Abstract

New York State's Medicaid reform efforts during the last five years have created a uniquely fertile environment in which to create Certified Community Behavioral Health Clinics (CCBHCs). The enormous state/federal partnership has focused on enhancing and expanding care management, especially for vulnerable populations, in order to improve outcomes and increase the health of the entire population. New York State's Medicaid Redesign Team's (MRT) Care Management for All agenda, our State Health Innovation Plan (SHIP), Health and Recovery Plans (HARPs) for individuals with serious behavioral health disorders and the massive Delivery System Reform Incentive Payment (DSRIP) program have established relationships, management structures and integrated evidence-based care models that will enable the swift growth of a robust network of CCBHCs.

HARPs are a comprehensive fully integrated specialty Medicaid managed care plan for individuals with serious behavioral health needs that include home and community based services that align well with services included in the CCBHC. The development of the comprehensive, high quality, integrated behavioral health services envisioned by the CCBHC model will further enhance and expedite the reform efforts that are currently underway.

The CCBHC Planning Grant will support State infrastructure necessary to develop a formal plan to pilot the implementation of CCBHC. CCBHCs provide an opportunity to improve the behavioral health systems through the provision of community-based mental health and substance use disorder treatment to further integrate behavioral health with physical health care, utilizing evidence-based practices and improving access to high quality care.

The CCBHC planning grant will enable New York to establish three to five CCBHC pilot sites, reflective of the regional diversity of the State's population and service delivery systems. The pilots will develop outpatient networks of primary care, mental health, substance use and programs will adopt a common set of tools, approaches, and organizational commitments to treat individuals in a seamless and integrated fashion. The MRT process has created a deep, broad and diverse process for stakeholder involvement that the State will be able to leverage in order to enable substantive input into the CCBHC design and advise us on ways to improve services.

The reforms being implemented in our behavioral health specialty services system has established a strong and robust foundation on which to build CCBHCs, placing New York State in a position to demonstrate the efficacy of the model rapidly, thoughtfully and comprehensively.

Table of Contents

Project Narrative

Section A: Statement of Need

A-1.

New York State has a long and proud history of leadership in behavioral health (BH) services. The Offices of Mental Health (OMH) and Alcoholism and Substance Abuse Services (OASAS) have responsibility for the planning, funding and oversight of mental health and substance abuse services. Both state agencies have developed an array of specialized inpatient, outpatient treatment, rehabilitation and residential services. Now, both agencies, in collaboration with the Department of Health (DOH) are playing a critical role in transforming the healthcare delivery system and integrating behavioral health and health services. Given the importance of behavioral health to the overall health of a population, and the extent to which the BH system interfaces with the drivers of the social determinants of health, New York State's behavioral health community is playing an essential role in the massive healthcare reform efforts now underway.

In line with federal legislation and national trends, New York has been a leader in moving our system from institutional care, to a focus on maintaining people in the least restrictive setting, to full community inclusion and population based behavioral healthcare. Over the past 30 years, the State has contracted the State operated adult psychiatric hospital census from over 20,000 to under 2,900 beds, and the State has reinvested the savings in increasing access to outpatient treatment, community supports, rehabilitation, and general hospital psychiatric inpatient services. More than 38,000 units of state supported community housing for people living with mental illness have been developed. These community based resources have created a safety net which has helped the mental health system evolve from a primarily hospital focused system to one of community support. The emergence of the peer recovery and empowerment movement in the 1990s has stimulated a shift in focus from support to recovery.

OMH now funds and licenses more than 2,500 mental health programs serving 700,000 people annually. These programs are operated by the State, local governments, not-for profit agencies and for profit organizations. They provide outpatient and inpatient treatment, rehabilitation, emergency services, housing, community support and vocational services. The majority of services are delivered to individuals with a serious mental illness (SMI) or children and adolescents who have a serious emotional disturbance (SED). These individuals suffer from the most difficult and complex mental health conditions and often have co-morbid physical health and substance use ailments.

OASAS plans, develops and regulates the State's system of substance use disorder and gambling treatment agencies. OASAS directly operates 12 Addiction Treatment Centers, which provide inpatient rehabilitation services to approximately 10,000 persons per year. In addition, the Office licenses, funds, and supervises nearly 1,000 community-based substance use disorder treatment programs, which serve about 100,000 persons on any given day and 245,000 unique individuals annually in a comprehensive range of services. The agency inspects and monitors these programs to guarantee quality of care and to ensure that clients receive care that is evidence-based including addiction and/or psychotropic medications when indicated by their history and symptoms.

New York's system is funded by a robust mix of Medicaid, State aid, county support, other funding, and private insurance. The New York State Department of Health is the single State agency responsible for the administration of the New York Medicaid Program. As the single State agency, DOH promulgates all necessary regulations and guidelines for Program

administration, as well as develops professional standards for the Program and develops rates and fees for medical services. The Medicaid program is the State's largest payor for behavioral health services, accounting for over 50% of the public behavioral health system. Presently, the behavioral health system is being integrated into New York's Care Management for All agenda, State Health Innovation Plan (SHIP) and Delivery System Reform Incentive Payment (DSRIP) program. These massive reform efforts rely on New York's robust BH safety net, which the State is strengthening with the establishment of Health and Recovery Plans, development of HCBS and Health Homes, HARPs provide an integrated insurance product tailored for the unique needs of people with SMI that will improve their care management and facilitate their incorporation into the Medicaid managed care system. Health Homes have generated strong partnerships between hospital systems, primary care providers and community based behavioral health agencies. They provide a care coordination infrastructure, including technology for real time alerts and information sharing. The 1115 demonstration waiver will cover recovery-oriented home and community based services like housing, education and employment for both children with SED and adults with SMI. Beginning October, 2015 New York State will begin including almost all behavioral health services into mainstream Medicaid Managed Care plans, including the Health and Recovery Plans.

DSRIP is creating Performing Provider Systems that will reduce unnecessary hospitalizations, drive care into fully integrated community settings, and create a coordinated network of providers—medical, specialty and behavioral—in order to improve quality and health outcomes and lower costs. Nearly all licensed behavioral health clinics are members of at least one Performing Provider System and so are poised to seamlessly integrate into these delivery system reform efforts. Several of the DSRIP projects involve the integration of behavioral health and primary care with a focus on evidence-based practices, early identification, rapid access to treatment (including emergency and respite behavioral healthcare), parity, and de-stigmatization of behavioral health disorders. Performing Provider Systems have all committed to these detailed, BH integration efforts that rely on New York's behavioral health service system for success.

A-2.

According to the National Survey on Drug Use and Health (NSDUH), New Yorkers experience behavioral health issues at a comparable rate to the National Average. Table 1 shows the NSDUH recorded prevalence rates of mental health and substance use conditions among youth, young adults, and adults within New York. While the findings highlighted in Table 1 demonstrate an average need among New York's total population, there are great behavioral health prevalence disparities among specific geographic areas and populations throughout the State.

Table 1. Mental Health Condition and Substance Use Disorder Prevalence in New York State, 2013

Condition	Youth (12 to 17) Population: 1,454,633		Young Adults (18 to 25) Population: 2,275,816		Adults (26+) Population: 13,135,246	
	Prevalence	Rate	Prevalence	Rate	Prevalence	Rate
Alcohol Dependence or Abuse	59,872	4.12%	315,254	13.85%	765,085	5.82%
Drug Dependence or Abuse	58,054	3.99%	183,709	8.07%	222,362	1.69%
Alcohol or Drug Dependence or Abuse	97,426	6.70%	424,436	18.65%	893,333	6.80%
Needing/Not Receiving Alcohol Treatment	58,740	4.04%	309,773	13.61%	731,216	5.57%
Needing/Not Receiving Drug Treatment	54,765	3.76%	170,998	7.51%	202,742	1.54%
At Least One Major Depressive Episode	107,795	7.41%	177,623	7.80%	823,123	6.27%
Any Mental Illness			428,609	18.83%	2,489,304	18.95%
Serious Mental Illness			84,168	3.70%	463,724	3.53%
Serious Thoughts of Suicide			156,765	6.89%	414,794	3.16%

Source: Rates from the National Survey on Drug Use and Health (2010-2012) applied to U.S. Census Estimates (2013

Urban Areas

Select urban areas within New York maintain higher prevalence of behavioral health issues. Within Bronx County- a geographic area predominantly made up of individuals who identify as Hispanic (54.3%) or Black (35.7%)[1]-for example, 7.1% of all people report experiencing serious psychological distress, with rates reaching to 9% in certain areas[2]. Such reports come in higher than the compared 5.5% in NYC overall. In addition, 13.4% Medicaid beneficiaries in the Bronx, (110,000) have a depression diagnosis, a rate nearly twenty percent higher than the city rate (11.3%). While rates of depression among enrollees in the Bronx are high throughout the county, prevalence in certain neighborhoods reach as high as 17.8%.

Rural Areas

Rural areas within New York yield disproportionately higher rates of behavioral health prevalence in comparison to the State's total population. The Finger Lakes Region for example, is comprised of 14 counties in the western portion of New York State: Monroe, Livingston, Ontario, Seneca, Wayne, Yates, Cayuga, Chemung, Schuyler, Steuben, Allegany, Orleans, Genesee[3]. Behavioral health conditions are prevalent in the Finger Lakes region, especially among the Medicaid population. As demonstrated in Table 2, this region has a much higher prevalence of depression, schizophrenia, stress and anxiety disorders, and substance abuse than the New York state Medicaid population as a whole.

Table 2: Medicaid Mental Diseases and Disorders, Prevalence / 1,000 Beneficiaries, 2012

Diagnoses (Not Mutually Exclusive)	FLPPS Region	NYS
Mental Diseases And Disorders	411.2	289.4
Depression	119.3	70.9
Chronic Stress and Anxiety Diagnoses	55.7	42.9
Schizophrenia	48.2	38.5
Chronic Mental Health Diagnoses - Moderate	15.6	9.2
Substance Abuse	99.5	86.8

Children and Youth

In 2013, the number of children and adolescents in New York who were served in the State's public health system increased to 160,123[4]. In New York City, there are 571,167 children ages 0-4, of which 47,407 (8.3%) are estimated to have a mental health disorder. Among children

ages 5-17, there are 1,343,715 children in New York City, of which 268,743 (20%) are estimated to have a mental health disorder[5]. Throughout the entire state, youth ages 10-19 experienced 1,800 self-injurious hospitalizations of which 84 resulted in suicide[6]. This number was an increase from the 2009-2011 baseline data which reported a total of 1,688 self-injurious hospitalizations of which 76 resulted in suicides.

In addition, NSDUH data shows that 59,872 New York youth have alcohol dependence or abuse conditions and 58,054 are diagnosed with drug dependence or abuse[7]. Moreover, 9.6% of adolescents (aged 12-17) in New York used illicit drugs and 15.8% engaged in binge-alcohol use within the last month. These rates are higher than the National average clearly indicating that the State needs to prioritize increased access to quality substance use services for adolescents in New York State.

