCP has developed and field-tested a Complex Care Management program that includes many of the elements of a health home program.

Through analysis of Medicaid claims data and collaboration with County Single Point of Access programs and participating providers, we identify high-risk individuals with serious mental illness and co-occurring medical disorders who might benefit from greater co-ordination of physical and behavioral health services.

Participating behavioral health providers that operate targeted case management programs designate specially trained Complex Care Coordinators to work with consumers to develop person centered individual services plans, taking into consideration physical, behavioral health and social needs of individuals and individual interests.

Beacon Case Managers are experienced clinicians who are trained in identification and treatment of co-occurring physical and behavioral health disorders. They provide consultative support to provider Care Coordinators to help behavioral health providers to identify the physical health needs of individuals with serious mental illness and work with Health Maintenance Organizations to develop a services plan and arrange for the delivery of physical health services.[5]

Beacon Case Managers have access to Beacon's software system, which includes a Case Management record system and supports operation of the program.

Results to date for persons served by this Complex Care Management model show significantly shorter lengths of stay compared to typical targeted case management users.

f. Coordination of Physical and Behavioral Health Services

The single greatest challenge for anyone interested in developing health homes for people with serious mental illness will be to forge working relationships between behavioral health providers, primary care organizations, and health maintenance organizations. It will be necessary to identify and enlist the cooperation of primary care organizations that are willing to serve people with serious mental illness and work with behavioral health agencies that serve as the health home. It will also be necessary to coordinate efforts by HMO case managers, behavioral health case managers and primary care providers.

The resources, cooperation and good will of HMOs that provide physical health benefits to people with serious mental illness will be essential to implementation of a successful health home program. HMOs are

[5] Beacon also works with New York State based Medicaid Health Maintenance Organizations to help HMOs manage care of individuals with chronic physical illnesses who may have co-occurring behavioral health disorders.

likely to benefit from such a program through reduced physical health costs of care of people with serious mental illness. NYCCP is hopeful that the NYS Department of Health will create incentives for HMOs to cooperate with NYCCP and other behavioral health agencies that wish to create specialty health home programs. If this program is to expand quickly, it will be important for HMOs to support it by promoting primary care provider participation, and arranging appropriate compensation of primary care providers that are prepared to take the time required to work with people with serious mental illness. HMO case management efforts should be informed by and coordinated with those of organizations such as NYCCP that have deeper experience in working with this highly vulnerable population and coordinating health, social services and recovery support services.

Over the past several years, NYCCP and its stakeholders have implemented several initiatives to promote better services planning and coordination of physical health and behavioral health services for people with serious mental illness.

- The Monroe County Department of Mental Health worked with the Monroe Plan for Medical Care to develop and pilot test a program to identify Monroe Plan enrollees with chronic co-occurring physical and behavioral health conditions and integrate individual services planning and case management efforts by the Plan and provider care coordinators. Among the things learned in that pilot was that there was remarkably little overlap between the population of people identified by the Monroe Plan as having serious mental illness and chronic physical health problems and the population served by targeted behavioral health case management programs. A second finding was that the cultures of physical and behavioral health providers were very different, and that it each group to learn about the culture of the other in order to have integrated services.

- In its implementation of the Complex Care Management program, case managers from Beacon Health Strategies met with and developed contacts with the case management staff of every Medicaid HMO that operates in the area served. The Beacon case managers have expertise in coordination of physical and behavioral health treatment of people with serious mental illness and provide a bridge between the HMOs and the behavioral health providers that have the principal day-to-day contact with individual patients.

- Working with a University of Rochester consultant, NYCCP developed training programs for behavioral health care coordinators to inform them about the physical problems commonly suffered by people with serious mental illness and coordination of physical and behavioral health services.

Certainly, these efforts would have to be expanded to support widespread implementation of a specialty health home program, but NYCCP has the foundation to begin that effort.

g. Health Promotion.

NYCCP has had a Health Promotion Committee for several years. This group has worked actively to promote smoking cessation programs targeted to people with serious mental illness.

