

On September 12, 2011, the Medicaid Redesign Team's Behavioral Health Reform ("BHR") Work Group held its fifth and final scheduled meeting at the NYS Department of Health (DOH) Metropolitan Area Regional Office, located at 90 Church Street in lower Manhattan. A copy of the meeting's agenda and the group's final draft report are attached.

I. Welcome and Meeting Overview

Michael Hogan, the Commissioner of the Office of Mental Health (OMH) and the co-Chair of the BHR Work Group, called the meeting to begin at 1:12 p.m. All Work Group members were in attendance with the exception of Ellen Healion, the Executive Director of Hands Across Long Island. Ms. Healion was scheduled to provide an overview of peer support recommendations on behalf of a coalition of statewide peer support advocacy organization. Harvey Rosenthal, the Executive Director of the New York Association of Psychiatric Rehabilitation Services, Inc., would present the recommendations on her behalf, and would additionally be providing recommendations on behalf of the peer support subgroup, of which he was the Chair.

Gail Nayowith, the Executive Director of SCO Family Services and the Chair of the Children's Subgroup of the BHR Work Group, discussed her Subgroup's final report and recommendations. In addition, Dr. Ann Sullivan, the Network Senior Vice President for Queens Hospital Network (NYCHHC), discussed her subgroup's work on problematic issues and key principles for the uninsured. The meeting would conclude with a review of the final draft report of the BHR Work Group.

There was no indication of whether the Work Group would be re-formatting the report's recommendations into the proposed template used by the MRT during Phase I. The Chairs indicated during the prior meeting that this was requested of them and all of the Work Groups by NYS Medicaid Director Jason Helgeson and Jim Introne, the NYS Deputy Secretary for Health and the Director for Healthcare Design.

Commissioner Hogan mentioned that he expected all of the recommendations set forth by the various subgroups to be incorporated into the BHR Work Group's final report. The Commissioner further noted that future comments on the draft report should be limited to glaring omissions and conspicuous errors. Co-Chair Linda Gibbs, the New York City Deputy Mayor for Health and Human Services, expressed that they were on the proper path to provide the Governor's Office with some substantial recommendations.

Kelly Hansen, the Executive Director of the New York State Conference of Mental Hygiene Directors, asked if they would be voting on the final package of proposals at the end of the meeting. The Commissioner answered that there would be no straight up and down vote, but based on the discussions they have had to this point, proposals already incorporated into the report, as well as those that would be discussed today by Mr. Rosenthal, Ms. Nayowith, and Dr. Sullivan, would be accepted as well.

II. Children's Subgroup

Commissioner Hogan then turned the meeting over to Gail Nayowith to provide a summary of the Children's Subgroup's final recommendations.

Ms. Nayowith explained that the Children's Subgroup, comprised of 22 member representatives from various mental health, substance abuse, and governmental backgrounds, met five times over the summer. While the MRT's charge related more broadly to Medicaid and families, many in the behavioral health community thought it was necessary to develop some universal standards specifically for children and their families.

The Subgroup Chair noted that there were four critical conclusions that serve as the foundation for their recommendations:

Early intervention is effective and reduces costs: the children's subgroup felt that it was important that they not assume the MRT actually understands children's behavioral health needs;

There needs to be accountability across payers;

Child and family services across NYS are siloed, creating complications, and efficiencies in cost and quality of care can be achieved through integration; and

The current behavioral health system for children and their families is underfunded.

Ms. Nayowith noted one specific recommendation was that children with serious emotional disorders (SED) be served in a specialty BH managed care program designed specifically for children who are eligible for Medicaid and meet defined criteria, such as SED or SUD, who also display complex behaviors and symptoms and meet a risk assignment threshold.

Some overarching issues recognized by the subgroup included:

Not all populations of children are adequately covered;

Geographic differences affect available services and integration; and

Given their budgetary and timeline constraints, there is a need to focus specifically on those services that can make the biggest difference.

Commissioner Hogan and the other members were very supportive of the subgroups efforts. The Commissioner noted that the subgroup's recommendations were deep but well grounded, and would work well within the system they currently have. Noting that he had seen a lot of support and appreciation for their work, Commissioner Hogan decided that the BHR Work Group would accept their recommendations and incorporate them into the BHR Work Group's draft report, and if anyone has any comments or problems with this down the road, they could inform the Chairs.

Ilene Margolin, the Senior Vice President of Public Affairs & Communication at Emblem Health & Health Plan Assoc., commented that while this was a very good statement of principles and values, the children's subgroup still needed to consider how they should

“sell” these ideas, since MRT members who are unfamiliar with children’s behavioral health services may not understand or appreciate the importance of investing in specific areas, when their principal focus is to save money.

Commissioner Hogan added that one avenue they should direct the MRT to, is evidence that investing in pediatric behavioral health would reduce admissions into adult hospitals. He also noted that having a viable and functioning behavioral health infrastructure is a duty and obligation of the mainstream health system. Thus, if the current system is deficient or is not being carried out as intended, investment is needed to remedy the problem.

John Coppola also noted that it is important to emphasize that the savings will not just be experienced in Medicaid, but across other systems as well, including juvenile justice.

III. Engagement Models and Strategies

As indicated at the outset, Harvey Rosenthal substituted for Ellen Healion and presented the group with proposals on behalf of the Coalition on Peer Support. Mr. Rosenthal noted that the coalition’s primary concern was that the new managed care and health home systems utilize peer educators or brokers to provide information to individuals who are enrolled (some for the very first time) in managed care and the new health homes. He explained that the peer community “is in the dark” when it comes to information about health homes, and requested that the State use peer educators to educate enrollees and provide representatives with information on the programs, including grievance and appeals rights for health homes enrollees.

In addition, Mr. Rosenthal stressed that engagement is about more than just ensuring that people take medication and receive follow up care. It must be self-directed and structured around each person’s individual needs. Mr. Rosenthal indicated that there is evidenced based data demonstrating that peer service coaches are effective for providing information and advocacy and should be a part of the health homes. One member asked, “Who pays for peer educators?” Mr. Rosenthal explained most get paid out of State aid. Commissioner Hogan also noted that there is an ongoing debate in the peer movement as to whether peer services reimbursed by Medicaid is one way to seek reimbursement they need, or if it is simply “selling out” to the care management system.

Following this comment, Mr. Rosenthal provided an overview of his work as chair of a subgroup devoted toward maximizing peer services. The subgroup, which the BHR Work Group is serving as a pass-through for, was formed pursuant to MRT recommendation #1058 “maximize peer services.” The group was comprised of peer service representatives, independent living stakeholders, and representatives from the behavioral health and substance use communities. The subgroup had four meetings and received comments from 46 individual stakeholders, which included recommendations from comprehensive care coordination teams, recovery coaches, and peer support specialists.

The group found that peer services are unique and extremely valuable, and play a critical role in patient care that improves the likelihood for recovery and overall wellness. The group wanted to clarify that peer services are not case management (someone who makes sure someone takes their medication) though this may wind up being an outcome of the relationship. The group strongly encourages health homes and managed care entities to subcontract with peer services organizations to provide peer support for their enrollees, and one of the subgroup's proposals was that peers be incorporated into a health home as a requirement of the application.

Mr. Rosenthal further discussed that there should be education and training programs to strengthen the peer services workforce, and accreditation standards. The group's greatest fear was that individuals would be assigned to a health home, medicated, and then sent to a case manager whose only responsibility is to make sure they take their medication.

There were few concrete details, however, concerning possible funding sources for their proposals. Mr. Rosenthal anticipated that most funding would come from grants, so peer services would not be reimbursed by Medicaid. He also noted one initiative undertaken by Arizona that provided a waiver for managed care programs to contract with peer services organizations.