Veterans

At approximately 950,000 individuals, New York State maintains the 5th largest veterans' population in the U.S. Returning Iraq and Afghanistan veterans show drastically higher rates of behavioral health conditions with 50 % who have a mental health need, and 8-10% who have a substance use disorder[8]. Moreover, the suicide rate among veterans is twice the rate in comparison to the general population.

Older Adults

In New York State, the number of people aged 65 or older is expected to increase more than 50 percent, from 2.5 million to 3.9 million, by the year 2030. Concurrently, the number of adults aged 65 or older who have mental illness in New York State is expected to increase by 56 percent, from 495,000 in 2000, to 772,000 in 2030[9]. This dramatic increase in the number of older adults who will require mental health services raises concerns about the ability of health, mental health, and aging services to provide adequate access to services that respond to the unique needs of older adults in a coordinated way.

Native Americans

New York State has the nation's 5th largest percentage of American Indians/Alaska Natives, with 114,152 individuals who identify as either AI or AN. (US Census Bureau, 2012). In addition, there are 9 federally recognized tribes throughout New York State and 25,000 Native Americans living in reservation communities throughout New York State (NYSDOH, American Indian Health Program, 2014). While data is limited, American Indians/Alaska Natives in New York State have shown higher rates of anxiety disorders in comparison to non-Hispanic whites, as well as increased rates of substance abuse disorders and suicide.[10]

A-3.

New York possesses a robust system of care that currently provides a full array of community behavioral health services. There are approximately 525 clinics licensed by OMH and OASAS that provide behavioral health services statewide. Licensing regulations for these clinics align well with major components of CCBHC, such as staffing, credentialing, cultural competence, and linguistic requirements. Licensed clinics within New York State are a critical point of access to New York's complete array of ambulatory mental health treatment and substance abuse services for individuals suffering from an acute episode of mental illness or substance abuse. The clinics provide the initial focal point to assess, stabilize, and prepare a patient-centered treatment plan; prescribe medications and provide treatment; and make referrals to other appropriate behavioral health services that will foster recovery.

In addition to the behavioral health services offered in the Medicaid State Plan, New York's 1115 waiver for Medicaid Managed Care was recently approved. The 1115 waiver establishes

Home and Community Based Services for individuals with SMI and SUD, as well as Crisis Intervention services. A similar managed care program and service design will be implemented for children in 2017. The existing service system and new HCBS service package create a strong foundation for the scope of services required in CCBHC. The State has reviewed all required CCBHC services against New York's current Medicaid State Plan. All services listed in Appendix II are covered under the plan. Here are several examples:

I. **Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization-** New York State regulations for OMH clinics currently include the requirement to provide a 24/7 crisis phone line that can be further enhanced with the CCBHC requirements. In addition, the 1115 waiver includes a waiver only service, Crisis Intervention that is consistent with the CCBHC program standards.

II. **Screening, assessment, and diagnosis, including risk assessment-** These are existing services that are currently provided in behavioral health clinics.

III. **Patient-centered treatment planning or similar processes, including risk assessment and crisis planning**- These are existing services that are currently provided in behavioral health clinics, but will be enhanced through CCBHC.

IV. **Outpatient mental health and substance use services**-These are existing services that are currently provided in behavioral health clinics.

V. **Outpatient clinic primary care screening and monitoring of key health indicators and health risk**- These are existing services that are currently provided in behavioral health clinics.

VI. **Targeted case management**- Care Management services are broadly provided in New York State, and have undergone a major enhancement and update through the rollout of health homes for adults three years ago. The rollout of health homes for children is currently underway.

VII. **Psychiatric rehabilitation services**- New York State has a State Plan Service called Personalized Recovery Oriented Services (PROS) that provides psychiatric rehabilitation services. OASAS Outpatient rehabilitation includes structured therapeutic activities, counseling, recovery oriented services and family therapy in an outpatient setting. In addition, the HARP program includes HCBS psychiatric rehabilitation services that many clinic programs have been designated to provide.

VIII. **Peer support and counselor services and family supports**- These services are currently available in New York State primarily through OASAS State Plan and state contract funding. The HARP program will include these services in its benefit package.

IX. **Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas**- New York State will work with the Veteran's Administration to ensure that such services are developed consistent with clinical mental health guidelines established by the Veterans Health Administration. CCBHCs will create significant opportunities for us to expand outreach and engagement of Veterans.

A-4.

In New York State there are well documented examples of health disparities between different racial and ethnic groups, age ranges, socio-economic conditions, levels of ability, sexual orientation and geographic regions; all of which create barriers to receiving quality behavioral health care. Throughout New York's Medicaid Redesign Team (MRT), DOH, OMH, and

OASAS have identified significant service quality issues. While national rankings tend to show New York as ranking average in overall health care quality, those statistics do not reflect the challenges faced through the state, , such as avoidable hospital use, a measure in which New York ranks 50th in the country[11].

In addition to quality issues, New York State is faced with great service underutilization among individuals with mental health and substance use issues. In the past year, approximately 61.1% of adults with a behavioral health condition did not receive treatment[12]. Moreover, it is estimated that more than 75% of older adults[13] and 80% of adolescents[14] who needed mental health treatment did not receive services. Similar to the issues raised in A-2, drastic rates of service underutilization can be attributed to specific geographic areas and populations yielding higher prevalence rates of behavioral health conditions.

Urban Areas

Racial and ethnic minorities frequently face decreased detection of mental disorders in primary care and have lower rates of entry into, adherence with, and retention in specialty mental health services. Such issues are of particular concern to urban areas of New York, such as Bronx County, due to the increased number of individuals who identify with a minority population. According to New York's Statewide Assessment of Treatment Gaps for Racial/Ethnic Groups in Need of Mental Health Services, 69% of Asian Americans, 64% of Latinos, and 59% of African Americans with depression did not access treatment within the past year, as compared to 40% of Whites[15]. Moreover, 88% percent of Latino children and 90% of children from other ethnicities did not receive mental health care, compared to 76% of White children and 77% of African American children.

In the Bronx, it is reported that approximately 54% of Medicaid recipients who were prescribed antidepressant medications did not complete the treatment in its entirety[16]. In addition, 44% of individuals were hospitalized for a mental illness did not received a follow up within a week after discharge.

Rural Areas

According to the Health Resources and Service Administrations (HRSA) Data Warehouse New York State, comprised of sixty-two counties, experiences behavioral health professional shortages in geographic locations within fifty-four counties.[17] The most prevalent shortage areas can be found in Western and Central New York-including the Finger Lakes Region. Such finding are detrimental to New York's rural population as rural residents are more likely to have low socioeconomic status, be in fair or poor health, and be uninsured compared to those who do not live in rural areas. While the prevalence of psychiatric disorders is similar among rural and non-rural adults, their service utilization differs. Rural residents with serious mental illness (SMI) receive fewer specialty services than those living in metropolitan areas. Rural residents with SMI have worse symptom outcomes over time compared to non-rural residents with SMI, particularly among those with co-occurring substance abuse.

Children and Youth

In 2012, the Citizens' Committee for Children of New York conducted a community mental health needs assessment for children in New York City[18]. Findings demonstrated an insufficient allotment of service availability for children and youth ages 0-17 with a behavioral health need. As such, the committee stated the child behavioral health services would have to increase by 296,637 slots in order to appropriately accommodate the need throughout all 5 boroughs.

Veterans

Although need for comprehensive behavioral health interventions for New York Veterans is prevalent, only 23% of New York Veterans utilize VA services[19]. Moreover, only 5,338 sought treatment at an OMH clinic during 2013[20]. Based on these findings, service outreach and engagement for veterans remains a prevalent issue for New York.

Older Adults

Presently, fewer than 25 percent of older individuals with mental health needs in New York State receive services[21]. Mental illness is common among the aging population due to a variety of factors including: increased physical health ailments, social isolation, decreased mobility, and a growing inability to complete various activities of daily living (ADL)[22]. With only a limited amount of services and supports in place, New York behavioral health agencies are not equipped to handle to the influx of older individuals in need of services. The implications of mental health issues are detrimental to older adults and their families due to the fact that untreated mental illness can jeopardize quality of life, community integration, and life longevity[23].

Native Americans

In New York State, the Native Indian/Alaska Natives (NI/AN) is approximately 59,200. Within this population, 23% (n=13,600) are uninsured and 61% live below the federal poverty level. This limits access to health care, because a large portion of this population is either unemployed or employed in low-wage jobs that don't offer health coverage[24]. Having access to health insurance is critical in this population where adults experience higher rates of frequent mental distress and where the suicide rates are two and a half times higher in young adults.

Section B: Proposed Approach

B-1.

New York State has one of the nation's largest networks of community based behavioral health services, including clinic treatment, psychiatric rehabilitation, crisis services, and peer and family support. Nonetheless, given the diversity of geography and population in New York State, gaps remain in capacity, access and availability throughout the state. The creation of CCBHCs in New York State will help expand capacity and increase access to services for individuals in the community.

New York State's wide-ranging Medicaid reform efforts will work synergistically with the CCBHC initiative to expand and enhance access to high quality behavioral healthcare for New Yorkers, especially those with serious mental illness and substance use needs. HARPs will benefit from the availability of coordinated, comprehensive care from CCBHCs integrated into the medical and behavioral health care system. DSRIP Performing Provider Systems and Advanced Primary Care providers will benefit from the ability to integrate care with evidence-based, high quality, accessible CCBHCs.

Specifically, CCBHCs will reach out to educate recipients and families about benefits and how to access them. Once an individual comes into contact with these service providers, CCBHCs will offer prompt intake and engagement in services. This will reduce the time that recipients wait between being assessed and receiving services, and once an individual is connected to services, CCBHCs will provide convenient, person-centered services in order to achieve better outcomes and recipient satisfaction.

CCBHCs will be accessible to all New Yorkers who need the services they offer. This can be accomplished in part by allowing mobile in-home telehealth/telemedicine, and online treatment services as well as ensuring transportation needs are met. These treatment modalities will ensure

that neither geography nor financial resources will act as a barrier to services, allowing individuals to focus on recovery without the added stress of overcoming these barriers. This is especially important in rural parts of New York State that have a scarcity of available services. CCBHCs in New York State will also provide increased access to 24x7 crisis management services that are delivered within three hours. This will expand the current crisis capacity in New York State and improve the response, which can range from 24-48 hours in New York City to an absence of capacity in rural parts of upstate New York. In addition, this service includes an interface with hospital emergency departments (ED), where individuals experiencing a psychiatric crisis often choose to go for lack of a better option. CCBHCs coordination with EDs will help to address the needs of individuals in psychiatric crisis in the community.