NYCCP also implemented the "Well-Balanced" pilot program in cooperation with the University of Rochester School of Nursing. In Monroe County, registered nurses provided outreach and disease management support to 80 seriously mentally ill individuals with co-occurring diabetes. Wyoming County served 30 individuals through an imbedded nurse at the mental health center, and targeted multiple health issues. Both projects used the same health risk assessment and outcome measures. The short-term clinical results, measured by weight and blood glucose levels, were good, but it was an expensive program for a behavioral health agency to implement. A successor program in Monroe County has identified Peer

Wellness Coaches as a possibly more cost efficient and equally effective alternative. Hopefully, development of a specialty health home program oriented towards long-term health and wellness will allow a return to this type of initiative.

h. Evidence Based Clinical Practice Guidelines.

Working with Beacon Health Strategies, behavioral health providers, and consumers, NYCCP developed Level of Care criteria as guidelines for admission to and continuing service in mental health and chemical dependency treatment programs. These guidelines are consistent with regulatory criteria for behavioral health programs established by the Office of Mental Health and the Office of Alcohol and Substance Abuse Services. These guidelines serve as the foundation for a nascent utilization management program.

NYCCP has established practice guidelines for person-centered services planning for people with serious mental illness, published those guidelines, and provided training programs about person-centered planning for providers throughout the region, including care coordinators, inpatient and outpatient service providers, and housing providers.

NYCCP does not have clinical practice guidelines for physical health services to people with serious mental illness. We are prepared to work with New York State and our physical health partners to develop and promote acceptance of those guidelines.

i. Continuous Quality Improvement.

NYCCP is a data driven project. We continuously monitor the cost of service, individual outcomes, and individual satisfaction with the program. We monitor emergency room utilization; hospital admissions and readmissions; cost of physical health, mental health, substance abuse treatment, and pharmacy services; provider adherence to the principals of person-centered planning; recipient reported quality of life; recipient reported satisfaction with the program; arrests; availability of stable housing; and participation in gainful activity. Our results are described in Appendix B.

j. Use of Information Technology.

NYCCP uses information technology extensively through analysis of Medicaid claims and patient outcomes data for purposes of case finding, continuous quality improvement, and program performance measurement. We have the ability to generate reports on claims data to present case managers with an overview of an individual's previous diagnoses, medications, and utilization of physical health and behavioral health services. We have an online application for use by County Single Point of Access programs to provide a point of referral of high needs individuals to behavioral health programs. Beacon Health Strategies has its "Flex-Care" information management system, which supports the Complex Case Management program. We plan to augment these capabilities to facilitate real-time services planning and information exchange between health home providers, using standard data exchange formats established by the Office of National Coordinator for Health Information Technology.

## 2. Catalyst for Development – The Health Home Network

If the State chooses to submit a State Plan Amendment to permit implementation of a health home program for people with serious mental illness, it will have a strong interest in ramping up this program quickly so as take advantage of the opportunity for 90% federal financial participation in the cost of health home services for the two year period following approval of the State Plan.

As discussed earlier, behavioral health providers, particularly those that currently provide case management services, are likely to be the best venue for delivery of health home services to many people with serious mental illness. While behavioral health providers are likely to have a strong interest in the health home program, relatively few will be immediately prepared to comply with all of the CMS standards. As also discussed, it will be necessary to create partnerships between behavioral health providers and physical health providers, and the nature of those partnerships will vary.

There are two ways in which NYCCP can help the State achieve the goal of rapid development of a specialty health home program.

First, we can provide the infrastructural support for the health home program described in part 1 of this proposal, and consult with County governments and behavioral health providers to support local development efforts.

The second model would be for the State to designate regional entities that have experience in coordinating care to people with serious mental illness (such as NYCCP) as specialty health home organizations that deliver services through networks of qualified providers. The health home entity would provide the infrastructure for operation of the program and would be accountable to the State for compliance with health home standards. It would have the flexibility to contract with direct care providers to deliver components of the health home service based on available local resources. This would allow smaller providers to participate in delivery of health home services without requiring them to establish co-located physical and behavioral health programs or to meet all health home program requirements. It would allow the State greater flexibility in definition of payment methodologies for health home services.