In general, members appeared very supportive of the peer services recommendations and providing overwhelmingly positive feedback. One member noted that there is real, evidenced based data that demonstrates that peer services improves outcomes and reduces unnecessary expenditures. Others commented that incorporating peer services into Medicaid Managed Care (MMC) would revolutionize how we operate behavioral health care by establishing a link between the clinician and peer support personnel.

Pam Brier commented that all of the peer services proposals sounded great with the exception of the peers' reliance on grant funding. Mr. Rosenthal explained that by "grants", he was referring to grant funding from Medicaid Managed Care plans, not categorical State grants. Still, Ms. Brier thought it would be much more effective for them to push the State to include funding for peer services as part of the per member per month (pm/pm) payment to MMC plans. Ilene Margolin agreed that peer services needs to be "baked into the pm/pm".

Commissioner Hogan indicated that the feedback was very supportive, and that they needed to determine whether peer services would be something that is integral to the program, or something that is used with leftover funds.

IV. Problem Statement/Principles Regarding the Uninsured

Dr. Ann Sullivan, the Network Senior Vice President for the Queens Hospital Network, a member of NYCHHC, presented her subgroup's recommendations for at-risk and vulnerable populations. Dr. Sullivan began by outlining what "uninsured" meant, and noted that this term encompasses many levels, including individuals who have

sometimes used up their benefits or “fell off” because they failed to renew their benefits. She noted that the second category was a big focus of Medicaid redesign (ensuring those eligible for benefits receive benefits).

Dr. Sullivan discussed some of the traditional ways that care for the uninsured has been provided citing specific DOH and OASAS programs, and noting that facilities have long enhanced their rates to be able to take on the uninsured. She also noted that public sector systems have high percentages of the uninsured.

Dr. Sullivan shared some of the subgroup’s recommendations, which include:

- Current levels of service to insured and uninsured must be maintained;
- The uninsured should be in some form of care coordination and management;
- Preserve and augment the buy-in to certain Medicaid benefits (capture those people who are insurable) and the proposed health insurance exchanges;
- Ensure plans comply with state and federal mental health parity laws.

V. Revised Working Outline for Final Report

Commissioner Hogan established the ground rules for the final report: they would look at the broad categories and not go item by item, and members should reserve comment unless something is missing or they have “major discomfort” with one of the items.

Dr. Sanjiv Shah, the Chief Medical Officer of Fidelis Care NY, offered the first comment as a point of clarification, asking if the Work Group was recommending a particular model (e.g., BHO vs. SNP) or if they are just recommending high level principles that would be applied to whichever organizations is implemented. Commissioner Hogan noted that the latter was correct. Commissioner Hogan further explained that since it is unclear which entity will take shape, it is more important to determine the principles that would apply regardless of the entity. The Co-Chair did note, however, that New York City has already made it known that they will proceed with a Special Needs Plan (SNP). The other regions have not yet decided what type of entity they will implement for Phase I.

Financing and Payment

Commissioner Hogan proceeded with an explanation and summary of each of the recommendations under this section. There were only two suggested revisions. Harvey Rosenthal wanted the fourth bullet point discussing the tracking of Non-Medicaid savings in state and local systems to include “peer services”. Philip Endress, the Commissioner of the Erie County Department of Mental Health, requested that whenever the report mentions the criminal justice system, it should likewise mention juvenile justice, in order to keep children and adults consistent.

Contracting with Plans (BHOs, SNPs, IDSs) and Benefit Package

Commissioner Hogan indicated that the second bullet point (“reduce incentives to institutionalize people in State hospitals”) was an attempt to gradually introduce population and resources currently in State hospitals into something that can be managed by the managed care entity. The savings that would be generated would be a source for reinvestment.

Gail Nayowith asked, “What happens to the people in the State system who do not have Medicaid at all?” The Commissioner responded that they would like to create a set of incentives that balance care, with the current problem being the difficulty of getting people into State hospitals and then the difficulty of getting them out. He noted there needs to be proper incentives for people to be able to move when appropriate and resources to move with them.

Ilene Margolin took issue with the bullet point that said provider networks for MMC plans “must be robust”. Ms. Margolin discussed that the recent trend, as evidenced by the focus on ACOs and other integrated delivery systems, is to make networks smaller and more accountable. The idea of “every willing provider” is “going out the door”, and in light of this, Ms. Margolin recommended that they omit this statement. However, if the rest of the Work Group felt strongly about including it, then they should at least discuss quality too, because “more is not necessarily better.”

VI. Wrap-up and Next Steps

Ms. Gibbs noted that after they submit their recommendations, the Work Group will remain in hiatus until they reconvene sometime in the winter. She hoped that everyone will help advance their work through their own lobbying efforts.

Commissioner Hogan also provided an update on the interim BHOs. He announced that the contractual negotiations have been going well, and that somewhere in the state will be all the leading national players, and the only group that has not emerged was a major health plan. He noted that they were close to finalizing deals in the Western NY region with the Western NY Care Coordination Group Committee and Magellan Health Services for the Central New York Region.

The next steps for the Work Group would be to finalize the recommendations and submit them to the full MRT, where they will be discussed and voted on at the full MRT meeting scheduled for November 1, 2011 at the New York Academy of Medicine, located at 1216 5th Ave. at 103rd St., in Manhattan.



MEDICAID REDESIGN TEAM
BEHAVIORAL HEALTH REFORM WORK GROUP

September 12, 2011

1:00 – 4:00 p.m.

*NYS DOH Metropolitan Area Regional Office
90 Church Street, 4th Floor, Conference Room A/B
New York City*

MEETING AGENDA

1:00 – 1:15 p.m.

WELCOME AND MEETING OVERVIEW
Mike Hogan and Linda Gibbs, Co-Chairs

1:15 – 1:45 p.m.

CHILDREN'S SUB-GROUP UPDATE
Gail Nayowith

1:45 – 2:00 p.m.

ENGAGEMENT MODELS AND STRATEGIES
Ellen Healion

2:00 – 2:15 p.m.

PROBLEM STATEMENT / PRINCIPLES REGARDING THE UNINSURED
Ann Sullivan

2:15 – 3:45 p.m.

REVISED WORKING OUTLINE FOR FINAL REPORT
Mike Hogan and Linda Gibbs, Co-Chairs
▶ *Framework and Approach*
▶ *Recommendation categories and structure*
▶ *Focused discussion of recommendations*

3:45 – 4:00 p.m.

WRAP-UP AND NEXT STEPS
Mike Hogan and Linda Gibbs, Co-Chairs

**Behavioral Health Work Group
of the
New York State
Medicaid Redesign Team
Report and Recommendations**

October 15, 2011

DRAFT

Members:

- **Co-Chair, Michael F. Hogan, Ph.D.** *Commissioner, New York State Office of Mental Health*
- **Co-Chair, Linda I. Gibbs**, *New York City Deputy Mayor for Health and Human Services*
- **Wendy Brennan**, *Executive Director, National Alliance on Mental Illness – NYC Metro*
- **Pam Brier**, *President & CEO, Maimonides Medical Center*
- **Alison Burke**, *Vice President, Regulatory & Professional Affairs, Greater New York Hospital Association*
- **Lauri Cole**, *Executive Director, NYS Council for Community Behavioral Healthcare*
- **Donna Colonna**, *Executive Director, Services for the Underserved*
- **John Coppola**, *Executive Director, New York State Association of Alcoholism and Substance Abuse Providers*
- **Betty Currier**, *Board Member, Friends of Recovery – New York*
- **Philip Endress**, *Commissioner, Erie County Department of Mental Health*
- **Arlene Gonzalez-Sanchez**, *Commissioner, NYS Office of Alcoholism and Substance Abuse Services*
- **Kelly Hansen**, *Executive Director, New York State Conference of Local Mental Hygiene Directors*
- **Ellen Healion**, *Executive Director, Hands Across Long Island*
- **Tino Hernandez**, *President & CEO, Samaritan Village*
- **Cindy Levernois**, *Senior Director, Behavioral Health and Workforce, HANYS*
- **Ilene Margolin**, *Senior Vice President, Public Affairs & Communications, Emblem Health & Health Plan Assoc.*
- **Gail Nayowitz**, *Executive Director, SCO Family of Services*
- **Kathy Riddle**, *President, Outreach Development Corp.*
- **Harvey Rosenthal**, *Executive Director, New York Association of Psychiatric Rehabilitation Services, Inc.*
- **Paul Samuels**, *Director & President, The Legal Action Center*
- **Phil Saperia**, *Executive Director, The Coalition of Behavioral Health Agencies, Inc.*
- **Sanjiv Shah, M.D.**, *Chief Medical Officer, Fidelis Care NY*
- **Richard Sheola**, *Executive Vice President, Value Options*
- **Ann Sullivan, M.D.**, *Network Senior Vice President, Queens Hospital Network; NYCHHC*

Commission Process/Charge

As part of Governor Andrew Cuomo's efforts to "conduct a fundamental restructuring of (the) Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure," the Governor appointed a Medicaid Redesign Team (MRT) composed of representatives from the legislature, health care industry, patient advocacy groups, New York City and State executive staff including the Commissioners of the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, and the New York State Medicaid Director.

The MRT created several work groups to review and provide recommendations for key areas, including behavioral health. The Behavioral Health Reform Work Group (the Work Group) mission was to:

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

Pursuant to MRT recommendations (specifically #93 – see Appendix A), in 2013 "currently carved-out" Medicaid behavioral health services will be subject to care management through regional Special Needs Plans (SNPs), Integrated Delivery Systems (IDSs), or Behavioral Health Organizations (BHOs). The Work Group was charged with helping establish the parameters of care management for New Yorkers with mental illnesses and substance use disorders.

The Work Group began meeting on June 30, 2011 in New York City and held four additional meetings – July 12 in Albany, August 1 in New York City, August 23 in Albany, and September 12 in New York City – which included expert presentations on relevant topics and lively discussions examining issues related to the Work Group's charge and potential recommendations to the MRT. Topics and issues discussed included components of effective treatment and services for SMI, SUD and SED; managed care principles and practices; the DOH health homes initiative; management of SUD; lessons learned from the Care Monitoring Initiative; performance standards to promote good care at reasonable cost; and reports on work by the children's sub-group.

Principles for Behavioral Health Services in a Managed Care Environment

Beginning with the first meeting, the Work Group engaged in a goal-setting and prioritization process to identify the key elements of design and practice needed for a managed behavioral health care system in New York State. The Work Group also identified critical types of metrics and indicators that should be measured to determine the extent to which these principles are met. The following are the principles established by the Work Group:

- 1. 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.**
 - Mental health, physical health, substance abuse should be addressed in an integrated manner.
 - Patient screening for mental illness and substance use disorders should be done across specialty and primary care settings and should use state-of-the-art techniques and technology.
 - Providers should use electronic medical records and available mechanisms for health information exchange. They should have access to and use their patients' Medicaid data.
 - There should be a "no wrong door" approach with standardized screening tool so that no matter where patients enter the system, they are guided to the right provider.
 - A system of empowered care coordination should be established, be stratified by risk/need of patient, and be the responsibility of the managed care entity.
 - Payment models should incentivize coordination among physical and mental health providers.
 - Duplication of services should be avoided.
 - Co-location of services should be one available model to promote integrated care.
 - Mental health and substance abuse services should be integrated.
 - There should be clarity around roles and accountability across service providers.
 - Linkages to other systems, such as the criminal, juvenile justice, and courts systems, should also be developed.

- 2. Payment for services should be tied to patient outcomes.**
 - Incentives should guide providers to the appropriate type and amount of care.

- The reimbursement rate structure should recognize the varying levels and capabilities of providers.
- There should be flexibility to finance wrap-around services.
- The fee-for-service “mentality” should be eliminated, although that does not preclude using fee-for-service payment mechanisms within a managed care arrangement.

3. Patient/Consumer input and choice is critical.

- Whenever possible, consumer choice should be preserved.
- There should be “warm touch” (in-person) care coordination activities for high-need users.
- Peer programs should be used to help engage patients.
- 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.

4. Attention should be paid to social factors that influence individual behavior and outcomes, such as employment and financial status.

- Available social services outside of healthcare should be utilized to their maximum.

5. Housing resources need to be directly available for timely use to avoid lengthy or repeat admissions, and to stabilize patients in the community.

6. Money saved should be smartly reinvested to improve services for behavioral health populations.

- Savings from better managed behavioral and physical health care should be reinvested to the extent possible for improved outcomes and reduced health cost.
- Reinvestment should prioritize non-clinical support services, such as housing, peer and family services.
- Investment in preventive services that avoid the need for tertiary care should be incentivized.
- Savings might be shared with consumers to incentivize engagement.

7. Children’s issues are unique and require special attention.

- The multiple systems in which children exist—such as education, child welfare, and juvenile justice—should be considered and integrated as much as possible into a system of care.
- A family-centric approach should be incentivized whenever possible.

8. Regulatory burden should be minimized.

- Unfunded mandates should be avoided.
- The paperwork required of providers should be reduced, or, at the very least, not increased.

9. The diversity of New York State's communities should be taken into account.

- Varying levels of patient needs and provider capabilities may dictate different approaches in different parts of the state, especially those which are predominately rural or urban.

10. Part of considering proposed changes will be analyzing budgetary implications. Key Outcomes at the individual, provider, and system levels:

- Sustainable medical-loss ratios and reasonable levels of reinvestment
- Good clinical outcomes for key chronic medical conditions
- Reducing the gap between prevalence of service engagement and prevalence of conditions in the population
- Cultural and linguistic competency and use of peer services
- Elimination of inappropriate financial barriers to care
- Reduced hospital admissions
- Reduced mortality and health disparities associated with mental illness and substance abuse
- Reduced criminal justice involvement
- Adequate reimbursement rates to ensure appropriate capacity
- Reduction in use of court-ordered outpatient treatment
- Improved care transitions (e.g. appointments after hospitalizations)
- Appropriate risk-adjustment to incentivize treatment of the harder to serve
- Improved functional status
- Payments that promote the delivery and use of the appropriate level of care
- Meaningful and useful communication across providers

Recommendations

The Work Group identified several overarching recommendations including:

- Develop managed care approaches using risk-bearing Special Needs Plans (SNPs), Integrated Delivery Systems (IDS), and/or Behavioral Health Organizations (BHOs), consistent with MRT recommendation #93 (See Appendix A) and State statutes. In New York City, based on its population of individuals with significant behavioral health needs and its delivery system infrastructure, full-benefit IDSs or SNPs should be developed.
- Use the 1115 waiver that is being developed to advance the recommendations outlined in this report,
- Advance the core principle that managed care approaches for people with behavioral health care needs should assist enrollees in recovery and in functioning in meaningful life roles
- The recommendations below are proposed to fund a restructuring of the behavioral health system. This restructuring is to be done with the redistribution of existing resources, as inpatient and emergency room services decrease; resources will be reinvested into community supports and rehabilitation services. Therefore individual recommendations cannot be costed out separately because they are part of an overall system restructuring.

