Redesigning
THE MEDICAID PROGRAM

MRT Work Group Meeting Summary

WORK GROUP NAME:

Behavioral Health Reform Work Group

MEETING DATE, TIME, LOCATION:

August 1, 2011
1:00 P.M. to 4:00 P.M.
NYS Department of Health NYC Field Office
90 Church Street
New York, NY

MEMBERS IN ATTENDANCE:

Mike Hogan (Co-Chair), Linda Gibbs (Co-Chair), Wendy Brennan, Pam Brier, Alison Burke, Lauri Cole, Donna Colonna, John Coppola, Betty Currier, Philip Endress, Arlene Gonzalez-Sanchez, Kelly Hansen, Ellen Healion, Tino Hernandez, Cindy Levernois, Ilene Margolin, Gail Nayowith, Kathy Riddle, Harvey Rosenthal, Paul Samuels, Phil Saperia, Sanjiv Shah, Richard Sheola, Ann Sullivan

SUMMARY OF KEY MEETING CONTENT:

Updates and Agenda Overview: Co-Chairs Linda Gibbs and Michael Hogan briefly outlined issues to be addressed during the meeting and a strategy for managing meeting time.

Meeting Minutes from July 23, 2011: Work Group members recommended a correction to the company name for one of the presenters Ilene Margolin, of EmblemHealth. One member noted that the minutes did not include any reference to discussion about state hospital savings. **Follow-up Action:** Co-Chair Hogan indicated that should be discussed further at a future meeting.

Outline for Final Report: Work Group members engaged in a conversation about a draft report outline Co-Chairs Hogan and Gibbs had assembled in an effort to help the Work Group focus on deciding the components of their final report. **Follow-up Action:** Co-Chair Hogan indicated that any suggested edits should be sent directly to Co-Chairs Hogan and Gibbs.

They reviewed the Work Group's charge and focus, as well as the deadline for completion, and identified three things they would be unable to directly address in that time frame, including the 1115 waiver, budget process, and BHO implementation. It was noted that physical/behavioral health integration was likely possible on a shorter timeline in the NYC area given its existing infrastructure, while other areas of the state may need to continue with BHOs until integration is achievable. Members expressed a desire for the Work Group to remain intact until beyond the submission of their report. Co-chairs Hogan and Gibbs agreed to consider the idea further, though pointed out to the group it may not be possible, further reinforcing the need for strong and concrete recommendations from the Work Group.

Members then reviewed the draft Principles and Outcomes document, assembled and refined in previous Work Group meetings, which would be included in the report to be used as a guide.

Members then engaged in a conversation about how the report should discuss issues related to financing and payment. A number of issues/concepts for inclusion in the report were discussed, including:

- *Savings from behavioral health reform beyond that needed to meet budget targetsshould be reinvested in the community with a high value placed on non-clinical supports including peer and community supports as well as services to assist in navigating health and behavioral health service needs. Consistent with the second charge from the MRT, peer services should be prioritized for all behavioral health, including mental health and substance abuse treatment. It was discussed that effectively addressing behavioral health needs and improving access to behavioral health care can create savings in physical health care costs by reducing hospitalizations and/or lengths of stay in residential and/or inpatient levels of care. These savings should also be reinvested into community behavioral health supports.* ***Follow-up Action:*** *Work Group should provide any models or data from other states demonstrating how physical health care costs are reduced by investing in behavioral health services. Monitor and regulate play payments. The state must ensure plan accountability; , identify mechanisms that ensure what entity is responsible for payment and coordination of different services; monitor plan payments and perhaps establish "floors" for spending on behavioral health services. Ensure that State and Federal standards on plan profits and plan reserves is followed.*
- *Licensing restrictions on billing for physical health or behavioral services should be reduced and cross-licensing should be facilitated.* ***Follow-up Action:*** *Request that DOH raise the 5% physical health billing threshold in behavioral health clinics.*

Members then engaged in a conversation about how the report should address issues related to Contracting with Plans. Work Group members shared the following ideas:

- *OMH and OASAS should have a lead role in contracting and monitoring managed behavioral health or special needs plans to ensure performance measures are based on best practices.*
- *Risk sharing, control of spending (but with certain parameters), mechanisms to determine who is responsible for payment at certain points, establishing a floor on services, and establishing performance incentives should all be considered in the report.*
- *Inclusion of recovery concepts is needed.* ***Follow-up Action:*** *Ellen Healion and Harvey Rosenthal agreed to identify and share models for self-directed care.*
- *Inclusion of incentives to assist individuals with achieving gainful employment, and economic self-sufficiency.*
- *Criteria for best practices, including standardized screening using evidence-based practices, recognition of diagnoses determined in other settings, access to appropriate medications, and adherence to requirements of the Federal parity law must all be considered.*

Follow-up Action: Any additional issues/concerns/proposed changes with outline should be submitted directly to Co-Chairs Hogan and Gibbs.

Children's Sub-group: Gail Nayowith, Sub-group Chair shared that the group has met and drafted its core beliefs and operating framework. The group has begun looking at cross-system issues and, as a result of the agreement with DOH to delay including children with serious emotional disturbances into health homes until next year, the group will give consideration to the best approach to care coordination for children and youth in the Fall. **Follow-up Action:** Comments on the operating framework are due to Gail or Kristin Riley by Wednesday, August 3.

Presentation: Behavioral Health Management of Substance Use Disorder Services: OASAS' Robert Kent, Chief Counsel shared a power point presentation (available at: http://www.health.state.ny.us/health_care/medicaid/redesign/behavioral_health_reform.htm) with the group, highlighting the following:

- *Medicaid managed care plans must meet federal behavioral health parity rules.*
- *MATS and TCM staff will need training on health care coordination. MATS and TCM will be treated the same during the transition to Health Homes. Clients will maintain their treatment relationship, but most people receiving substance use services do not receive TCM or MATS so health homes will expand access.*
- *Some Health homes may need to acquire substance use treatment expertise which should be added to the EBP outline, particularly around medication.*

Health Homes – Development of Recommendations – Mike Hogan and Linda Gibbs emphasized that the Health Home application is expected to be posted today, 8/1/2011and that responses are due in one month (Since extended to 10/3/11) and facilitated a discussion and straw poll exercise with Workgroup members identifying and then voted on recommendations for improving current Health Home guidance/program requirements. **Follow-up Action:** Work Group members are to submit any changes/updates/additional thoughts to Co-Chairs Hogan and Gibbs by 8/3/11. The following are the Work Group's final recommendations submitted to DOH:

- *Health homes must include behavioral health expertise and leadership.*
- *A transitional strategy must be in place to assure the smooth transition of behavioral health services (especially "case management" services) from the 2 year enhanced FMAP stage into the SNP/BHO/IDS environment that will be put in place for 2013.*
- *All Health homes should include networks providing both physical and behavioral health care and rules should not distort spending on either category of care, whether in health homes with a specialty capacity to serve individuals with SMI and SUD, or other health homes.*
- *Health homes must coordinate with non-health service providers and have explicit relationships with local governments that often coordinate these services.*
- *Screening and Brief Intervention for Referral to Treatment (SBIRT) and standard depression screening should be a mandatory element of every Health Home patient assessment.*
- *The State must clarify the roles and responsibilities of health homes participants.*
- *The State should work to preserve patient choice.*
- *If patients are automatically assigned to health homes, the State should take steps to ensure that assignment is appropriate.*
- *The State should incentivize health homes to reach culturally diverse communities and measure performance in this domain.*
- *Clearer timelines and paths for the implementation of health homes are needed.*
- *Both the State and health homes should present consumers with user-friendly information.*
- *Health home employees should be held to appropriate qualification standards, in which the standards of the state BH agencies should be considered.*
- *The State should implement health homes in a fashion that reduces regulatory burden while improving the quality and continuity of care.*

NEXT MEETING DATE, TIME, LOCATION:

August 23, 2011
Office of Alcoholism and Substance Abuse Services
1450 Western Avenue, 4th Floor Conference Room
Albany, New York

Co-Chairs Hogan and Gibbs identified preliminary agenda and to-do list including:

- *Compilation of health homes discussion with comments back from Workgroup within one to two days.*
- *Revise report outline, including the incorporation of OASAS information.*
- *Presentation on Outcome Measures.*