A question for the State to consider is whether it would be necessary for such a health home organization to be a licensed Medicaid provider. The CMS Letter to State Medicaid Directors emphasizes that State's have flexibility in their designation of entities that are qualified to deliver health home services. It does not say this explicitly, but it *suggests* that a State may deem accountable care organizations, provider networks or managed care organizations to be appropriate entities to provide the systems and infrastructure to support delivery of health home services by contracted providers.[6]

Essentially, we are proposing that the State designate NYCCP as a behavioral health accountable care organization that will arrange for the delivery of health home services in collaboration with local providers and managed care organizations. [7]

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[6] This inference is supported by CMS's description of the history of Medicaid involvement in medical home models and delivery systems, the goal of expanding the traditional medical home models to build linkages to other community and social supports, and its note that some States are using full-risk managed care plans to implement medical homes. It is also supported by CMS's discussion of the possibility that States may choose capitation as a method of payment for health home services.

[7] Another question for the State is whether a health home organization that delivers services through a contracted network of providers and which is not a licensed managed care organization must be qualified as an independent practice association.

This "Specialty Health Home Network" organization would:

- Contract with the State to arrange for the delivery Health Home Services to designated populations;
- Collaborate with County Local Governmental Units and area HMOs in development of networks of behavioral health and physical health providers that will collaborate in delivery of health home services;
- Assist behavioral health providers in development of affiliation and linkage agreements with primary care organizations;
- Adopt evidence-based standards of practice for delivery of physical health and behavioral health services to people with serious mental illness;
- Enter provider agreements with participating providers;
- Provide education and training to Care Coordinators identified by participating behavioral health providers;
- Provide education and training to primary care providers regarding person-centered care of the physical health needs of persons with serious mental illness;
- Review Medicaid data to identify candidates for health home services;
- Provide a point of referral to health home services;
- Work with consumers, health home providers and HMOs to arrange for health home services;
- Provide Complex Care Management services to support direct care providers;
- Provide Information Technology required to support operation of the Health Home Program;
- Maintain a Personal Health Record for participating individuals, accessible to treating providers as permitted by the individual;
- Pay providers for delivery of Health Home Services;
- As agreed by State and County government, pay for the delivery of supplemental primary care or behavioral health services to people enrolled in the health home program;
- Gather quality outcomes data as required by CMS and the State; and
- Monitor and evaluate program performance based upon Medicaid data analysis and analysis of outcomes and consumer satisfaction.

(Continued on following page)

In this model, Contracted Direct Care Providers would:

- Develop linkage agreements between behavioral health and physical health providers;
- Provide behavioral health assessment;
- Provide physical health assessment;
- Ensure that Complex Care Coordinators are appropriately qualified and trained (qualifications to be discussed);
- Work with individuals to develop person-centered services plans;
- Directly, or in consultation with Complex Care Managers, provide referrals to needed physical health, behavioral health and social services;
- Assist individuals in gaining access to services;
- Assist in arranging transitional care between inpatient and outpatient services, and between child and adult systems of care;
- Monitor the well-begin of participating individuals and revise services plans as appropriate;
- Be required to submit Continuity of Care Documents to the health home network, in standard electronic formats whenever possible.

(Continued on following page)

**Questions/Issues for Discussion**

This proposal offers a structure for development of a specialty health home program for children with serious emotional disturbance and adults with serious mental illness. It does not address a number of questions that require discussion with State agencies, including:

- Does the State have any preliminary ideas about payment methodologies for health home services?

- Do State Medicaid payments to HMOs account for the time required for primary care providers to treat people with serious mental illness? Do HMO payments to primary care providers allow these providers to deliver care to this population? Are they sufficient to allow primary care providers to collaborate with behavioral health providers in delivery of health home services for people with serious mental illness? Should a specialty behavioral health home organization purchase services directly from primary care providers?

- How can DOH promote cooperation between HMOs and specialty health home organizations?