Through deliberation, the Work Group reached consensus to advance the following more specific recommendations consistent with its principles and mission as part of the MRT:

A. Financing and Payment

- Initial premium levels for managed care entities should be based on prior service spending including health home and targeted case management spending, and should be designed to encourage plan investment in prevention and development of capacity for cost-effective evidence-based services. Savings should not be targeted for the first year of risk-based behavioral health managed care.
- There should be transparency with respect to the portion of premium attributable to behavioral health actuarial assumptions and actual behavioral health service spending by plans.
- Formal mechanisms should be established for reinvestment of Medicaid savings into clinical and non-clinical services that can improve the quality and cost-effectiveness of care for people with serious mental illnesses and substance use disorders. Savings on behavioral and physical health care attributable to improved care coordination of behavioral health populations should be tracked. Reinvestment should be focused on high priority areas,

including housing, employment services, and family support. Reinvestment planning should be done by counties on a regional basis, in consultation with managed care entities, providers, consumers and other stakeholders, and should be approved by the State.

- Non-Medicaid savings in state and local systems serving patients with behavioral health needs should also be tracked. These systems with potential savings include criminal justice, homeless services, cash assistance/benefits, Special Education, and child welfare, among others.

B. Contracting with Plans (BHOs, SNPs, IDSs) and Benefit Package

- Behavioral health managed care entities should be tailored to local health delivery infrastructure and populations. Managed care entities, whether full-benefit SNPs, IDSs or carve-out BHOs, should be jointly overseen by the state and local behavioral health agencies with close SDOH collaboration. Contracting responsibility for BHO/SNP should rest with OMH/OASAS coordinated with DOH in consultation with the counties.
- To reduce incentives to institutionalize people in State Hospitals, responsibility for clients and resources in State facilities should be managed by the SNP/BHO with facility downsizing occurring on a phased basis. As State Hospital resources are freed up these funds will be used for managed care premiums, to fund non-Medicaid services (housing, employment, peer support, family and children's support), with a modest amount taken as savings.
- Managed care entities should offer comprehensive behavioral health benefits, and 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 BHOs for management and coordination of behavioral health services. Non-clinical services, including peer services that contribute to continuity of care, wellness, and recovery should be included in the behavioral health service array. The SNP benefit should include pharmacy.
- SNPs and BHOs should be required to participate in coordination activities with the relevant social and human services system including the criminal justice system and children's service system.
- Protocols should be developed to ensure coordination of services covered by BHOs or SNPs and Medicaid-covered or non-covered benefits/services that are carved out of managed care. These protocols

should ensure resources are targeted to highest need populations. Managed care entities should be measured on their performance coordinating enrollees with social services and supports.

- Care Coordination. Managed care entities should develop robust care coordination activities that include intensive data-driven strategies to identify high-need consumers (e.g., those disengaged from care; those at high risk of suicide; those with history of violence); policies and procedures to exchange information with and hold accountable clinical providers; and programs of direct, community-based engagement with consumers. Special attention should be placed on points of transition: discharge from hospital or emergency department, from jail or prison, from shelter, and outreach to people disengaged from care, especially people potentially at high risk.
- Managed care entities should be required to have networks of providers that are appropriate to enrollee needs and existing provider relationships and to foster strong and collaborative plan/provider network partnerships. Continuity of care, access to an appropriate array of providers, and opportunities for consumer choice in providers should be prioritized. The number of managed care entities in a region should be limited, in order to ensure accountability and access.
- Expected best practices in behavioral health managed care include:
 - Appropriate risk sharing between payer (state) and plan
 - A defined floor on services spending in sum (e.g., Medical Loss Ratio) and for key services or service categories.
 - Coordination with housing and other social services and supports, e.g., employment and rehabilitation, family support services.
 - Special emphasis on appropriateness of ambulatory and inpatient services
 - Expanded access to office-based ambulatory services e.g. psychotherapy; Utilization Management is typically not applied to these services
 - Reduced use of inpatient care consistent with assured timely and appropriate access whenever it is clinically necessary
 - Appropriate development and substitution of less costly and more appropriate alternatives to inpatient care
- Managed care entities should be required to use standardized assessment and level of care protocols.

C. Eligibility for SNPs/BHO Enrollment

- SSI status should not be the single determinant of eligibility of Medicaid recipients for specialty managed care. Eligibility should be based on clinical status and/or utilization. A mechanism should be established to ensure that disengaged individuals can also be enrolled in SNPs. Clinical status should include the presence of either a mental illness or a substance use disorder (or both) and a level of illness severity and/or functional impairment.
- Given the high percentage of individuals with behavioral health disabilities who are dually eligible for Medicaid and Medicare consideration should be given to integration of Medicaid/Medicare benefits through the 1115 waiver.

D. Promotion of Improved Behavioral Health care in primary care/non-specialty settings, including provided through mainstream managed care plans

- OMH, OASAS, and DOH should review and revise clinic licensing requirements to allow for co-licensure, reduce duplicative or contradictory requirements, and incentivize more co-located behavior health/physical health services.

E. Health Information Technology and Information Exchange

- **Electronic Health Information Exchange**- plans should require and fund the participation of their contracted providers with the SHIN-NY (State Health Information Network of New York) through promotion of EHR use and RHIO membership, and the elimination of barriers to participating in health information exchanges.
- **Claims data**- Plans should report all paid claims and encounter data to the State in a timely manner and according to statewide protocols. The State should share claims data in a timely manner with plans for any carved out services.
- **Sharing of claims data**- Plans should adopt comprehensive, consent-based data-sharing protocols and make claims data available to providers to ensure appropriate care and care coordination. Where there is state-wide or national consensus on these protocols, plans should adopt those and not pursue proprietary methodologies.

- **Statewide HIE consent form-** OMH, OASAS and DOH should develop a state-wide standard consent forms and guidelines for use, including protocols for electronic information exchange. Plans should mandate that providers use these consent forms (as opposed to creating their own proprietary ones), and should also assist with the consent process by making the HIE consent form a standard component of enrollment.

F. Performance Metrics/Evaluation

- **Performance Monitoring and Incentives.** Managed care entities should be held accountable for providing and coordinating enrollees' health care, and for outcomes. Plan payment should include a performance based premium payment incentive program that measures performance and pays more for plans that perform better.
- Plan performance should be based on validated measures across a variety of different domains – including access, network adequacy, adoption of best practices, patient satisfaction, efficiency, care coordination and continuity, and clinical and recovery outcomes. Disparities in measures between racial/ethnic and other sociodemographic groups should also be tracked.
- Mainstream plans should be evaluated on a more robust set of behavioral health performance measures, including clinical outcomes for depression and anxiety disorders; access to specialty services; and continuity of care. Depression screening and use of SBIRT should be required, measured, and strongly incentivized.
- There should be public reporting, by plans and aggregated by State, of Medicaid spending on behavioral health services over time, including before and after reform initiatives are implemented. The reporting should include the behavioral health sector as a proportion of total Medicaid spending and absolute spending on behavioral health services and populations.

G. Special Issues on Populations

Uninsured. Placeholder: To be expanded after the uninsured subcommittee submits its recommendations.

H. Children, Youth and Families

Placeholder: To be expanded after the uninsured subcommittee submits its recommendations.

I. Peer Services and Engagement

Placeholder: To be expanded after the Peer Report is considered by Subcommittee.

J. Health Homes

Consistent with its mandate to provide guidance on health homes, the Work Group reviewed current plans for development of health homes at its August 1 meeting. Because development of health homes proceeded prior to completion of this final report, the following interim recommendations were shared with the MRT to help shape the development process over the next several months.