The State will also be able to utilize existing training and education platforms to ensure consistent staff and program development in a timely manner. Major initiatives such as the HARP have required substantial infrastructure and resources that can be leveraged for the CCBHC. Examples include: the web-based training platform for the Community Mental Health Assessment of the interRAI, the work of the Clinic and Managed Care Technical Assistance Center for increasing staff competencies in the delivery of clinic and Home and Community Based Services as well as technical information on finance and billing through face-to face and web-based training. Additionally, the State has collaborated with Columbia University through the Center for Practice Innovations in the development of over 20 web-based evidence-based training modules supported through a distance learning collaborative.

The creation of CCBHCs in New York State will also enhance the pre-existing efforts to coordinate care, including health homes and DSRIP Performing Provider Systems. In NYS, Health Homes provide care coordination in a person-centered manner, taking into account the family's or recipient's needs and preferences. This underlying philosophy aligns with the care coordination requirements of the CCBHCs, which will also prioritize a individual's preferences.

B-2.

New York State has a long-standing commitment to broad based and substantive stakeholder input. In addition to a number of advisory bodies mandated by state statute, the State regularly empanels advisory bodies in order to ensure that policymakers have the benefit of input from recipients, family members, service providers, advocates, academics and other concerned citizens. The CCBHC initiative will be established in concordance with these methodologies. OMH and OASAS will consult with, and solicit input from, the Behavioral Health Services Advisory Council (BHSAC),[1] which is the joint advisory body to OMH and OASAS. The statutorily mandated BHSAC membership consists of recipients, family members, providers, tribal representatives, military service members, veterans, and local government officials representing mental health and substance abuse perspectives.[2] In addition, the BHSAC includes

[1] A complete list of BHSAC membership may be found here: https://www.omh.ny.gov/omhweb/bh_services_council/membership.pdf

[2] New York State Mental Hygiene Law Section 5.06 establishes a "behavioral health services advisory council, the purpose of which shall be to advise OMH and OASAS on matters relating to the provision of behavioral health services; issues of joint concern to the offices, including the integration of various behavioral health services and the integration of behavioral health services with health services; and issues related to the delivery of behavioral health services that are responsive to local, state and federal concerns."

two members who also sit on the New York State Public Health and Health Planning Council which advises the State Department of Health.

OMH and OASAS also meet regularly with the New York State Conference of Local Mental Hygiene Directors and its membership (which is made up of the leaders of the 58 local mental health authorities in New York State[3]) to provide updates on formal projects as well as conduct free-ranging conversations about issues of concern. As this project proceeds, the State will include CCBHCs among the items regularly discussed.

Both of the above groups meet with OMH and OASAS on at least a quarterly basis and this structure will be utilized more frequently during the planning grant.

OMH and OASAS will also provide information on the CCBHC demonstration program through statewide and local planning processes and the Mental Hygiene Planning Committee which includes representatives from OMH, OASAS, the State Office of People with Developmental Disabilities, and county mental health authority representatives. The main areas of the local planning process in which the agencies can engage stakeholders for their input on the CCBHC demonstration project include:

- Public hearings held by OMH and OASAS in which the agency commissioners receive feedback from the general public on key agency initiatives and other priorities that should be included in statewide planning efforts.
- The annual Local Services Planning Guidelines which are issued to local mental health authorities to develop their local service plans, and to the general public to provide general information on agency priorities that localities will be considering in developing local services plans. The Guidelines provide information on agency initiatives and can be used to solicit direct input from all local mental authorities through the online county planning system.
- The Statewide Comprehensive Plans required under New York State Mental Hygiene Law 5.07 are developed based in part on the input provided by the local services plans and public hearing comments described above.

Additionally, as part of the SAMHSA Block Grant process, OMH and OASAS meet semi-annually with representatives of the tribal nations in New York (typically Tuscarora, Oneida, Onondaga, Seneca, and others). The Tribal representatives also represent either mental health or substance abuse providers in their areas. Due to the fact that OMH and OASAS meet with tribal nations on a limited basis, the State will establish additional meeting times during the planning grant period to ensure appropriate engagement with tribal representatives.

[3] New York State Mental Hygiene Law Section 41.10 establishes a State Conference of Local Mental Hygiene Directors with the following powers: To review and comment upon rules or regulations proposed by any of the offices of the department for the operation of local service plans and programs. Comments on rules or regulations approved by the conference shall be given to the appropriate commissioner or commissioners for review and consideration; and to propose rules or regulations governing the operation of the local services programs, and to forward such proposed rules or regulations to the appropriate commissioner or commissioners for review and consideration. The chairman of the conference may appoint, for the purpose of advising the commissioners, such other committees of the conference as he may from time to time deem necessary.

Lastly, the State will leverage the existing Behavioral Health Medicaid Redesign Team workgroup[4] structure, which is providing a deep, broad and diverse process for participant involvement in the Medicaid redesign efforts. This exceptional stakeholder process will enable us to rapidly secure substantive support for the implementation and integration of CCBHCs. The State's robust stakeholder engagement system provides OMH and OASAS with a variety of communication options that can be used to inform stakeholders and community members on CCBHC input opportunities and planning updates. Such modalities include the OMH and OASAS websites, as well as private and public listservs. New York State will create capacity under these communication methods to ensure that information is disseminated appropriately, efficiently, and timely.

B-3.

The selection of qualified and experienced providers to participate as a CCBHC is an essential element of the planning period and program demonstration. As such, New York will select existing providers within the State that have a demonstrated history of providing comprehensive, high quality behavioral health services to ensure a strong initial foundation is created for CCBHC implementation. In addition to meeting the extensive certification criteria established by SAMHSA, prospective CCBHCs within New York State must fit within the State's current licensing and regulatory constructs, as well as the changing health care landscape. New York will work with stakeholders to identify qualified providers meeting the specific requirements essential to the program's success within the State's existing health care structure.

Selection Criteria

OMH, OASAS and DOH have collaboratively selected a set of criteria in addition to the SAMHSA criteria that will be used in the selection process. The criteria for a CCBHC within New York State will include: possession of a mental health, substance use, or integrated clinic license, established history of providing an array of behavioral health services, active participation in New York's current health care reform initiatives, demonstrated ability to meet the CCBHC criteria as directed by SAMHSA including the necessary data collection and reporting, and representation of an underserved area.

Mental Health, Substance Use, or Integrated Licensing

It is necessary for potential CCBHC providers to maintain a minimum of an OMH mental health or OASAS substance use clinic license. However, preference will be given to agency's who concurrently have both as CCBHCs are required to provide mental health and substance use services. Possession of these licenses ensure that providers have an existing capacity to provide comprehensive mental health and substance use services, as well as the demonstrated ability to meet current State regulatory requirements. Moreover, agencies licensed by New York have an existing relationship with State entities, therefore enhancing the support and technical assistance relationship. Consideration will be given to agencies that also possess an Article 28 health clinic license, in addition to a 31 and 32, or integrated license, in effort to facilitate a higher level of integrated care.

Demonstrated History of Providing an Array of Behavioral Health Services

New York will show preference to providers who currently provide a wide range of behavioral health services under state oversight. Such services may include: integrated outpatient services, Home and Community Based Services, crisis intervention, and State plan services such as

[4] A full list of MRT Workgroup members may be found here: https://www.health.ny.gov/health_care/medicaid/redesign/2015_wrk_grp_members.htm

Personalized Recovery Oriented Services (PROS) and Assertive Community Treatment (ACT). This will ensure that CCBHCs can rapidly and efficiently integrate into the comprehensive array of services available in New York.

Active Participation in New York's Current Health Care Reform Initiatives

If selected, the CCBHC program demonstration will be fully integrated into New York's current health care reform agenda. As such, potential CCBHC providers will need to be active participants within one or more of the State's health reform initiatives, such as DSRIP, HARP, Health Homes, integrated licensing and other system and practice transformation efforts. This preference will demonstrate that the agency has the understanding and capacity to be successful as a CCBHC within New York's dynamic health care environment, as well as aid them in operationalizing the critical integration and coordination elements of the CCBHC model.

Demonstrated Ability to Meet the CCBHC Criteria

All potential CCBHC providers must have the ability to meet the extensive certification criteria established by SAMHSA. Due to the fact that CCBHC is a new program, the State anticipates that potential providers may need support to meet all CCBHC criteria prior to certification. As such, the State will work with County Directors of behavioral health services to assess providers' ability to meet the above criteria, as well as their capacity to operationalize the CCBHC requirements within their agencies. New York will prioritize agencies that meet key CCBHC criteria prior to selection such as: possessing an existing relationship with a Federally Qualified Health Center (FQHC), Rural Health Centers, or appropriate alternative, and currently operating a crisis service program.

Representation of an Underserved Area

Per the expectations outlined by SAMHSA, New York will show preference to agencies that meet the above qualifications and represent an underserved area of New York based on OMH and OASAS planning data. One of our priorities is to ensure that the selected CCBHCs comprise a diverse geographic range, including underserved areas of New York City, Long Island, and both urban and rural areas of upstate New York. As such, New York will ensure that CCBHCs are selected in both rural and urban areas with a goal enhancing the availability of services in these underserved areas.

CCBHC Selection Process

If selected for the planning grant, New York will immediately develop and implement a process for behavioral health providers to demonstrate interest in becoming a CCBHC. Once identified, OMH and OASAS licensing staff will utilize New York's robust quality management protocols to evaluate any financial or quality concerns that may hinder an agency's ability to successfully participate as a CCBHC. New York's CCBHC Project Director and staff will then work with State agency leads and the established steering committee (as outlined in section C-2) to assess each provider's ability to meet SAMHSA's CCBHC certification criteria, as well as the additional measures established by New York. Following these quality and capacity assessments, the State will engage key stakeholders during the final selection process. New York will certify a minimum of one urban and one rural area agency as a CCBHC, but has the goal of selecting five across various regions of the State during the planning grant period.

Support and Technical Assistance

A provider's selection as a CCBHC will be contingent on their ability to meet all certification criteria. During the planning grant year, the CCBHC Project Director and Staff will closely monitor the selected CCBHCs and provide technical assistance to ensure their ability to meet all CCBHC criteria by the end of the planning grant year. The State will utilize existing strategies

and infrastructure developed under key State initiatives such as: Health Homes, HCBS, PROS, and Managed Care to support the provider's development programmatically, administratively and fiscally. These include the Clinic and Managed Care Technical Assistance Centers, as well as the Center for Practice Innovations (as discussed

The CCBHC Project Director and staff will work closely with the prospective agencies to provide training program staff in order to prepare the program for conversion to CCBHC. During this process, the State encourages programs to educate and prepare the participant community regarding the new program model. Technical assistance activities for CCBHCs will include but are not limited to: on-site visits to address effective service delivery and adherence to regulatory requirements; how to interact as a CCBHC within the State's health reform environment; and workforce recruitment and training regarding cultural and linguistic competence, new service delivery, and evidence-based practices.

B-4.

