NEW YORK ASSOCIATION ON INDEPENDENT LIVING

CID-NY

Behavioral Health Organizations and the Expected Impact on People with Disabilities

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Community Health Advocates

Community Health Advocates (CHA) is a network of 31 organizations that assist consumers and advocates to navigate New York's healthcare systems and services. NYAIL and CIDNY partner to serve people with disabilities statewide through individualized counseling and group presentations. We help consumers to obtain and navigate coverage, and we help the uninsured to find free or low-cost care.

Behavioral Health Organizations and the Expected Impact on People with Disabilities

- The 2011-12 NYS Budget provided authority for OMH and OASAS to contract with regional Behavioral Health Organizations (BHOs).

- BHOs are targeted to persons with serious mental illness and/or substance dependence who have a history of:
  - multiple psychiatric admissions/readmissions
  - emergency service use
  - dependence relapses and detoxifications
  - incarceration
  - homelessness.

Behavioral Health Organizations

- The goal of BHOs is to transition from a fee-for-service environment to a care management environment, following the growing recognition that “unmanaged care” is no longer satisfactory for individuals with mental illness and that mental health care integrated with other physical and substance use services is preferable.

- However, little experience exists with managed care arrangements involving individuals with the most severe mental health conditions.

Rationale for BHOs

- New York's behavioral health system is large and fragmented and serves over 600,000 people.
  - accounts for over $7 billion in annual expenditures.
- The publicly funded substance use disorder treatment system serves over 250,000 people.
  - accounts for about $1.7 billion in expenditures annually

Rationale for BHOs

- There is little comprehensive care coordination, even for the highest-need individuals.
- There is little accountability for the provision of quality care and for improved outcomes.
- This fragmentation is compounded since the mental health and substance use care and treatment systems are separated and have discrete regulations and funding streams, even though there are substantial rates of people with co-occurring serious mental illness and substance use.
- Behavioral health also not well integrated or coordinated with physical health care at clinical, regulatory and financing levels.

Rationale for BHOs

- The behavioral health system is currently funded primarily through fee-for-service Medicaid, while a substantial portion of physical health care for people with mental illness or substance use disorders is financed and arranged through Medicaid managed care plans. This also contributes to fragmentation and lack of accountability.

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

Phase One of BHOs

- Not managed care per se – the BHO in the first three years is intended to reduce fees for service utilization for the “carved out” (of managed care) fee-for-service Medicaid behavioral benefit. No provider networks.

- BHOs are not intended to interact with beneficiaries directly; rather, with inpatient/outpatient providers to improve their effectiveness.

- Five regional BHO contracts have been awarded, one BHO per region.

BHO Regions

Phase One Regional BHO Contracts

- NYC Region: OptumHealth
- Hudson River Region: Community Care Behavioral Health
- Central Region: Magellan Health Services
- Western Region: NY Care Coordination Project
- Long Island Region: Long Island Behavioral Health Management LLC

- Each entity has demonstrated experience and expertise in managing behavioral health services for individuals with substance use and serious mental illness.

Phase One of BHOs

- Focus is on readiness – BHOs will collect and submit data to help OMH and OASAS learn how to improve care in preparation for the transition to a managed care environment in Phase Two.
- Learn about effective care management practices for populations never before included in managed care benefit structure.
- Identify areas for improvement in inpatient discharge planning; ambulatory engagement and continuity of care; and utilization of Medicaid data to inform treatment and care planning.

Phase One of BHOs

- Monitor behavioral health inpatient length of stay;
- Reduce unnecessary behavioral health inpatient hospital days;
- Reduce behavioral health inpatient readmission rates;
- Improve engagement rates in outpatient treatment post discharge;
- Better understand clinical conditions of children with Serioius Emotional Disturbance (SED) diagnosis;
- Profile provider performance.

Phase One: Concurrent Review Process

- Inpatient providers must notify BHO within 24 hours of an admission for a behavioral health condition.