- **Health homes must include behavioral health expertise and leadership.** Individuals with Serious Mental Illness (SMI) and those with substance use disorders (SUD) are a priority for early enrollment in health homes. The Subcommittee recognizes there is great potential to improve the quality and continuity of care for this population (e.g. by integrating medical with behavioral care). There is also potential for harm; many individuals in the population with SMI rely primarily on behavioral health providers, may have limitations or reluctance in using other health services, and need specialty attention. Therefore, the Subcommittee recommends that there should be health homes with specific specialty capacity (e.g., network, staffing, care coordination practices) to serve individuals with SMI and SUD. In addition to specialized capacity, health homes serving the SMI/SUD population should be evaluated on specific and robust performance and outcome indicators related to this population. Government behavioral health officials should play a key role in selecting and guiding the development of and overseeing these health homes. (#14)
- **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.** Before patients and funding are shifted to health homes, the State should formulate and articulate a strategy ensuring that people, funds and

services are maintained and transitioned into the managed care environment now being designed for 2013. A critical part of such a strategy will be ensuring that funding at its current levels moves along with consumers into new models of care organization, payment and delivery, especially dollars slotted for targeted case management and Managed Addiction Treatment Services (MATS)

- **All Health homes should include networks providing both physical and behavioral health care and rules should not distort spending on category of care, whether in health homes with a specialty capacity to serve individuals with SMI and SUD, or other health homes.** An integrated approach to health and behavioral health care necessitates routine basic screening for BH disorders and other medical problems in all health homes, and the presence of routine ambulatory health services (e.g. internal medicine) and behavioral health services (e.g. addiction, mental health counseling) in all health homes. Current licensing barriers and rules that limit behavioral health providers billing for routine outpatient physical health services severely limit successful integration. These rules should be abolished. Health homes must also assure access to essential specialty services such as obstetrics and gynecology that are often underutilized by BH clients. The number of managed care entities in a region should be limited, in order to ensure accountability and access.
- **Health homes must coordinate with non-health service providers and have explicit relationships with local governments that often coordinate these services.** Since health problems are often exacerbated by non-health situations—such as a lack of stable housing or employment—the State must assure that health homes take into account social and other non-health services when designing an approach to treatment, especially for seriously mentally ill patients. Part of this structure should be a requirement and procedure for health homes to work with county governments. Explicit partnerships with local governments, particularly those that employ a single point of access (SPOA) process, may be the only feasible way to provide key connections to non-health social services.
- **Behavioral health care should be improved for enrollees receiving services through mainstream managed care plans.** Mainstream plans should be evaluated on a more robust set of behavioral health performance measures, including penetration rates for specialty services, clinical outcomes for depression and anxiety disorders; access to specialty services; and continuity of care. Screening for common mental health problems, suicide risk and substance use problems (SBIRT) should be required, measured, and strongly incentivized.

- **The State must clarify the roles and responsibilities of health homes participants.** At present, the roles of various entities, including providers and insurance plans, have not been adequately defined. While local collaborations leading to an application can help refine arrangements, the State must provide some direction. Among the issues that need immediate clarification are the roles, responsibilities, and lines of accountability for health homes, insurance plans, and participating providers. For example, an explanation of what happens to a patient who is assigned to a health home that uses providers with which the patient's insurance plan does not have contracts is a pressing concern. Further special attention should be paid in clearly identifying the role of the first phase BHOs.
- **The State should work to preserve patient choice.** Certain individuals, such as people with significant BH issues, are much more likely to seek and accept care from providers with whom they are familiar. To the extent possible, patients should be allowed to choose which health home they join, and be permitted to transfer health homes when/if they change providers.
- **If patients are automatically assigned to health homes, the State should take steps to ensure that assignment is appropriate.** Before any patients are assigned to health homes, the State should establish and implement a process of ensuring that patients are funneled to appropriate health homes, and that critical service relationships (e.g. relationships with case managers or long term behavioral health treatment by a non-participating provider) are not impaired. One criterion of appropriateness is having a physical location the patient can easily travel to. It is critical to confirm the current residence of patients before health-home assignment, as many patient records, especially those of the seriously mentally ill, are out-of-date on this point.
- **The State should incentivize health homes to reach culturally diverse communities and measure performance in this domain.** As part of this incentive structure, the State should encourage the use of peer services.
- **Clearer timelines and paths for the implementation of health homes are needed.** A key part of this timeline should be a detailed explanation of how complete a health home must be in order to start operation. A process of technical assistance and consultation by potential health home providers should include the responsible BH agencies. If there are different levels of readiness, contingencies for readiness to commence operations are important.
- **Both the State and health homes should present consumers with user-friendly information.** The transition to health homes can be a

complicated one. It is incumbent on both the State and health homes themselves to create user-friendly documents to distribute to consumers to educate them about the process and their rights, and the availability of personal advice/assistance to explain these rights. These documents should be written at a grade-school reading level.

- **Health home employees should be held to appropriate qualification standards, in which the standards of the state BH agencies should be considered.** The development of health homes will bring an expanded role for care managers and other sorts of health industry employees.
- **The State should implement health homes in a fashion that reduces regulatory burden while improving the quality and continuity of care.** The implementation of health homes should proceed in an expedited fashion with an eye towards mandate and regulatory relief.

Important Issues Outside Scope of Charge

The following issues were raised in discussion but were determined to be outside the Work Group's scope

- Role of Block Grants
- Forensic Services

Appendices

MRT Behavioral Health Subcommittee Meeting Agendas

MRT Behavioral Health Subcommittee Meeting Minutes

MRT Behavioral Health Subcommittee Meeting Presentations

Other

MRT #1058 Peer Support Services

Executive Summary

For MRT Peer Project #1058, Department of Health staff met with staff from six state agency areas and representatives from 16 peer provider organizations and coalitions, and surveyed 46 peer providers statewide, to gather information on peer support services currently operating in New York State, and their concerns and recommendations for integrating peers into a redesigned health care system. Any definition of peer services incorporates its unique relational aspect between equals, although there are necessary distinctions for those serving different disability populations (mental health, addiction, chronic conditions, multiple disabilities and developmental disabilities). Children must be treated as a separate, special group. Recommendations include promoting an understanding of the unique role of peer services in the health care field, accommodating funding for services, and for training, certification and leadership development, sponsoring accreditation for peer-run organizations, incorporating peer support services into health homes, and addressing the special value of peers for supporting children and their families in the health care reorganization.

Introduction The Medicaid Redesign Team (MRT) Peer project #1058, merges suggestions received through the MRT process regarding peer support services as a cost effective, successful way to assist in the recovery wellness process. This MRT project committee's charge is to submit a report with recommendations for maximizing the use of peers in a redesigned health care system that is more efficient, effective and person-centered.

Public suggestions to the MRT on this topic included: comprehensive care coordination teams that recognize individualized needs, including peer supports that target independent living skills; peer-run respite as diversion from hospitalization; peer-run recovery centers; peer services in Behavioral Health Homes, Patient Centered Medical Homes, and Health Homes; regionally managed behavioral health care carve outs to preserve peer services and the integrity of peer agencies; State (Department of Health) certification for peer support specialists, support and recovery coaches, to facilitate Medicaid reimbursement; Medicaid funding for peer services; and NOT having direct Medicaid reimbursement per service but paying peer-run organizations for providing appropriate, needed supports; opposition to managed care plans (HMOs) handling special needs of people with mental health disabilities.

To carry out its charge Department of Health (DOH) staff held four meetings, and had significant correspondence with representatives of the Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), Office for People with Developmental Disabilities (OPWDD), DOH Long Term Care (LTC), DOH Chronic Illness Demonstration Projects, and 16 other stakeholders, including several who had provided input to the MRT process (Attachment 1), and conducted a survey of forty-six stakeholder organizations from across the state (Attachment 2) and had input from an OMH Regional Advisory meeting of approximately 400 individuals. Participants represent the interests of persons with mental health, substance use, developmental and intellectual delays, multiple disabilities, chronic and/or severe physical disabilities, and the parents/families of children with any of these conditions. The purpose was to learn more about how peers are currently providing various services throughout New York State (NYS), and to discuss how they might be included to further the Medicaid Reform initiative.