- What is the relationship between specialty health home services for people with serious mental illness and targeted case management services such as Intensive Case Management or ACT? Should "health homes" replace targeted case management programs? If so, how can this transition be staged?

- What would it cost to operate a "Specialty Health Home Network" program? Is this cost effective? Do federal rules allow for Medicaid reimbursement of this cost?

- Is it necessary for a licensed Medicaid provider to operate the "Specialty Health Home Network"? Does that impact federal reimbursement of the cost of the program? Would it be necessary to establish an Independent Practice Association?

- If it is necessary for NYCCP (or others) to upgrade its health information technology to facilitate information exchange between behavioral health and primary care providers that participate in the specialty health home program, can the State provide financial support for this infrastructure development using funds made available to the State by the Office of National Coordinator for Health Information Technology?

## Appendix A – Background About the New York Care Coordination Program

NYCCP is a collaborative undertaking by county governments, providers and consumers who share interests in promoting recovery and conserving resources for the support of children with serious emotional disturbance and adults with serious mental illness. Stakeholders from Erie, Monroe, Onondaga, Wyoming, Genesee, and Chautauqua counties have worked together since 2000. Westchester County joined the consortium in 2009. Stakeholders from each county actively participate in program planning, governance, working groups, and training programs. Our work is based upon a common belief in recovery, and a holistic, person-centered approach to planning and delivery of health, behavioral health, and social support services.

The Care Coordination Program is moving along five related tracks towards behavioral health system transformation:

**1. Cultural Change**. First and foremost is the establishment of a positive culture for change through meaningful, substantial, and continuous participation by local stakeholders. The Care Coordination Program is governed by a Steering Committee that includes county mental health directors, consumers, family members and service providers. We have created a learning community that values diverse views and focuses on common interests. This has enabled collaboration among counties, and among stakeholders who have different roles and experiences. Trust in the integrity and openness of the process has led to ground level support of program initiatives. The Care Coordination Program serves as a platform for dissemination of best practices across a diverse demographic and geographic area.

**2. Education and Training**. The Care Coordination Program has developed curricula and educational materials about person-centered planning and coordination of physical and behavioral health services to people with serious mental illness. We have ongoing education and training programs for provider agencies, clinical staff and consumers in each participating county, along with "train the trainer" programs and a website where people can practice application of the principals of person centered planning. All of this has resulted in a cultural shift throughout the region, and a refocus on the hopes and dreams of individuals that has led to demonstrable results.

**3. Data Analysis.** NYCCP is a data driven project. The participating counties have entered a Medicaid Data Exchange Agreement with the Office of Mental Health and worked with OMH to establish protocols to secure current Medicaid claims data for recipients of mental health services in the seven participating counties. We use data to identify high needs individuals, and to support outreach, complex care management, and continuous quality improvement of local behavioral health service systems.

In 2006, we obtained permission from the federal government to receive Medicare Data for six counties, enabling CCSI to analyze utilization patterns and total costs of care of Erie and Monroe County residents who were dually eligible for Medicare and Medicaid in 2005. Now that we have Medicaid claims data for all of the participating counties, we intend to renew this data request.

**4. Performance Measurement.** NYCCP continuously measures the performance of its program. Our current performance measures include:

Medicaid utilization and costs – An independent study by the Office of Mental Health confirms that utilization and costs are lower in the participating counties than in a comparable group of NYS counties. Our own studies confirm favorable cost trends for combined physical and behavioral health costs as compared to the rest of New York State.

Quality of Life Indicators – We periodically collect information to assess the impact of the Care Coordination Program on participating service recipients. These indicators include gainful activity, arrests, physical harm to others, suicide attempts, self-harm, emergency room visits, and days spent in a hospital. All indicators suggest that the Care Coordination Program has had a positive impact on participants.

Quality of Provider Individual Services Plans - Each year, the participating counties review sample individual services plans, using common standards and testing for inter-rater reliability. These reviews reveal steady improvement in the degree to which services plans are individualized and reflect client goals and objectives for recovery.