- BHO will contact the inpatient provider within 72 hours after admission and provide information regarding the individual's recent Medicaid service use history. The goal of this communication is to enable the BHO to assist in the development of effective treatment and discharge plans.

- Follow-up reviews will be conducted at regular intervals depending on the individual's treatment plan.

Phase One: Concurrent Review Process

- If the BHO determines that a continued inpatient stay is no longer medically necessary, BHO issues a notice of preliminary determination. If the admitting provider disagrees, he/she may request reconsideration within 24 hours.

- If the BHO still determines that a continued stay is not necessary, the provider has 48 hours to discharge the individual; otherwise, the BHO will issue a notice of clinical determination to the provider and the State.

Phase One: Concurrent Review Process

- There will be no financial impact on the provider based on the BHO's determination. If the provider disagrees with the BHO, he/she may continue to treat the patient and receive Medicaid payment, documenting his/her reasons for medical necessity in the patient's records.

- BHOs also will contact outpatient providers to assess post-discharge follow-up with scheduled appointments and to assist with care coordination when indicated.

Providers Subject to Concurrent Review

- OMH-licensed psychiatric units (all ages) in general hospitals (Article 28 hospitals);
- Children and youth admitted to OMH-licensed private psychiatric hospitals (Article 31 hospitals);
- Child/youth direct admissions to OMH State-operated children's psychiatric centers/units of psychiatric centers;
- OASAS Certified Part 816 Inpatient Detoxification Services (Article 28/32);
- OASAS certified hospital (Article 28/32) or freestanding (Article 32 only) Part 818 Chemical Dependence Inpatient Rehabilitation Services.

BHO Engagement of Key Stakeholders

- BHOs are required to engage key stakeholders in their regions. If they have not already done so, BHOs will reach out to key stakeholders including behavioral health inpatient providers (Article 28, 31, and 32), behavioral health outpatient providers, consumers, peers and family peer advocates, child and adolescent clinical experts and advocates, and representatives from other related systems (e.g., Administration for Children's Services, the Office for People with Developmental Disabilities).

Phase Two – Managed Care

- To be shaped by MRT Behavioral Health Work Group to establish the parameters of the transformation to care management for New Yorkers with mental illnesses and substance use disorders.

- Phase 2 BHOs will be awarded through a separate procurement and are scheduled to begin in 2013

- Will include some form of risk-bearing Medicaid managed care for adults and children with serious mental health issues or substance use disorders.

Phase Two – Managed Care

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

MRT BHO Workgroup

- Co-chairs: OMH Commissioner Mike Hogan & NYC Deputy Mayor for Health and Human Services, Linda Gibbs. Consisted of representatives of individuals receiving services, advocates, service providers, and health insurers in the mental health and substance use disorder fields.
- The need for a subgroup was recognized for additional concentration on issues specific to children with serious emotional disturbances and substance use disorders.
- BHO Workgroup website has additional information at: http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_reform.htm

MRT Recommendations for BHOs

- There should be mechanisms at multiple levels for connecting and coordinating all of the different participants, including healthcare providers, payers, and care managers. The delivery of clinical care should be coordinated and efficient.
- Payment for services should be tied to patient/consumer outcomes.
- Patient/Consumer input and choice is critical.
- There should be in-person care coordination activities for high-need users.
- Peer programs should be used to help engage patients and consumers.

MRT Recommendations for BHOs

- Families should be integrated into care whenever possible.
- Treatment should be based on condition, and not on insurance status.
- There should be a person-directed focus on wellness and recovery.
- Consumer access should be considered as part of any data-sharing initiative.
- Attention should be paid to social factors that influence individual behavior and outcomes, such as employment and financial status.

MRT Recommendations for BHOs

- Housing resources need to be available directly for timely use to avoid lengthy or repeat admissions, and to provide stability for patients/consumers in the community.
- Money saved should be reinvested smartly to improve services for behavioral health populations.
- Distinction in the design and operation of care models must be made to address the unique needs of children & families.
- The needs of older adults are unique and require special attention.