CCBHC aligns with the significant investments that New York State is currently making to transform the behavioral health system. This transformation is focused on moving individuals from inpatient to community care while creating a more standardized, accessible and high-performing community behavioral health system that addresses the needs of Medicaid's most expensive and complex populations. In New York State, these reform efforts include Health and Recovery Plans, Delivery System Reform Incentive Payments System and Health Homes.

New York CCBHCs will be able to leverage the current Health Home structure by integrating with pre-existing health home networks. Health Homes have already established the groundwork for integrating behavioral and primary health care for Medicaid members with high cost and complex chronic conditions. Within the health home structure, all enrollees are assigned a Care Manager who oversees and provides access to all of the services an individual needs to stay healthy and prevent hospital and emergency room admissions. By making Health Home participation a requirement for CCBHCs, the State will ensure that CCBHCs build upon the Health Home networks and strengthen New York's commitment to care management for all. CCBHCs, by providing sophisticated, integrated and coordinated care, will also enhance and supplement the services and provider networks that have are being established through the Health and Recovery Plans in New York State. HARPs will allow Medicaid beneficiaries to gain access to Home and Community Based Services, including: crisis respite, employment, education and peer services. HCBS are designed to assist individuals with their recovery in the least restrictive setting possible and promote improvements in the State's behavioral health system as it moves towards a more recovery-based delivery model.

Finally, the CCBHC program will augment the goals of DSRIP by enhancing systemic integration and accountability. DSRIP focuses on collaboration by requiring the development of Performing Provider Systems which are networks comprised of health and behavioral health care providers, social service providers, health homes and community-based organizations. CCBHCs will be included in at least one Performing Provider System, and many of the metrics and service delivery standards that are required of CCBHCs align with DSRIP.

The comprehensive nature of the CCBHC services will enable programs to more effectively meet the needs of individuals for integrated care either directly or through formal agreements. The prospective payment methodology further buoys the sustainability of this model of care similar to an organized health care system. The current service structures that will provide the platform for CCBHS service provision are detailed in Table 3 below, most of the required CCBHC services are available and currently being delivered in various parts of New York's

behavioral health system, CCBHCs will enable us to create a focused, comprehensive and coordinated service delivery model that will greatly assist us in our redesign efforts for behavioral health. As detailed in Section B1, the State will be able to utilize existing training and education platforms to ensure consistent staff and program development in a timely manner.

Table 3: CCBHC Service Delivery

CCBHC Service	Provision of Service
Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization	Behavioral health clinics, Comprehensive Psychiatric Emergency Programs, and State funding
Screening, assessment, and diagnosis, including risk assessment	Behavioral health clinics
Patient-centered treatment planning or similar processes, including risk assessment and crisis planning	Behavioral health clinics and PROS programs
Outpatient mental health and substance use services	Behavioral health clinics
Outpatient clinic primary care screening and monitoring of key health indicators and health risk	Behavioral health clinics and PROS programs
Targeted case management	Health Homes
Psychiatric rehabilitation services	PROS programs and HARP HCBS
Peer support and counselor services and family supports	ACT, behavioral health clinics, HARP HCBS, and state funding
Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas	To be developed at CCBHC behavioral health clinics

Whether provided by a CCBHC or a Designated Collaborating Organization (DCO), the CCBHC will still maintain full responsibility and accountability for the clinical care of recipients. Additionally, the CCBHC will ensure that the services provided are consistent with the individual's freedom to choose, and reflect person and family-centered, recovery oriented care, which recognizes the particular cultural needs, values and preferences of the individual. Recipients will have access to the CCBHC's grievance procedures, which will satisfy the requirements of New York State's and Medicaid's quality standards.

DOH, OMH and OASAS will utilize many of our existing licensing and quality assurance processes, currently being used, to implement an oversight framework that will ensure that CCBHCs and their DCOs provide integrated, high quality, person centered, recovery-oriented services that deliver on the promise of this BH service system reform.

B-5.

New York State's behavioral health services system has a history of promoting evidence-based practice (EBP) in its program design for over a century. OMH operates two research institutes that inform our program planning, oversight and implementation. The New York State Psychiatric Institute (PI), a collaboration between OMH, Columbia University and New York Presbyterian Hospital, was one of the first institutions in the United States to integrate teaching, research and therapeutic approaches to the care of individuals with mental illness. For over 120 years PI has been at the forefront of psychiatric research and its translation into practice. And the Nathan S. Kline Institute for Psychiatric Research has earned a national and international reputation for its pioneering contributions in psychiatric research.

OASAS and OMH have been leaders of the evidence-based practice movement with a wide range of initiatives designed to ensure that New Yorkers have access to effective treatment that

leverages the latest scientific research and New York's robust academic and research communities. OMH established the Schools of Social Work Deans' Consortium Project for Evidence-Based Practice in Mental Health as a partnership with 12 participating Schools or Departments of Social Work in New York State in order to provide education and training to advanced Masters-level social work students in recovery oriented, evidence-based practices. OMH has also established the Evidence Based Treatment Dissemination Center to provide clinical training and consultation to mental health professionals with the aim of closing the 15 to 20 year gap[25] between the time treatments are proven to work and the time it is available for New Yorkers with behavioral health challenges.

As a result of these investments, New York State is positioned to ensure that clients receiving services from CCBHCs have access to appropriate EBPs that are provided with careful fidelity to their models. New York State will provide training and technical assistance to CCBHCs to ensure that all of the below mandatory services are available at all CCBHCs:

Integrated Treatment for Co-occurring Disorders

Traditionally, individuals with mental health and substance use disorders have been treated separately for each condition. More effective than traditional treatment is Integrated Treatment, an evidence-based practice in which the same clinician or team of clinicians, working in one setting, provide appropriate mental health and substance use interventions in a coordinated fashion. Treatment planning takes into account stages of change/treatment and client choice in developing an individualized treatment plan. Services include screening, assessment, assertive outreach, health promotion, pharmacological treatment, counseling, group treatment, family psycho-education, and self-help groups. Integrated Treatment was selected as a required CCBHC practice because the consequences of untreated or inadequately treated co-occurring mental health and substance use disorders are severe. The benefits of treating both disorders together are well documented, with most individuals receiving Integrated Treatment achieving abstinence or substantially reducing harm from substance use and reporting improvements in independent living, control of symptoms, and competitive employment.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an evidence-based practice used to identify individuals who use alcohol and other drugs at risky levels with the goal of reducing and preventing related negative health consequences, disease, accidents, and injuries. Using valid and reliable instruments that are easy to score, Screening provides specific information about an individual's substance use. Brief Intervention is a time limited, client-centered discussion that aims to change an individual's behavior by increasing insight and awareness of his or her substance use. Referral to Treatment, a more advanced treatment option, involves referring an individual to a higher level of care that is most often provided at specialized substance use treatment programs. SBIRT was selected as a required CCBHC practice because it decreases the severity of drug and alcohol use (substance use screening and intervention help people recognize and change unhealthy patterns of use), reduces the risk of physical trauma and the percentage of at-risk clients who go without specialized substance use treatment, and reduces health care costs (fewer emergency department visits, non-fatal injuries, hospitalizations, arrests, and motor vehicle crashes).

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) focuses on connections between thoughts, feelings and beliefs and teaches techniques to reduce behavioral symptoms including: depression, anxiety, and urges and cravings to use substances. Evidence supports the effectiveness of cognitive

behavioral therapies across the broad range of behavioral health disorders that CCBHCs are expected to treat, which is why the State has selected CBT as an EBP for CCBHCs.

Medication Assisted Recovery for Addiction

Medication Assisted Treatment (MAT) uses medication, in combination with counseling and behavioral therapies, to treat people with severe addictions. Medications can reduce the cravings and other symptoms associated with withdrawal from a substance by occupying receptors in the brain associated with using that drug (agonists or partial agonists), block the rewarding sensation that comes with using a substance (antagonists), or induce negative feelings when a substance is taken. MAT has been primarily used for the treatment of opioid use disorder but is also used for alcohol use disorder and the treatment of some other substance use disorders. It is a vital component of treatment for substance use disorders, which is why the State has selected it for CCBHCs.

Motivational Interviewing

Motivational Interviewing is a clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach upholds four principles— expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy. Motivational Interviewing is an effective approach for integrated settings as it can target a broad range of behaviors. the State has chosen this approach for the CCBHC because it is an effective treatment that can also support integration efforts. All staff can be trained in Motivational Interviewing to promote a common approach towards behavioral and physical health conditions across disciplines.

B-6.

Presently, the State has operationalized a licensing process in which OMH, OASAS, and DOH collaboratively oversee and license integrated outpatient service providers. The Integrated Outpatient Services regulations are the culmination of a 4-year initiative by OMH, OASAS, and DOH to develop, implement and oversee the "Integrated Licensure Project." This collaboration resulted in the development of clinical and physical plant standards, staffing requirements, and a single application and review process – all with the goal of reducing the administrative burden on providers and improving the quality of care provided to individuals with multiple needs. The certification process consists of both on-site and off-site reviews and are conducted by staff from all three State entities.

The protocols established under the Integrated Licensing Project will be utilized to operationalize the certification process for CCBHCs. The CCBHC certification and oversight process will be embedded into existing annual licensing visits conducted by OMH and OASAS. OMH and OASAS will tailor the integrated licensing evaluation criteria to meet the specific needs and certification requirements of CCBHC. Moreover, New York will follow the rural and urban certification considerations, as established by SAMHSA, to ensure that CCBHCs in areas are certified and overseen appropriately.

New York State maintains existing staff capacity within OMH's Bureau of Inspection & Certification and OASAS' Bureau of Certification to perform the necessary components of certifying the selected CCBHCs. They, in addition to the staff hired as a part of this grant application, will closely work with selected programs to ensure that the CCBHC standards are fully implemented.

B-7.

New York recognizes that organizational change will occur at both the State and agency level if selected for the program demonstration. New York State will ensure the completion of all grant requirements, including soliciting input with respect to the development of the CCBHC demonstration from key stakeholders, certifying at least two clinics as CCBHCs, establishing a Prospective Payment System, creating the capacity within New York State to provide the required CCBHC services, and developing data collection and reporting capacity. Planning activities surrounding these requirements will be finalized through the development and submission of the final proposal and thorough preparation for potential participation in the national evaluation of the CCBCH demonstration program.

In an effort to ensure success in finalizing planning activities and initiating the program demonstration, a pre-implementation strategy will be developed and followed; the pre-implementation strategy will be a collaborative effort between the State, selected CCBHCs, and stakeholders, and will take shape in the form of a comprehensive action plan. The established action plan will serve as a road map, outlining the State's specific path towards implementation. Under the plan, the State and CCBHCs will address specific tasks surrounding key issues such as, realigning new or existing staff for program operationalization, informing the greater community of the new program, enhancing peer and family governance, anticipating and accommodating service volume, identifying and addressing potential implementation barriers and other key responsibilities that must be addressed prior to program installation.