This Report summarizes the input DOH received from peer agencies including the scope of peer support services currently operating throughout NYS, concerns and recommendations of representatives from several populations utilizing peer support services, and suggestions about how peer services could be further utilized in the Medicaid Redesign of NYS's health care system.

Peer Supports are Unique Peer support programs have grown out of the Independent Living Movement, the emergence of self help groups, the movement of people with special needs out of institutions into the community, and ideas of consumer inclusion and of recovery. Peer support is a relationship system of giving and receiving help founded on principles of respect, shared responsibility and mutual agreement as to what is helpful.

The basis of peer support differs from the traditional medical model. Introducing and incorporating peer services into health homes or other medical models changes the focus to the well being of the whole individual and can provide necessary connections to community supports. Shifting from a Medical Model to a Recovery Model changes the provider focus from tasks of stabilization and custodial care based on staff wisdom to education and involvement in an environment conducive to recovery based on consumer wisdom, increased self-advocacy and taking responsibility for one's own recovery.

Peer support also differs from case management in that case management primarily should be a link and brokerage service, to help the consumer locate and obtain services delineated in the service or treatment plan. Peer support models recovery and or wellness, and engages the individual as a co-equal with mutual responsibility, while case management is a relationship with a professional, someone at a different level. Because of the differences described here, many peer support organizations express concerns about having peers work in a medical environment, although they believe that their services are very appropriate and effective in promoting wellness.

Research Supports Theory Research is too broad to summarize here but is available in the Resources provided (Attachment 3). The Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized peer supports as evidenced based, and research reviews indicate that the impact of peer supports is sufficiently rigorous and outcome based to consider peer support services as an evidence-based practice. Studies show symptom improvement, reduced hospitalization/shorter in-patient stays, improved daily functioning, self-esteem and illness management, all with associated cost benefits. Including families in care and treatment has shown to promote treatment adherence and psychiatric stability, and to reduce relapses and substance use. The impact of peer services is as effective as those of non-peers when peer-delivered services are the alternative to traditional mental health services. Peer-run respite as alternative to hospitalization shows a marked decrease in number of hospitalizations/length of inpatient stays, and increased recipient satisfaction.

Survey Results

Forty-six peer stakeholder organizations from across the state completed a survey detailing the populations they serve, types of services provided, qualifications and training, documentation and supervision, settings, if and how the services are paid, and other concerns and best practices. Great variability in types of services, qualifications and sources of reimbursement/payment was reported. From stakeholder discussion subsequent to the survey, other differences between and within disability groups became apparent. Terminology is population-specific but the relational aspect of peer supports is key to all concerned. For example, "increased wellness and quality of life" may be more useful goals for some than "recovery". Whether as wellness or recovery, the peer model expands the health home ideal of linking individuals to community supports, beyond a psychiatric or medical condition to whole health well-being.

All the participant peer groups offered in-depth definitions of the special and unique characteristics of peer services as applicable to particular populations (Attachment 4). Funding sources and compensation range from donations, grants, state, county and local funding to Medicaid funded waiver services and from volunteers to salaried employees. NYS agencies have facilitated the following credentials for peer workers within their own organizations: OMH initiated a civil service title of peer support specialist and trains peer specialists who work throughout the state; OMH's Division of Children and Families is working with Families Together of NY to achieve a family advocate credential; OASAS sponsors a Recovery Coach credential based on CCAR training; Long Term Home Health Care's Nursing Home Diversion /Transition waiver has a peer mentor waiver service.

Concerns expressed through the survey include that Medicaid funding may reduce services through capitation and managed care; governmental regulation may hamper ability to provide customized flexible services; peers may be ineffective when under oversight of traditional providers. Current challenges for provider agencies include limited funding, disparity from other providers in pay and in

opportunities for growth and advancement, limited number of peers relative to demand, Medicaid documentation requirements as a disincentive, limited access to services due to lack of transportation, confidentiality issues when peers receive services in the same agency, and potential conflict of interest concerns if peers will have to go against their employer when advocating for a recipient. Stakeholders indicated barriers to recovery coaching that include lack of understanding of the peer role, lack of respect for peers by professional staff, and lack of certification for peers.

At present, most of the peer-run groups recommend and advocate for funding of peer services that is flexible and grant based (e.g. via state and local aid and Medicaid managed care contracts) to ensure fidelity to true peer support and self-directed recovery centered approaches. They support the concept of peer agency/program accreditation rather than peer practitioner credentialing which would more likely lead to placing peer staff in non-peer supported roles supervised by non-peer staff. The following suggestions were made as important to program administration: clearly defined role of peer, provider qualifications and/or certifications, service oversight responsibilities, payment mechanisms, state entity oversight of health homes with peer & family representation. Choice and careful matching of individuals with peers is very important; personal characteristics may mean that some people are better in certain peer roles than others. To avoid the drift toward traditional medical model structure a clear job description, standards, qualifications and expectations should be communicated prior to hiring. A culturally appropriate and sensitive approach allows more individuals to respond to peers. Peers should be independent of managed care, not trying to convince people to join a plan.

Services suggested that peer run programs could deliver to managed care programs include Wellness Recovery Action Planning (WRAP), advance directives, cultural and gender specific issues groups, alternative and holistic supports, self advocacy, a recovery- focused, trauma informed approach to services, hospital diversion/peer respite services, 24/7 peer support line. Further suggestions included implementing the CIDP model in the Forensic Hospitals and for people with mental illness in the Department of Corrections; using a transition or Bridger program for inpatient/forensic recipients coming into the health homes.

Peer Services in NYS

Mental Health

In 1994, the NYS Office of Mental Health created a Civil Service position of Peer Specialist, Grade 9, which currently has 48 filled positions. Approximately 2000 peer support specialists, trained under OMH auspices, are employed around the state in OMH facilities and in agencies that OMH supports. OMH utilizes Family Advocates of which there are 10 employed fulltime across the state. There are 400 trained advocates.

OMH recently has undertaken two initiatives to promote peer services: 1. the State's Medicaid Infrastructure Grant (MIG) "New York Makes Work Pay" (NYMWP), a statewide initiative to improve the rate of employment among people with disabilities, with a strategic planning goal to improve the use of peer-driven employment services; 2. a Transformation Transfer Initiative Grant to explore Recovery Centers which would be run by peers and provide supported education and employment.

New York has three peer- run crisis centers/respite which provide a cost-effective alternative to psychiatric hospitalization: Rose House Hospital Diversion Program operated by PEOPLE, INC.; Essex

MRT # 1058 Peer Support Services Report - Draft

County Crisis Alternatives Program operated by the Mental Health Association; and Voices of the Heart, Inc. Respite Program. For 2010, the annual cost for Rose House to provide care for 227 guests, for 748 resident days was \$264,000 compared to \$1,047,200 based on the average cost in local hospitals. Parents with Psychiatric Disabilities (PWPD) need programming to support families for reunification or to stay intact as they often are reluctant to reach out for mental health services for fear of being under scrutiny that will result in losing custody of their children. Offering respite to allow these parents to get necessary help to stay out of hospitals and participate in treatment is cost effective and helps families stay intact.

Substance Use

Primary peer services for people with substance use are provided by Recovery Coaches. OASAS reports nine paid trainers and 117 recovery coaches statewide who are trained through a self-directed program modeled on the Connecticut Center for Addiction and Recovery (CCAR) and paid by organizations that receive state funding. OASAS hopes to establish a NYS Recovery Coach Academy to ensure the integrity of the CCAR model, to develop standards and a code of conduct, and to maintain a database of recovery coaches and a statewide learning collaborative.