MRT Recommendations for BHOs

- Care coordination, care management, and health home services should be fully integrated into BHOs for management and coordination of behavioral health services.

- Nonclinical services, including peer services that contribute to continuity of care, wellness, and recovery, should be included in the behavioral health service array.

Recommended Benefit Package

- Integrated Delivery System; Special Needs Plan; BHO.
- Managed care entities should offer comprehensive behavioral health benefits. Full-benefit SNPs should also offer comprehensive physical health benefits. Care coordination, care management, and health home services should be fully integrated into SNPs, and also integrated into BHO's for management and coordination of behavioral health services.
- Nonclinical services, including peer services that contribute to continuity of care, wellness, and recovery, should be included in behavioral health service array. SNPs should include pharmacy.

Recommended Benefit Package

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

Peer Services

- DOH recognizes that peers make unique contributions in delivering services that help people, promote wellness, and decrease costs.
- Funding for training and education, certification, and leadership development would strengthen the peer workforce.
- ILCs could train and staff peer services as part of BHO package.

Independent Living Centers and BHOs

- ILCs are cross-disability organizations and serve people with mental health and substance use diagnoses. ILCs have potential to contract with BHOs to provide peer services to help consumers stay in or return to the community and independent living.

- Programs already in place at ILCs such as Independent Living Inc. may serve as prototypes for BHO peer models of care.

Existing Models of Care
Peer Hospital Diversion Program

- Mobile Mental Health Team of ILC employees
- Emergency Department of local hospital evaluates consumer and determines he/she needs support but not psychiatric hospitalization.
- ER contacts Peer Hospital Diversion Program.
- ILC sends peers to engage consumer, help re-acclimate to community.
- Peers provide intensive peer services for 30-45 days.
- Consumer may receive follow-up services as needed.

Existing Models of Care
Peer Bridgers

- On call at mental health units of local hospitals.
- Engage consumer upon admission and begin discharge planning immediately in partnership with consumer.
- Connect consumers with necessary community supports to continue with their journey toward recovery.
- Help develop wellness and recovery action plan (WRAP).
- Provide intensive peer intervention and support.
- Transport consumers to and from mental health hospitals, to clinical follow-up appointments, for any follow-up housing program referrals.
- Peer services for about two weeks post-discharge.

Existing Models of Care
Regional Recovery Center

- 12 full-time peer recovery specialists.
- Meet consumers where they live, esp. congregate care.
- Goal is to help transition to independent living situation.
- Help consumer develop life goals, develop WRAP plan
- Consumer has authorship of plan and can modify as needed.
- “Work your WRAP”
- Monthly sessions to discuss WRAP and modify as needed. WRAP is a living document.
  - Determine what does and doesn’t work about plan.

Peer Mentoring

- Peers are themselves consumers of mental health services with expertise and skills in crisis intervention, individual advocacy, systems advocacy, ethics and confidentiality, negotiation skills, self-help skills, patient rights, benefits and entitlements, cultural competency, navigating resources.
- Help apply for Medicaid, food stamps, HEAP.
- Help consumers find affordable, accessible housing.
- Work with service providers and w/ family members to help cultivate a strong system of supports for each individual.
- Follow up after discharge to encourage positive outcomes as transition to community.

Peer Mentoring (Continued)

- Peers are not hospital employees nor members of clinical team.
- Peers serve as mentors/facilitators.
- Because they are peers, can fully understand challenges to overcoming barriers that seem insurmountable, both from a personal and professional perspective.

Independent Living Centers and BHO's

- How will ILCs be paid for peer services?
- Some at DOH state that ILCs must subcontract with licensed mental health agencies in order to be paid. Doing so may flout independent living philosophy since these agencies run on a clinical/medical model.
- ILCs are not licensed; however, MCOs may in theory contract with whomever they choose. ILCs would need DOH's approval. BHOs' surplus revenues might also be used to pay ILCs.

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Thank You!

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