New York will utilize existing pre-implementation protocols established under recent initiatives such as PROS and HCBS to help the selected CCBHCs operationalize the new services and delivery system, as well as Prospective Payment System. The CCBHC and OMH and OASAS Licensing Staff will review the proposed program space, staffing plan (includes specific Evidence Based Training) and policies & procedures to ensure the CCBHC meets all certification requirements. Once the CCBHC is in operation, OMH and OASAS will closely monitor the new program and provide technical assistance as needed.

The development of HCBS as a part of the HARP benefit package illustrates our ability to quickly create the necessary infrastructure needed for CCBHCs. HCBS required us to establish program guidelines for 12 new services, create a process to designate programs capable of providing the services, provide technical assistance, create guidance documents, and establish an oversight process for service delivery consistent with standards. Additionally, the State has established requirements for continued education utilizing a web-based learning management system for specific services and evidence-based practices that tracks participants learning.

B-8.

New York State proposes to use PPS-1 in the development of CCBHC program. the State believes that the billing structure under PPS-1 of a daily rate will allow an easier transition for CCBHCs as it conforms more closely to the billing structure currently utilized by New York State clinics. The daily rate will help to assure a more accurate monitoring of the services provided by DCOs due to the direct correspondence of DCO services and billable visits under PPS-1. Additionally, the State believes it may be easier for the CCBHC to initially administer. The State also prefers the coding structure under PPS-1, where all service-specific procedure and diagnostic codes can be included on the claim, as opposed to a monthly structure, which may not include that level of detail on the claim.

As specified in Appendix III, both system-wide and CCBHC applicant-specific cost and visit data will be collected during the planning grant period. Supporting data (the system-wide data)

will be collected by New York State from historical cost data for behavioral health outpatient services, while New York State anticipates using CCBHC-supplied actual cost and visit data. This state-wide data will be regionalized and then used for quality assurance purposes, to validate and test budgeted cost data for reasonableness and scope. A CCBHC-program-specific reporting template will be developed, which would be used to collect the cost and service volume data for all nine CCBHC services, whether provided directly by the CCBHC or a DCO. The State plans to rebase from budgeted CCBHC rates to rates based on actual cost as soon as possible. If allowed by the Center for Medicaid and Medicare Services (CMS), New York State will rebase to actual cost for rate year 2 using year 1 actual cost data. That data will be supplied within 5 months after the end of year one and the year 2 rate will be established retroactive to the beginning of year 2 within another 2 months. If retroactive rate setting is not allowed, New York State will create year 2 rates based on year 1 trended to year 2 and then rebase for year 3 based on year 1 actual cost data.

Base cost data will include total annual allowable CCBHC costs and estimated costs related to services or items not incurred during the planning phase but projected to be incurred during the demonstration. It also includes the cost of care associated with the DCOs with which each CCBHC has or will have formal relationships during the demonstration.

Visit data will include visit data collected during the planning grant period that aligns with the period for which costs will be collected.

New York State will implement the optional Quality Bonus Payment (QBP) and will use the planning period to identify specifically which optional measures in addition to the required core measures will be utilized to determine QBP. The State will identify measures that will enable CCBHC providers to demonstrate that their services have generated some savings for the New York State Medicaid system, and will establish a QBP that enables them to share in that savings. This will enable New York State to develop a CCBHC PPS that is consistent with the commitments New York State has made to CMS regarding Value Based Payment.

Optional measures may be derived from the New York State InterRAI Community Mental Health (CMH) assessment which will be completed with adult service recipients to determine housing status and additional social outcome indicators.[26] Optional measures may also be derived from the Child and Adolescent Needs and Strengths Assessment (CANS-NY) which will be implemented with children and youth under age 21 to determine social and behavioral needs and strengths for children and their families.[27]

These assessments are a core part of the New York State implementation of Health Homes in the behavioral health population and the Medicaid Managed Care 1115 Waiver carve-in of behavioral health services. These assessments will allow New York State to examine non-clinical factors, commonly referred to as "social determinants of health," such as education and income that have a major impact on health and behavioral health outcomes.

B-9.

New York State plans to use PPS-1 for CCBHC payment, with the understanding that it is a fixed amount for all CCBHC services provided on a given day to a Medicaid beneficiary. New York State will use cost and visit data collected in the planning grant period, as reported above in B.8., to create the rate for demonstration year one, updated by the Medicare Economic Index to the start date for the rate period. To establish the daily rate, total annual allowable CCBHC costs (including DCO cost) will be divided by the total number of CCBHC daily visits per year.

To support the calculation of the PPS for Demonstration year one, New York State will identify allowable costs necessary to support the provision of CCBHC services using a uniform cost

report demonstration wide. The report will adhere to 45CFR 75 Uniform Administrative Requirements, Cost Principles and Audit Requirement for HHS awards and 42 CFR 413 Principle of Reasonable Cost Reimbursement and any additional provisions specific to the CCBHCs Planning Grant as specified in RFA No. SM-16-001. New York State has proper fiscal control and accounting procedures in place to permit the tracking of funds to ensure funds are not used in violation of applicable statutes. New York State's uniform cost report package and source documentations adhere to federal and state record retention requirements.

New York State looks forward to the opportunity to integrate the PPS model for CCBHCs with the Value Based Purchasing Model required under our DSRIP waiver. New York State intends to fully support the PPS model, paying full reasonable CCBHC-specific costs, and to also include the optional Quality Bonus Payment using the required performance measures detailed in RFA Appendix III, Table 3. In addition, during the planning period, New York State will explore mechanisms to share systemic savings (e.g., inpatient, emergency department, etc.) that can be attributed to the outcomes of the program with the CCBHC. This will enable New York State to develop a CCBHC PPS model that is consistent with the commitments New York State has made to CMS regarding Value Based Payment.

B-10.

OASAS, OMH, and DOH have made it a priority to engage directly with community stakeholders on an ongoing basis during the design, implementation, and maintenance phases of major health and behavioral healthcare initiatives in the State. New York State will work with the leading statewide organizations and other stakeholders and governmental entities that represent a diversity of interests and perspectives in order to receive their specific input on the selection process and criteria for potential CCBHC demonstration sites. This includes organizations representing service recipients and peers, family members, substance use and mental health providers, local government, advocates, academics, veterans, and tribal nations. The New York State Office of Mental Health has received letters of support from 14 behavioral health providers and advocacy organizations, reflecting strong support for the CCBHC demonstration and planning grant and willingness to participate in the development and implementation of CCBHCs. The specific organizations the State plans to engage in this process includes but is not limited to the following list; letters of commitment received from the organizations listed below are included in Attachment 1.

- Association for Community Living
- Coalition of Medication Assisted Treatment Providers and Advocates
- NY Association of Alcoholism and Substance Abuse Providers
- NYS Coalition for Children's Mental Health
- NYS Council for Community Behavioral Health
- NYS Division of Veterans' Affairs
- The Coalition of Behavioral Health Agencies, Inc.
- Therapeutic Communities Association of New York, Inc

As indicated in section B-2, New York State will also include the Behavioral Health Services Advisory Council, the Mental Hygiene Planning Committee, and tribal nations in the CCBHC selection criteria and development process.

B-11.

New York State will establish a certification process for CCBHC demonstration sites. Part of the certification process will require verification that the CCBHS's governing board be substantially composed of recipient and family members representative of the population served by such

CCBHC, or that the governing board otherwise have a formal advisory body that can effectively represent the perspectives of recipients, families, and other community members. New York State will require that CCBHCs provide the names of governing body members and their affiliations to ensure that they sufficiently reflect diverse perspectives, and an attestation that such members are representative of the demographic makeup of the clinic service area and reflect the types of disabilities treated at the clinic.

To ensure that recipients have meaningful input into the governing process, the State will require demonstration sites to outline the frequency of governing board meetings, procedures in place for training members and assessing board performance, and the scope of the governing board (i.e. types of services, hours of service, community outreach mechanisms, and strategic planning).

To the extent that any CCBHCs governing body cannot be substantially composed of recipients and family members, the State will require an explanation for such inability to do so; if satisfactory, the State will require that an alternative formal advisory body be formed and meet at a similar frequency to that of the CCBHC's governing board to ensure meaningful participation in the policies and operations of the CCBHC. Such acceptable reasons may include a pre-existing overarching corporate governance structure, or difficulty in identifying and engaging self-identified recipients, families, and persons in recovery. When necessary, the State will assist sites in engaging statewide recipient and family organizations to assist demonstration sites in identifying recipients and family members in the respective CCBHC catchment areas to serve on governing boards or alternative advisory bodies.

In order to ensure that demonstration sites remain in compliance with the above certification requirements, the governing board requirements will be included in the program audit criteria, and are subject to review during OMH and OASAS program site licensing visits which currently take place for clinics and other licensed programs in New York.

In addition to site-specific requirements for meaningful participation by recipients and family members, the inclusion of recipients and family organizations in the statewide advisory and engagement process as outlined in B10, will serve as a broader forum to ensure that recipients and family voices are included in the demonstrations.

Section C: Staff, Management, and Relevant Experience

C-1.

The New York State Office of Mental Health and its collaborating agencies, the New York State Office of Alcoholism and Substance Abuse Services and the New York State Department of Health are experienced in, and capable of, planning and implementing important health and behavioral health initiatives such as CCBHC.

New York State's **Medicaid Redesign** initiative has built not only a programmatic foundation for CCBHCs, but has also demonstrated New York state government's ability to balance stakeholder interests while managing highly complex service system transformation activities. The Medicaid Redesign Team – which involves all three agencies – has been at the forefront of leading change and advancing the state toward the seamless integration of health and behavioral health care for Medicaid beneficiaries. The State is focused on improving access to physical and behavioral health care services for individuals with mental health and/or substance use disorders; better treatment and management of costs for individuals with co-occurring disorders; improved health outcomes and increased satisfaction for those receiving care; and service delivery that supports employment, success in school, housing stability, and social integration.

The collaborative commitment of OMH, OASAS, and DOH to recovery-oriented care is most recently illustrated in our development of **Health and Recovery Plans**, a distinctly qualified, specialized, and integrated managed care product for adults with significant behavioral health needs, including an enhanced benefit package. The development of HARPs is designed to promote significant improvements in the Behavioral Health System as the State moves into a recovery- based Managed Care that is delivered in a culturally competent manner. A recovery model of care emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance disorders through empowerment, choice, treatment, educational, vocational, housing, and health and wellbeing goals.

OMH and OASAS continue to work with DOH on the implementation of **Health Homes**, comprehensive provider networks that support the provision of coordinated, integrated medical and behavioral health care to individuals with chronic health conditions through care management and utilization of health information technology. OMH and OASAS are also engaged with DOH in the development of Health Homes designed to meet the unique needs of children.