Recipient Satisfaction - Our efforts to establish person-centered approaches to service are reflected in the generally positive attitude of enrollees about the services planning process being person-centered and recovery-focused and improved ratings for the efficacy of services, as indicated by enrollee surveys.

**5. Direct Services.** The Care Coordination Program has taken a number of steps to improve the quality of services to participating recipients. These include: education and training regarding person-centered planning; development, testing, and ongoing improvement of common instruments for individual services planning and outcomes measurement; and establishment of pilot programs for coordination of physical and mental health services to people with co-occurring physical and mental illnesses.

Together with Beacon Healthcare Strategies, we have developed and implemented a Complex Care Management Program for individuals identified as being at high risk of inpatient admission or with complex co-occurring physical and mental illnesses.

The Complex Care Management (CCM) model serves individuals with serious mental illness and complex behavioral health and medical needs, who have had issues engaging successfully with providers, and with over/under-utilization of appropriate services. The program is short term (3-6 Months), and is designed to help identify and address barriers to care, facilitate coordination among behavioral health and medical providers, and then transition individuals to a constellation of services and supports within the community so that they can move towards greater self-management of their health care. An individual's participation is voluntary; and person-centered approaches are utilized to support recovery goals. Direct services are provided by Complex Care Coordinators who are intensive or supportive case managers, or are members of ACT teams in Erie, Monroe and Onondaga Counties. Beacon's Complex Care Managers each work cooperatively with multiple provider based Complex Care Coordinators to identify individuals with complex medical conditions, conduct outreach, engage individuals, develop person-centered services plans, and work with physical health providers to arrange necessary medical care. Beacon's role is educational and consultative.

**6. System Restructuring and Managed Care.** For several years, NYCCP has worked to design and implement organizational and financial structures to support long-term improvement of the quality and appropriateness of services, considering the interests of consumers, providers, and government at all levels.

In cooperation with OMH, we developed and have implemented a "*Pay for Performance*" demonstration program to align the interests of participating Community Mental Health providers and County Departments of Mental Health. The Pay for Performance program establishes performance measures focused on access to care, fidelity to person-centered practices, and recovery. It provides fiscal incentives to providers to achieve improved outcomes at the individual consumer level as well as at the county mental health systems level. So far, the program has been implemented in Erie and Monroe Counties. The program will be extended to other participating counties in the future.

In 2009, NYCCP entered a partnership with **Beacon Health Strategies** to take the first steps towards establishing managed local/regional systems of care for the delivery of behavioral health services and coordination of physical and behavioral health services to people with serious mental illness. Together with Beacon, we have taken a number of steps towards achievement of this goal:

Beacon has conducted a ***System of Care Readiness Assessment***, including an assessment of the managed care readiness of local behavioral providers and a Geo-Access analysis to identify potential gaps in a NYCCP provider network.

A multi-disciplinary workgroup of providers and consumers worked with Beacon to develop ***Level of Care Criteria***, consistent with OMH and OASAS regulations, to be applied for purposes of determining the appropriateness of admission to and continued treatment of patients at various levels of care. These criteria are used in a ***Non-Binding Utilization Management*** program to help participating providers prepare for managed care for currently carved out services and avoid Medicaid disallowances.

Beacon and the participating counties have worked to improve the practices of local Single Points of Access by creating a standardized and secure system to allow providers, consumers and families to complete and submit an ***Online SPOA Application***. This on-line capability enables SPOA staff to complete SPOA evaluations via the Internet, with all evaluation and placement information being collected in a centralized database. Careful attention has been paid to protection of individual privacy and data security. We regard this as the first step towards development of a common Case Management Record for people enrolled in the Complex Care Management Program.

## Appendix B – Results of the Care Coordination Program

The following are measured results of the performance of the New York Care Coordination Program.

2008 Comparable County Medicaid Cost Comparison

Updated data comparing ICM/SCM/Blended/ACT recipients in 6 NYCCP counties to 6 comparable counties shows that costs per recipient are lower by 92% for inpatient, 42% for outpatient, 13% for community support, and 41% in total. Per person costs increased by 15% from 2003 to 2008 in the NYCCP counties compared to a 24% increase in the comparable counties.