Recovery Community Centers (RCC) offer nonclinical specialty services such as linkages to clinical services, peer-led support groups, transportation support, training in parenting, nutrition and meal planning, financial management, facilitating education and career planning, resume writing and computer skills. OASAS recently awarded funding to three Recovery Community Centers which have served about 1000 people to date: Phoenix House of New York, Inc., Center for Community Alternatives in Rochester and Friends of Recovery of Delaware and Otsego Counties, Inc.

OASAS has a SAMSHA grant to implement the New York Supports Opportunities for Accessing Recovery Services (NY SOARS) initiative, a vouchering system for consumer-determined choices of faith based and community based recovery support services and/or enhanced opportunities for treatment services including Recovery Coaching. Recent revisions to Part 822 of 14NYSRR include changes to facilitate Ambulatory Patient Group (APG) Medicaid billing for peers to deliver Peer Support Services in clinics.

Multiple Disabilities

At least a quarter of the individuals who have the greatest behavioral needs, often have both substance use and mental health issues, and are in both the OMH and OASAS system. Many people have a combination of disabilities that include physical impairment and chronic conditions. NYS agencies are working to help those with cross-system problems get the proper help they need but the current governmental structure is not organized to facilitate this.

Advocacy groups such as Centers for Independent Living (ILCs) address the multiple needs of individuals with multiple needs and several survey respondents were ILCs. The New York State Independent Living Council (NYSILC) is a not-for-profit, non-governmental, consumer controlled organization, with 37 independent living centers (community-based organizations) statewide, directed by and for people with disabilities. The council is composed of 27 appointees from around the state, a majority with disabilities, representing diverse cultures and needs. The council's state plan partners are New York State Education Department/Office of Vocational and Educational Services for Individuals with Disabilities (VESID) and

the Office of Children and Family Services and Commission for the Blind and Visually Handicapped (CBVH).

Intellectual/Developmental Disabilities

The Office for People with Developmental Disabilities (OPWDD) provides peer support through family support services for those families who have a child with a developmental and/or intellectual disability, most of whom are in the Home and Community Based Services waiver.

The Developmental Disabilities Planning Council (DDPC) includes a Consumer Caucus of peers who are involved throughout Council functions. DDPC sponsored *The Peer Mentoring and Supports in Employment*, a collaboration to implement peer-based support, mentoring and other consumer-led approaches that positively impact individuals' with disabilities ability to obtain, maintain and sustain employment. Individuals who successfully utilized the vocational rehabilitation system (e.g., VESID, CBVH, One Stops) were paired with individuals just entering the system or who had previously been unsuccessful in benefitting from vocational rehabilitation. Participating agencies developed new service opportunities through the VESID Unified Contract Services (UCS). In January 2009, twenty-five independent living centers established VESID UCS contracts totaling about \$1 million.

The Self-Advocacy Association of New York State, Inc. (SANYS) is a not-for profit, grassroots organization run by and for people with developmental disabilities with the goal to create a person-centered and person-directed system of supports. Through supporting self-advocates and self-advocacy groups regionally and statewide, SANYS is providing peer supports to its members.

Chronic Conditions

Four of the six DOH Chronic Illness Demonstration Projects (CIDP) utilize peers as part of Interdisciplinary Care Teams composed of a registered nurse, social worker, care manager and peer support specialist (PSS). The PSS services include outreach and enrollment, health coaching, relapse prevention, reminding enrollees of appointments and escort services, assisting with links to needed services, assisting enrollees with building social skills, identifying recovery goals with enrollee, and participating in treatment meetings and case rounds. An example of cost savings for one individual in this project: the year prior to enrollment in CIDP \$52,282 was spent in Medicaid claims, and for the year in CIDP \$20,650 was paid in Medicaid claims.

DOH's Office of Long Term Care Nursing Home Transition Diversion Medicaid waiver utilizes Peer Mentoring as an individually designed service intended to improve the waiver participant's self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community through education, teaching, instruction, information sharing, and self-advocacy training. Peer Mentoring is a short-term service only, to address specific goals for waiver participants (seniors and people with disabilities) who have recently transitioned into the community from a nursing home, or as needed during times of crisis.

Serving Children and their Families in NYS

Children are best treated within the structure of their families who will continue to care for and support them. Best practices include programs that promote mental and physical wellness for the entire family,

parents/caregivers and children. A special Children's Team for MRT Behavioral Health Reform is considering how best to address children's issues in the BHO model. To prevent the progression of children's mental health problems, intensive parenting skill building and supports, continuity of primary care provider, direct assistance and skill building in systems navigation, natural supports and resiliency, therapeutic mentoring and respite, could all be provided by peer support services.

The Medicaid waivers that currently provide peer support through a variety of family support services are Home and Community Based Services 1915(c) waivers for Children and Adolescents with Serious Emotional Disturbance (OMH SED); the Long Term Home Health Care Waiver for Medically Fragile Children; the HCBS Comprehensive Waiver for People with Developmental Disabilities (OPWDD); and the Bridges to Health Waivers for children in all three disability areas (SED, Developmentally Disabled, and Medically Fragile). Parent to Parent of NYS is a statewide organization staffed by parents or close relatives of individuals with disabilities, health care and/or behavioral needs, who provide support, information, referral and training to families of individuals with similar disabilities. Parent matching and systems navigation are important family to family peer services.

Other States - What have they done?

To date, over 30 states have some form of peer support in place although not all are Medicaid reimbursable. The following are examples of peer support programs recommended by our participants as possible models.

Arizona – This state's program is recommended as an exciting model because of its unique training and certification set-up and its extensive use of peers throughout its programs. Arizona is distinguished for promoting family roles in its children's behavioral health system. The Arizona Community Services Agencies Waiver for peer and family services maximizes the ability of peer-run programs to offer creative services by not "certifying" workers, by using more than one curriculum, by not requiring a licensed clinician to sign off on everything done by peers and by offering a career ladder for peer supervisors and a specialized type of licensure, developed just for peer- and family-run programs. For Medicaid reimbursement, a service must be a measureable step toward stated goals. The Arizona Department of Health Services as the single state Medicaid agency contracts with BHOs. (Attachments 5 and 6)

Georgia was the first state to implement peer support as a Medicaid billable service under the Medicaid Rehabilitation option. The service is structured with scheduled activities that promote recovery, self-advocacy, development of natural supports and maintenance of community living. The Certified Peer Specialist (CPS) is under the direct supervision of a mental health professional, who is a psychiatric rehabilitation specialist credentialed by the US Psychiatric Rehabilitation Association and who is also a CPS. CMS approved Peer Supports Services directed to specific individualized service plan (ISP) goals, supervised by Mental Health Professional, provided in a clinic or the community. Georgia has also used a CMS Real Choices Grant to develop a position of peer supports to help people with disabilities learn to advocate for themselves through a "train the trainer" program. This program focuses on skills such as listening and communicating, understanding self-directed care, connecting to community services, developing relationships, knowing when to refer or dealing with a crisis and employment issues.

Minnesota uses Community Health Workers (CHWs) to bridge the gap between communities and the health and social service systems, navigate the health and human services system, and advocate for

individual and community needs. CHWs work in a variety of settings: health clinics, mental health centers, public health departments, mutual assistance associations and other community organizations and agencies that provide counseling, advocacy and health education. In Minnesota, CHWs are now serving deaf, aged and disabled populations. Their work includes health education; information and referral to medical care and a range of social services; outreach; cultural consultation to clinical and administrative staff; social support, such as visiting homebound clients; informal counseling, goal setting, encouragement, motivation; advocacy; and follow-up to ensure compliance with treatment.

Pennsylvania In February, 2007 CMS approved Pennsylvania's State Plan Amendment to include Peer Support Services in rehabilitation services for behavioral health. Efforts are underway to expand these services to seniors, transitional youth and forensics. This state's program is similar to, and perhaps based on Arizona's and has been recommended by some stake holders as outcome based.