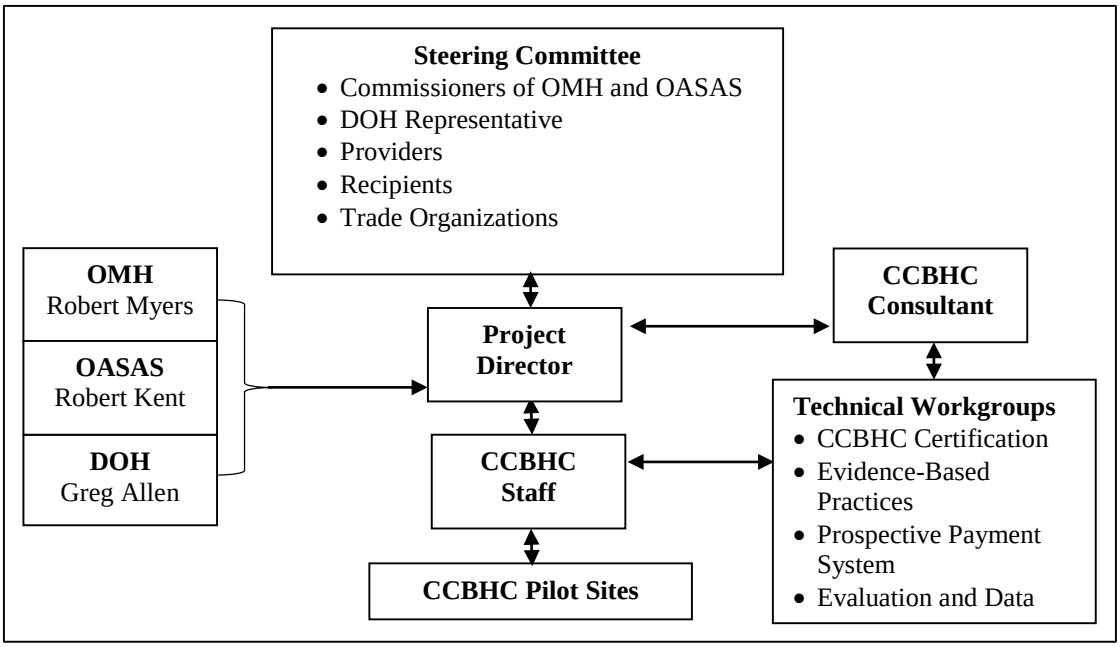
New York State has also established **Integrated Outpatient Services** regulations to further the integration of physical and behavioral health care in OMH, OASAS, and DOH licensed outpatient clinic settings throughout the state. The identical regulatory language appears in the regulations of each of the three agencies and is the result of a nearly four-year collaboration that resulted in the development of clinical and physical plant standards, staffing requirements, and a single application and review process to improve the quality of care provided to individuals with multiple needs and reduce the administrative burden on providers.

C-2.

New York State proposes to utilize a combination of in-kind and grant-hired staff in order to meet all requirements under the planning grant. The organizational chart below (Table 4) shows the overall framework that the CCBHC planning grant will operate in. In-kind staff will include, but are not limited to: Agency leads from each State entity; The Commissioners of OMH and OASAS, as well as a high-level DOH representative to sit on the Steering Committee; and State management staff to provide expertise on the program, evaluation, and finance components of CCBHC development. In-kind staff will bring vast experience to the CCBHC planning grant, primarily regarding the current New York State health care infrastructure. Experience and qualifications for in-kind staff can be found in Sections C-3 and E.

As detailed in Section E of this grant application, New York State will hire four staff to operationalize all required activities. The four full-time project staff supported by the grant will include (1) a Project Director, (2) a Project Assistant, (3) an Evaluation Director, and (4) an Evaluation Assistant. The Project Director has overall management and supervisory responsibilities for the project; he or she is required to have at least a Bachelor's degree and six years of post-degree professional/clinical administrative experience in behavioral health. The Project Assistant is to have at least a Bachelor's degree and two years of experience with mental health and substance abuse populations. The Evaluation Director has overall responsibilities for project data collection and evaluation and receives specialized and evaluation and research consultation and supervision from OMH's Director of Adult Services for Evaluation and Research; he or she is required to have a minimum of an MA/MS degree and two years of research experience – or PhD in a relevant research field – and experience with mental health and substance abuse populations. The Evaluation Assistant is to have at least a Bachelor's degree and two years of professional research experience in human services.

Table 4. CCBHC Staff Organizational Chart



C-3.

OMH, OASAS and DOH will contribute substantial in-kind supports from senior management and staff of all three agencies to ensure the success of the CCBHC grant (see Section E). Key staff overseeing the CCBHC grant have substantial experience in the development and management of numerous large scope projects within New York State as part of its Medicaid redesign process, such as the Medicaid 1115 waiver amendment that will enable the State to fully implement the Medicaid Resign Team's action plan to facilitate innovation, lower health care costs, and improve the care delivery system. Waiver amendment dollars will address critical issues throughout the State and allow for comprehensive reform through the Delivery System Reform Incentive Payment program, which will promote community-level collaborations and focus on system reform; with this funding based on performance linked to achievement of project milestones, safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement.

Key staff with demonstrated experience to create the necessary infrastructure for a CCBHC include Robert W. Myers, PhD, LMSW (OMH); Robert A. Kent (OASAS); and Gregory S. Allen, MSW (DOH). Dr. Myers is Senior Deputy Commissioner and Director of the Adult Services Division at OMH. His responsibilities include policy, planning, and operational responsibility for adult mental health services in 57 counties in New York State and New York City, as well as oversight of 15 adult psychiatric centers. Much of Dr. Myers' recent focus has been on the development and implementation of recovery oriented services for individuals with serious behavioral health disorders. He has worked over more than 30 years in the mental health field and has successfully implementing major project initiatives including OMH's residential program and, more recently, the special managed care plan for individuals with significant behavioral health problems called the Health and Recovery Plan. Mr. Kent is Chief Counsel in the Office of Counsel and Internal Controls at OASAS. He provides overall legal support and guidance and direction to the Executive Office and all its divisions in an agency that that oversees one of the nation's largest addiction treatment systems with nearly 1,600 prevention,

treatment, and recovery programs. He previously served as Assistant Counsel with the OMH, advising the Commissioner on legal matters related to forensic mental health and representing OMH interests before the New York State Legislature. Mr. Allen is Director of the Division of Program Development and Management at DOH. His responsibilities include Medicaid services policy and planning; developing new and emerging program areas; managing policy and payment support for New York State Medicaid's inpatient, clinic, practitioner, and pharmacy services; as well as payment policy for mental health, chemical dependence, and developmental disabilities services. He has played a key role in the State's Medicaid Redesign process, including the roll-out of the Health Home care management program, and has had lead responsibility for managing the State's recently approved $8B Medicaid Waiver, including the Delivery System Reform Incentive Payment program.

Section D: Data Collection and Performance Measurement

D-1.

Overview

New York State's Medicaid reform efforts during the last five years have provided an investment in **Health Information Technology (HIT) and the development of a core performance measurement and evaluation infrastructure which will be leveraged in the CCBHC initiative. Examples of changes in the HIT environment include the NYSDOH** All Payer Database, New York State of Health exchange, Regional Health Information Organizations and Statewide Health Information Network of New York which provide robust, secure technology infrastructure that CCBHCs will be able to utilize for their data collection and sharing needs. The **performance measurement and evaluation** infrastructure developed as part of DSRIP will make it possible for CCBHCs to meet and exceed the reporting requirements detailed in the RFA. Additionally, the web of relationships that have been established as a result of the SHIP, including regional Population Health Improvement Programs, IPAs—some of which include both behavioral health providers and FQHCs—and DSRIP Performing Provider Systems will enable the rapid establishment of the comprehensive, fully integrated behavioral health services CCBHCs are responsible for providing.

New York State recognizes that performance indicators are critical to measuring performance and improving services and outcomes, and are committed to the use of accurate, timely, and meaningful performance indicators to guide the CCBHC initiative. OMH and OASAS have been active participants in major national efforts sponsored by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors (NASMHPD) aimed at developing standard performance management domains, indicators and measures for use by all states.

Performance Management and Performance Indicators

The OMH Office of Performance Measurement and Evaluation, in coordination with NYSOITS, has developed web portals to display behavioral health performance metrics.[28] The BHO Performance Metrics Portal[29] provides 35 Medicaid behavioral health metrics in a public web-portal. OMH and OASAS submit the Uniform Reporting System (URS) performance measures, National Outcome Measures (NOMs) and Mental Health Client-Level (MH-CLD) data annually as part of participation in the SAMHSA Community Mental Health Block Grant. OASAS participates in the SAMHSA's Center for Substance Abuse Treatment's Treatment Episode Data Set reporting systems.

As part of the NOMs project, OMH reports recipient satisfaction data from youth, families and adults receiving services in the public mental health system.[30]

DOH has developed performance metrics for policy changes impacting the behavioral health population, including Health Homes[31] and DSRIP.[32] DOH also offers secure applications to collect and report data submitted from providers in the community. These include the Medicaid Analytics Performance Portal (MAPP)[33] and the Health Commerce system for the exchange of provider information.[34] In addition, DOH supports the use of SALIENT Health Care information system for performance metrics reporting for the DSRIP and Health home initiatives.[35]

Behavioral Health Transition to Medicaid Managed Care

For the Adult Behavioral Health transition to Medicaid Managed Care under the New York State 1115 Medicaid Waiver, OMH and OASAS have adopted existing National Committee for Quality Assurance (NCQA) indicators and will participate in the New York State Medicaid Managed Care Quality Strategy to ensure quality.[36] In addition, the New York State InterRAI Community Mental Health (CMH) assessment will be used to assess service needs for a behavioral health specialized Medicaid Managed Care product line (HARP).[37] This assessment will be used in the evaluation of the CCBHC where possible to capture a range of social indicators for the behavioral health population.[38]

Plan for Data Collection for CCBHC

The implementation and development of the CCBHC will be monitored during the demonstration period by collection of the following process measures:

The number of organizations or communities implementing mental health/substance use-related training programs as a result of the grant;

- The number of people newly credentialed/certified to provide mental health/substance use-related practices/activities that are consistent with the goals of the grant;
- The number of financing policy changes completed as a result of the grant;
- The number of communities that establish management information/information technology system links across multiple agencies in order to share service population and service delivery data as a result of the grant;
- The number and percentage of work group/advisory group/council members who are recipients/family members;
- The number of policy changes completed as a result of the grant;[5]

[5] For purposes of this FOA, "policy" refers to programs and guidelines adopted and implemented by institutions, organizations and others to inform and establish practices and decisions and to achieve organizational goals. Policy efforts do not include activities designed to influence the enactment of legislation, appropriations, regulations, administrative actions, or Executive Orders ("legislation and other orders") proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, and awardees may not use federal funds for such activities. This restriction extends to both grass-roots lobbying efforts and direct lobbying. However, for state, local, and other governmental grantees, certain activities falling within the normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking and administrative processes within the executive branch of that government are not considered impermissible lobbying activities and may be supported by federal funds.