2003 - 2008 Medicaid Claims Data - All Services

The rate of increase between 2003 and 2008 for total Medicaid costs for case management recipients is 8% for Erie and 13% for Monroe, compared to a 20% increase for individuals in the classification of NYS SSI/Disabled-Rest of State.

2009 Periodic Reporting Form Data

Analysis of data from the quarterly Periodic Reporting Form shows continuing positive changes in the lives of individuals enrolled in the Western New York Care Coordination Program – gainful activity up 31% (including a 51% increase in competitive employment), arrests down 25%, physical harm to others down 53%, self harm down 54%, emergency room visits down 46%, inpatient down 53%.

2009 Enrollee Satisfaction Survey

Year to year increases in enrollees reporting that services resulted in a better quality of life correspond with increases in enrollees reporting that services were person-centered – and the timelines correspond with training for person-centered practices.

2009 Review of Individual Service Plans for Person-Centered Practices

The 2009 survey of ISP's shows continuing improvement in the degree to which service plans reflect person-centered, recovery-focused practices, with higher ranking for the easier to achieve indicators. As easier indicators are achieved, they are being replaced by new indicators, including in 2008 ones related to employment and an integrated approach to physical and behavioral health.

2008 Physical Health Services Survey

The 2008 self-reported physical health survey results were largely similar to those obtained in 2004. Enrollees have significant physical health challenges with 64% being overweight or obese, 41% rating their health as fair to poor, 62% smoke, 49% had one or more emergency department visits for medical care, 28% had one or more hospital admissions for medical issues, 14% take 7-9 prescription medications and 11% take 10 or more. Although on the decline, failure to coordinate care between physical health and mental health providers remains a substantive challenge with 36% of total respondents reporting lack of communication between providers when a health concern in present.

2010 Cardio metabolic Indicators Survey

A survey of behavioral health providers showed that a policy for monitoring (1) smoking status was in place for 50% of respondents, (2) blood pressure for 44%, and (3) BMI for 26%. When policies were in place, respondents reported relatively high levels of medical staff adherence, potentially indicating the importance of establishing agency policies addressing key cardio metabolic indicators.

Non-medical staff involvement in monitoring these indicators was reported as 77% participating in monitoring for smoking status, 40% for body mass index and 24% for blood pressure. Further work will be done to explore how training for non-medical staff could assist in changing the behavioral treatment culture to one that supports recovery through integrated physical/ behavioral health promotion strategies.

Erie County Children's System of Care

- Average annual net savings* (actual cost reductions for Erie County) $2,000,000
- Over double the average annual number of youth served (2004–2009) 450 – 1103
- Over 50% reduction in number of youth placed in RTC (2004–2010) 228 – 108
- Over 55% annual reduction in acute inpatient bed days
- ALOS in acute psychiatric inpatient reduced from 29 days to less than 10 days
- 69% reduction in daily average secure detention census
- 70% reduction in average daily census in non-secure detention
- 76% reduction in Number of PINS youth placed on formal Probation
- Average increase in spending for community based services approximately $ 10,000,000

*Net Savings equal to total gross expenditures for Residential Services + expanded community based services calculated on an annual basis. Amount not adjusted for inflation based upon 2005 dollars.

(Continued on following page)

Westchester County Complex Case Management Program

N=31

| | Medicaid (other than hospital) | Incarceration | State Hospital | Total |
|---|---|---|---|---|
| 2007- 2008<br>Pre-Enrollment | $ 822,119 | $ 870,260 | $ 592,150 | $ 2,284,529 |
| 2008-2009<br>1 year after | $ 535,634 | $ 410,860 | $ 129,850 | $ 1,076,344 |
| Savings $ | $ 286,485 | $ 459,400 | $ 462,300 | $ 1,208,185 |
| Savings % | 35% | 53% | 78% | 53% |

In addition, there was a significant decrease in days of homelessness and an increase in attendance of chemical dependency treatment programs.