Rhode Island. The Pediatric Practice Enhancement Project (PPEP), one of the most successful and innovative programs nationwide, is a medical home initiative that seeks to increase the capacity and quality of care for children with special health care needs through the use of Family Resource Specialists in pediatric primary and specialty care practices. These Family Resource Specialists are true "peers" to parents raising children with disabilities and special health care needs—they are all family members in similar situations themselves. Family Resource Specialists work in medical practices for 20 hours per week, five of which are paid for by the physician practice. They save staff time and provide patient families with support and information and the medical staff with help in understanding the family's questions and perspective. Data from 2004-7 show 38% lower average inpatient utilization for PPEP participants, and 15% lower annual healthcare costs than for non-PPEP participating families, and high satisfaction ratings from PPEP participants.

Federal Involvement and Funding

The CMS State Medicaid Directors' letter dated August 15, 2007 supplied guidance to states interested in providing peer support services under Medicaid in the mental health field. With the emphasis on recovery, "a process in which people are able to live, work, learn and participate fully in their communities", peer support services are considered an evidenced-based mental health model of care for mental illness and substance use in which peer support services are part of a comprehensive service delivery system.

To qualify for federal Medicaid funding and receive Federal Medical Assistance Percentage (FMAP), states must provide a core set of services to all eligible persons under the State Plan. An option allows for providing additional services and supports using the rehabilitation services option under the State Plan 42 CFR 440.130(d) and under the 1115 and 1915 waiver authority. Section 1915(b) (3) allows states to use cost savings from a Freedom of Choice Waiver to provide additional services. In 2010, CMS amended the section 1915(i) waiver benefits allowing states to provide "other services" as permitted under the 1915(c) waiver.

The Medicaid Rehabilitation Option is designed for mental health and substance abuse services and has been used by states adopting a recovery model for their state-funded programs, so that consumer-driven values for recovery can be integrated into all mental health services. Section 1905(a) (13) allows states to provide rehabilitative service in the Medicaid State Plan. Additionally, states can use CMS's

Real Choice Systems Grants for Community Living to increase opportunities for people with disabilities living in the community.

Pillars of Peer Support (a joint initiative by SAMHSA, Center for Mental Health Services (CMHS), National Association of State Mental Health Program Directors (NASMHPD), Depression and Bipolar Support Alliance (DBSA), OptumHealth, Carter Center, Wichita State University, Appalachian Consulting Group, Georgia Mental Health Consumer Network) was designed to develop and foster the use of Medicaid funding for peer support services in mental health settings. Two summit conferences were held. The first, in 2009, included those states currently providing formal training and certification for peer providers in mental health systems to identify the state support necessary for a strong workforce. Nationally recognized experts and stakeholders identified twenty-five “pillars” as strengths for a peer specialist certification program. Seventeen states surveyed indicated that they had a distinct certified peer support service that was Medicaid billable. Fifteen of the 17 indicated that they had certification processes. The most common barriers to implementing peer services were: acceptance of peers in mental health centers, financial issues, and understanding of the Certified Peer Service (CPS) role. (Attachment 7 includes the 8/15/07 CMS letter to state Medicaid Directors.)

The second Pillars summit in 2010 gathered several states not currently billing Medicaid for peer support services to identify opportunities and assistance to begin the process. Reported results of a survey on states’ use of peer supports listed some concerns also expressed by our MRT participants: need to recognize the uniqueness of peer support providers, system co-option of peers addressed by adequate training and job description, and incorporating peers into routine operations. Supervisor training is essential and must include focus on recovery. The supervisor should also be a peer, who has had the same training as those being supervised. Half of the 22 responding states indicated that their Medicaid reimbursement was embedded in payment to another entity, e.g. MCOs, behavioral health carve out vendors. Five states (23%) received Medicaid payment for peer services as a distinct service.

The SAMHSA Evidence Based Practices publication “Building Your Program” lists the following funding sources that have been or are being used for consumer-operated services: Federal Mental Health Block grants; other community federal sources such as SAMHSA, National Institute of Disability and Rehabilitation Research (NIDRR), Departments of Veterans Affairs (VA) and of Housing and Urban renewal (HUD); state or county general funds; other state funds such as Vocational Rehabilitation; community reinvestment; Medicaid; grants from foundations; contracts with MCOs and BHOs.

Certification, Accreditation, Assessment and Evaluation: Evaluation can foster program improvement and add intrinsic value to services. As the value of peer supports gains recognition and acceptance, peer-run provider agencies seek association with delivery models such as health homes and behavioral health organizations, as well as continued funding for their own programs in the community. Lack of certification for individuals and accreditation for programs and agencies may disadvantage consumer operated support programs in competing for Medicaid and other funding. States, Medicaid and Medicare, and insurance companies who would reimburse provider agencies for peer services will have requirements for workers to be qualified or certified on a comprehensive set of workforce competencies.

Certification for the individual worker fosters a qualified, ethical, diverse workforce through a test-based certification and/or licensing process and enforcement of code of ethics. Some states run their own

certification programs for peers, with accepted curriculum and other criteria. Peer-run organizations need valid, reliable skill assessment tools, training protocols and management information systems to measure outcomes. They need to identify program functions and staff competencies and to develop appropriate information management systems. Fidelity is a systemic effort to identify critical operational components of programs that are key to producing desired outcomes. SAMHSA's Multisite Study identified common elements in peer programs: program structure, program environment, belief systems, peer support, education and advocacy. The Fidelity Assessment Common Ingredients Tool (FACIT) is an anchored scale based on the identification and definition of the common program ingredients above. The Peer Support Outcomes Protocol Project developed, validated and field-tested a peer outcomes protocol (POP) that measures the effectiveness of peer support services for persons with mental illness.

Recommendations: It is appropriate and cost effective to incorporate peer services into the Medicaid Redesign shift toward whole wellness by integrating physical and behavioral health with other necessary aspects of successful functioning in the community (housing, employment, education, etc.)

1. **Promote acknowledgement and respect for the unique contributions and value of Peers in delivering services that help people, promote wellness and decrease costs.** Peer support providers need the respect of others in their fields as well as the support of upper management wherever they work, and in the health care industry and in government. All boards, committees, advisory groups and planning activities for organizations or programs pertaining to peers and peer services must have meaningful and significant peer representation.
2. **Facilitate ways to accommodate Medicaid funding for peer services, such as waivers, grants and funding for programs rather than for the position itself. Funding for training and education, certification, and leadership development would strengthen the peer workforce.** Currently in NYS peer services are delivered in many ways addressing different types of needs. This allows providers more flexibility than would be possible if a position were to be specifically defined in regulation.
3. **Establish an accreditation process for peer-run agencies which would professionalize their activities and require that supervision be provided by a trained peer to preserve the unique, whole health/wellness approach that peers provide.** A core evaluation would be appropriate for all peer-run organizations with additional modules for the specific populations. Model development must include consultation with and active participation of peers in the field.
4. **Incorporate peer services into health homes as a required element in health home applications, given the recognition that peer services are evidence-based practices which can improve outcomes while being cost effective.** Peer-run organizations are optimal for providing peer services and therefore, the model of a Health Home contracting with an outside peer support agency to provide services is the best model for integrating peer services and Health Homes. Any contract or RFP must identify how peer services will be incorporated into the Health Home. Peer support services should appropriately and effectively be extended into more situations, such as hospitals and nursing homes, to augment transitions to the community.
5. **Address children and their care separately.** Services appropriate for families and caregiver needs must be addressed by the same health care unit. Family peer support

must be a required service of each Health Home. Best practices include programming that promotes mental and physical wellness for families, parents and children.