- The number of organizational changes made to support improvement of mental health/substance use-related practices/activities that are consistent with the goals of the grant; and
- The number of organizations collaborating/coordinating/sharing resources with other organizations as a result of the grant.

This information will be gathered by the Evaluation Director using the uniform data collection tool provided by SAMHSA. Data will to be reported quarterly using the Common Data Platform, a web system.

During the post demonstration period, data will be collected from CCBHCs via secure applications used to collect and report data submitted from providers in the community such as the Medicaid Analytics Performance Portal (MAPP)[39] and the Health Commerce system for the exchange of provider information.[40] Guidance will be provided by the state to CCBHC regarding metric set, file format and file transfer protocol similar to what is currently used for HEDIS/QARR submission in NYS.[41]

CCBHC will submit a person level numerator and denominator file to the State for calculation of performance metrics and for linking to additional Medicaid and/or state data. The State may use this file to link to the recipient's pharmacy claims or utilization information, inpatient and outpatient claims, and any other State data or Medicaid claims or encounter data necessary to report the measures identified in Appendix A. The state will identify a comparison population from state Medicaid data. The state will flag data to distinguish the individual CCBHCs and individuals served by CCBHCs, as well as a comparison group of clinics and recipients. These linked claims and encounter data will be made available to the evaluator.

New York State will engage CCBHCs in the collection of encounter, clinical outcomes, and quality improvement data for annual reporting. The data collected will include: (1) access to community-based behavioral health services; (2) quality and scope of services provided by CCBHCs compared with non-CCBHC providers; and (3) federal and state costs of a full range of behavioral health services (including inpatient, emergency, and ambulatory services) (PAMA § 223(d)(7)(A)). New York State will also encourage the use of recipient and family led individual perception of care evaluations of the CCBHCs to ensure recipients and families are involved in this aspect of service design and delivery.

D-2.

OMH, OASAS and DOH will support CCBHCs as they build performance measurement infrastructure and implement continuous quality improvement processes. Monitoring will include oversight of the CCBHC quality management program and interim reports of service utilization and performance monitoring using CCBHC submitted and Medicaid service data. The CCBHCs will submit a quality management program for review and approval to the state during certification. The quality management program must specify how CCBHCs will develop, implement, and maintain an effective CCBHC-wide data-driven continuous quality improvement (CQI) plan for clinical services and clinical management. New York State will review the quality management programs to ensure that one or more individuals are designated as responsible for operating the CQI program.

The CCBHC quality management program will refer to the New York State Medicaid Managed Care Quality Strategy framework and the New York State Behavioral Health Quality Strategy as a framework means to monitor and ensure quality.[42] Quality strategies will include monitoring access, quality, utilization and satisfaction with care using NCQA standards as well as the development of performance improvement projects specific to population health needs.

OMH/OASAS will work with CCBHCs on an annual basis to develop performance improvement programs and focused clinical studies specific to the clinical program of the CCBHC, including outpatient clinic behavioral health care and primary care screening and monitoring of key health indicators and health risk.

The State will work with CCBHCs to determine that the number and scope of distinct CQI projects conducted annually are based on the needs of the CCBHC's population and reflect the scope, complexity and past performance of the CCBHC's services and operations using existing public data.[43] [44] CQI projects will be clearly defined, implemented, and evaluated annually by NYS. The CQI plan must demonstrate a focus on indicators related to improved behavioral and physical health outcomes, and take actions to demonstrate improvement in CCBHC performance. Each CQI project must be documented and submitted to OMH/OASAS annually describing the project implemented, the reasons for the projects, and the measurable progress achieved by the projects.

The CCBHC-wide CQI plan will address priorities for improved quality of care and client safety. Events related to recipient health and safety will be reportable to the New York State Justice Center which is committed to supporting and protecting the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigation of all allegations of abuse and neglect so that appropriate actions are taken.[45]

D-3.

The CCBHC will report and track encounter, outcome, and quality data, including but not limited to data capturing: (1) recipient characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) recipient outcomes. CCBHCs will annually report all data/measures CCBHCs are required to report (RFA, Appendix A Table 1) for all CCBHC recipients, or where data constraints exist, for all Medicaid enrollees in the CCBHCs. The CCBHCs will be responsive to changes in metric sets as required by CMS or due to changes in national measure sets. The CCBHCs will also report metrics required to determine the Quality Bonus Measures (QBMs). The CCBHC will utilize existing electronic health records and/or modify electronic health records systems to capture the required data elements. Metrics derived from the Medicaid Adult core metrics set and Medicaid Child Core metrics set will be reported from Medicaid claims and encounter data systems. The CCBHC will implement the MHSIP recipient survey to report patient experience with care on an annual basis. The CCBHC will implement the MHSIP family survey to report family experience with care on an annual basis. CCBHC will implement the New York State CMH assessments with adult service recipients to determine housing status and additional social outcome indicators.[46] CCBHC will implement the CANS-NY with child service recipients to determine social and behavioral needs and strengths for children.[47]

The State will report metrics listed in the RFA, Appendix A, Table 2 using Medicaid claims and encounter data and New York State CMH assessments. The adult core metrics set and Medicaid child core metrics set data will be reported from Medicaid claims and encounter data systems. Housing information will be collected from the OASAS Treatment Episode Data Set or from New York State CMH assessments.

The State will provide a person level data file for each recipient with unique individual identifier, Medicaid id, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis to the external evaluator through MMIS/T-MSIS. CCBHC will submit a person level numerator and denominator file to the State for calculation of performance metrics and for linking to additional Medicaid and/or state data. The State may use this file to link to the recipient's pharmacy claims or utilization information, inpatient and outpatient claims, and any other State data or Medicaid claims or encounter data necessary to report the measures identified in Appendix A. These linked claims and encounter data will be made available to the evaluator. All data collected and reported by the state will be flagged to distinguish the individual CCBHCs and recipients served by CCBHCs, as well as a comparison group of clinics and recipients.

CCBHCs will annually submit cost reports with supporting data within six months after the end of each demonstration year to the state. The state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each demonstration year to CMS.

Data Reporting and Managed Care Contract Requirements

The state's contract with the managed care entity will be modified to contain requirements for reporting CCBHC data. The following items will be amended to the contract: (1) data to be reported; (2) the period during which data must be collected; (3) the method to meet reporting requirements; and, (4) the entity responsible for data collection. New York State will collect data to allow for oversight of managed care contract execution with CCBHCs and to remedy performance issues.

D-4.

There are a number of challenges that may be encountered in collecting the data required for the national evaluation.

Challenges related to Electronic Health Record and Health Information Systems

The clinics selected for the pilot will need to have robust electronic health records (EHRs) and health information technology (HIT) to support the metric and quality improvement requirements of the program. A challenge will be the need to modify existing information systems to accommodate the collection of new patient level metrics specified in the grant. These systems will need to be modified to produce real time reports on sentinel events as well as trend and outlier reports for managing the quality improvement program. These changes will rely on the flexibility of the IT infrastructure within selected CCBHC.

In order to provide requested metrics, CCBCH will need to receive health information from DCO, care coordination and other providers outside of the clinic setting. This includes services provided related to heath, recovery and home and community based services that may come from a wide range of providers within the CCBHC network. An integrated information network solution will be needed to obtain all of the health information provided.

In addition, CCBHC will need to provide the state with client level files for the calculation of system wide outcomes and for submission to the national evaluation. The technology needed to compute the metrics and submit data and metrics to the state will need to be developed by the CCBHC.

Challenges Related to Measurement of Social Determinants and Recovery

CCBHCs are expected to monitor individual recovery processes and assess social determinants related to health and recovery. Standard measures for recovery and social determinants of health have generally been the concern of public health and are generally not integrated into EHRs.

However, to achieve improvements in health outcomes valued by the pilot, determinants of health—like physical activity levels, employment and living conditions will need to be considered. The Institute of Medicine has provided recommendations for standards for social and behavioral data to be incorporated into patient EHRs.[48]

However, this work is new and still needs to be operationalized in HIT solutions. This presents a challenge for CCBHCs responsible for monitoring the distal outcomes that are determined by these factors. The New York State Medicaid Managed Care 1115 Wavier will use the New York State InterRAI Community Mental Health suite to determine care coordination and home and community service needs. This instrument includes measures of social determinants, functioning and recovery.[49] This assessment will be completed on individuals enrolled in specialized behavioral health Medicaid managed care plans (HARPs) some of whom may be patients in the CCBHCs. However, this assessment information will not be integrated in the CCBHC EHRs and will not be available for behavioral health patients not enrolled in HARPs.

CCBHCs will need to develop HIT solutions to monitor social and behavioral determinants of health for this population.

Challenges Related to State and CCBCH data monitoring and exchange

The pilot requires the submission of person level files from the CCBCH to the state. Currently, the New York State Department of Health (DOH) collects person level file submission for metric calculation for of HEDIS/QARR metrics.[50] CCBHC clinics would participate in this process to the extent that they are a contractor responsible for submitting data to one of the Managed Care entities required to report DOH QARR metrics. New York State behavioral health agencies (OASAS and OMH) do not have a process whereby clinics submit recipient level metrics on the populations served. Developing a system parallel to QARR will require state administrative overhead and collaboration between state agencies as well as with the CCBHCs and other managed care entities.

Challenges related to collection of recipient satisfaction information

OMH and OASAS currently utilize surveys that are derived from the MHSIP Consumer survey and MHSIP Family Survey. CCBCH clinics may currently be part of the data collection effort conducted annually by the state, if not CCBHC clinics would need to develop a similar process to collect, analyze and submit data on recipient satisfaction from the MHSIP surveys indicated in the planning grant. The State and CCBCH clinics would need to coordinate efforts and perhaps consolidate survey forms so as to not confuse recipients.

D-5.

The State will use propensity score matching to identify a comparison group of Medicaid eligible patients receiving care at OMH and OASAS clinics who are not participating in this initiative. Using prior utilization and diagnostic information from Medicaid data, this approach will identify patients with similar characteristics at CCBCH and non-participating sites.

A sub-set of individuals enrolled in the New York State Medicaid Managed Care Health and Recovery Plans from both CCBHC and non-CCBHC clinics may also be identified. Propensity score matching for this sub-population will also be conducted to identify similar participants. Individuals in the HARP plans will have access to a wide array of home and community based services depending on New York State CMH eligibility screen and assessments. These services are not otherwise available to the Medicaid population served in clinics.[51]

A variety of quasi-experimental methods may be applied to examine cost, utilization and outcome metrics. Change in pre, during and post discharge Medicaid service utilization metrics and costs will be examined. Statistical significance testing (e.g. chi-square, t-tests and mean

percentage change) will be used to examine differences between time points and between groups of participants.
Medicaid Health and Behavioral Health service utilization and costs (e.g., behavioral health services and pharmacy, physical health services and pharmacy, hospitalization and ER, Home and Community Based Services) will be examined 6-months pre, during and 6-months post for CCBHC participants and propensity matched comparison group.
A difference in difference approach may be applied to the two groups to determine cost savings related to the value state of decreased utilization of emergency and inpatient readmissions for behavior health reasons. The average change over time in utilization and costs of ER and IP will be compared overtime for the CCBCH group relative to the comparison group.
An alternative method may be to utilize interrupted time series regression analysis to examine a pre/post analysis of individuals enrolled in the CCBCH and individuals in the matched comparison group. In the post-intervention period, actual rates for the various metrics for each month will be compared to expected rates controlling for characteristics of the patients actually enrolled in the program. This approach helps control for any changes in the underlying trends of cost and utilization that may affect all patients or a large subgroup of patients, as well as possible regression to the mean among "enrolled" patients. Analysis will be limited to patients with Medicaid eligibility for at least 10 of the 12 months prior to "enrollment." Variables included in the regression adjustment will include factors such as prior inpatient, ED, and primary care utilization patterns (frequency and recency), other resource use, diagnostic history, etc.

D-6.

Section D1 outlines the experience New York State has with Medicaid claims and encounter data, patient records and patient experience data. DOH, OMH and OASAS have significant experience collecting patient level data and in working with Medicaid claims and encounter data. New York is well prepared to collect the data needed to inform the national evaluation.
An overview of the State data infrastructure is provided below.

New York State Data Infrastructure:

The New York State Office of Information System Technology supports health related state agency cluster including Health and Behavioral Health state agencies. NYSOITS supports health information systems through development and maintenance of a secure, confidential, full-spectrum information systems environment. NYSOITS supports an enterprise data warehouse (EDW) for Medicaid claims and encounter data and other administrative data as well as a standard suite of software for business and analytic needs. The EDW makes it possible to perform rapid ad-hoc analysis, reporting and dynamic portals.[52] OMH and OASAS have behavioral health specific HIT that facilitate strategic monitoring of the behavioral health system. NYSOITS supports this HIT with secure web-based applications to collect client level data from community providers.
In addition, DOH is developing an All Payer Database that will contain health care claims data from insurance carriers, health plans, third-party administrators, pharmacy benefit managers, Medicaid and Medicare that can be synthesized to support the management, evaluation, and analysis of the New York State health care system.[53] DOH also offers secure applications to collect and report data submitted from providers in the community. These include the MAPP[54] and the Health Commerce system for the exchange of provider information.[55] In addition, DOH supports the use of SALIENT Health Care information system for performance metrics reporting for the DSRIP and Health home initiatives.[56]

[1] U.S. Census Bureau. (2013). *American FactFinder*. Retrieved from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

[2] New York Academy of Medicine. (2014). New York City Health Provider Partnership Bronx Community Needs Assessment Final Draft November 14, 2014. Retrieved from https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/st_barnabas_hosp_dba_sbh_health_system/3.4_st_barnabas_cna.pdf

[3] Finger Lakes Health Systems Agency. (2014). Community Needs Assessment: Finger Lakes. Retrieved from http://www.flhsa.org/uploads/pages/pdf/FINAL%20CNA%20Report%2012-18-14.pdf

[4] RTI International. (2014). Behavioral Health Barometer. Retrieved from Substance Abuse and Mental Health Services Administration website: http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_2/BHBarometer-NY.pdf

[5] Citizens' Committee for Children of New York. (2012). New York City's Children and Mental Health: Prevelance and Gap Analysis of Treatment Slot Capacity.

[6] New York State. (n.d.). NYS KWIC - KWIC New York State Indicators - Kids' Well-being Indicators Clearinghouse - KWIC NYS. Retrieved from http://www.nyskwic.org/

[7] RTI International. (2013). National Survey on Drug Use and Health (NSDUH). Retrieved from Substance Abuse and Mental Health Services Administration website: https://nsduhweb.rti.org/respweb/homepage.cfm

[8] MHA of NYC. (n.d.). VMHC Publications | MHA of NYC. Retrieved from http://www.mhaofnyc.org/vmhc/vmhc-publications/

[9] NYS Office of Mental Health. (2014). Geriatric Mental Health Information. Retrieved from http://www.omh.ny.gov/omhweb/geriatric/

[10] New York State Office of Mental Health. (2011). Unmet needs assessment report: Statewide assessment of treatment gaps for racial/ethnic groups in need of mental health services. Retrieved from: https://www.omh.ny.gov/omhweb/cultural_competence/reports/unmet_needs.pdf

[11] New York State Department of Health. (2011). A Plan to Transform the Empire State's Medicaid Program. Retrieved from https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf

[12] RTI International. (2014). Behavioral Health Barometer. Retrieved from Substance Abuse and Mental Health Services Administration website: http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_2/BHBarometer-NY.pdf (SAMSHA Behavioral Health Barometer, New York, 2014)

[13] NYS Office of Mental Health. (2014). Geriatric Mental Health Information. Retrieved from http://www.omh.ny.gov/omhweb/geriatric/

[14] New York State Office of Mental Health. (2011). Unmet needs assessment report: Statewide assessment of treatment gaps for racial/ethnic groups in need of mental health services. Retrieved from: https://www.omh.ny.gov/omhweb/cultural_competence/reports/unmet_needs.pdf

[15] New York State Office of Mental Health. (2011). Unmet needs assessment report: Statewide assessment of treatment gaps for racial/ethnic groups in need of mental health services. Retrieved from: https://www.omh.ny.gov/omhweb/cultural_competence/reports/unmet_needs.pdf

[16] New York Academy of Medicine. (2014). New York City Health Provider Partnership Bronx Community Needs Assessment Final Draft November 14, 2014. Retrieved from https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/st_barnabas_hosp_dba_sbh_health_system/3.4_st_barnabas_cna.pdf

[17] Health Resources and Services Administration. (2015). HPSA Find. Retrieved from http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx

[18] Citizens' Committee for Children of New York. (2012). New York City's Children and Mental Health: Prevelance and Gap Analysis of Treatment Slot Capacity.

[19] MHA of NYC. (n.d.). VMHC Publications | MHA of NYC. Retrieved from http://www.mhaofnyc.org/vmhc/vmhc-publications/

[20] NYS Office of Mental Health. (2013). NYS Office of Mental Health Patient Characteristics Survey. Retrieved from http://omh.ny.gov/omhweb/statistics/pcs-message.htm

[21] NYS Office of Mental Health (2014). Geriatric Mental Health Information. from http://www.omh.ny.gov/omhweb/geriatric/index.html

[22] Kaufman, A., Scogin, F., Malonebeach, E., Baumhover, L., & Mckendree-Smith, N. (2000). Home-Delivered Mental Health Services for Aged Rural Home Health Care Recipients.Journal of Applied Gerontology, 19(4), 460-475.

[23] Yang, J., Garis, J., & Mcclure, R. (2005). Clinical Mental Health Outreach to Older Adults: Serving the Hard-to-Serve. Clinical Gerontologist, 29(2), 71-79.
[24]Kaiser Family Foundation. (2013). Health Coverage and Care for American Indians and Alaska Natives. Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2013/10/8502-health-coverage-and-care-for-american-indians-and-alaska-natives.pdf
[25] The Institute of Medicine. (2001). Crossing the Quality Chasm. Retrieved from http://iom.nationalacademies.org/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf IOM's Quality Chasm Report
[26] InterRAI. (n.d.). Community Mental Health (CMH) – InterRAI. Retrieved from http://www.interrai.org/community-mental-health.html
[27] New York State Department of Health. (2015). CANS: NY. Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/cans_6_21.pdf
[28] NYS Office of Mental Health. (2014). NYS Office of Mental Health Statistics and Reports. Retrieved from https://www.omh.ny.gov/omhweb/statistics/index.htm
[29] NYS Office of Mental Health. (2014). NYS Office of Mental Health Statistics and Reports. Retrieved from https://www.omh.ny.gov/omhweb/statistics/index.htm
[30] NYS Office of Mental Health. (n.d.). Consumer Assessment of Care Survey. Retrieved from http://bi.omh.ny.gov/cacs/index;%20http://bi.omh.ny.gov/kids/index
[31] NYS Department of Health. (2014). Medicaid Health Homes. Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
[32]NYS Department of Health. (2014). Medicaid Health Homes. Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
[33] NYS Department of Health. (2015). Medicaid Analytics Performance Portal (MAPP). Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_mapp.htm
[34] New York State. (n.d.). Health Commerce System. Retrieved from https://commerce.health.state.ny.us/public/hcs_login.html
[35]Salient HHS. (n.d.). Healthcare Data Analysis Software. Retrieved from http://www.salienthhs.com/
[36] New York State Department of Health. (2014). Quality Strategy for the New York State Medicaid Managed Care Program 2014. Retrieved from: https://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf
[37] InterRAI. (n.d.). Community Mental Health (CMH) – InterRAI. Retrieved from http://www.interrai.org/community-mental-health.html
[38] NYS Office of Mental Health. (2015). Home and Community Based Services (HCBS) Manual. Retrieved from https://www.omh.ny.gov/omhweb/News/2014/hcbs-manual.pdf
[39] NYS Department of Health. (2015). Medicaid Analytics Performance Portal (MAPP). Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_mapp.htm
[40] New York State. (n.d.). Health Commerce System. Retrieved from https://commerce.health.state.ny.us/public/hcs_login.html
[41] New York State Department of Health. (2015). 2015 Quality Assurance Reporting Requirements: Technical Specifications Manual. Retrieved from https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2015/docs/qarr_specifications_manual.pdf
[42] New York State Department of Health. (2014). Quality Strategy for the New York State Medicaid Managed Care Program 2014. Retrieved from: https://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf
[43] New York State Department of Health. (n.d.). State of New York | Open Data Health. Retrieved from https://health.data.ny.gov/
[44] New York State Department of Health. (2014). DSRIP Performance Data. Retrieved from https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/performance_data/
New York State Department of Health. (n.d.). State of New York | Open Data Health. Retrieved from https://health.data.ny.gov/
[45] New York State Department of Health. (2014)
. DSRIP Performance Data. Retrieved from https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/performance_data/
lth.html
[47] New York State Department of Health. (2015). CANS: NY. Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/cans_6_21.pdf

[48] Institute of Medicine (U.S.). Board on Population Health and Public Health Practice, issuing body. (2014). Capturing social and behavioral domains and measures in electronic health records: Phase 2. Retrieved from http://iom.nationalacademies.org/Reports/2014/EHRdomains2.aspx
[49] InterRAI. (n.d.). Community Mental Health (CMH) – InterRAI. Retrieved from http://www.interrai.org/community-mental-health.html
[50] New York State Department of Health. (2015). 2015 Quality Assurance Reporting Requirements: Technical Specifications Manual. Retrieved from https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2015/docs/qarr_specifications_manual.pdf
[51]NYS Office of Mental Health. (2015). Home and Community Based Services (HCBS) Manual. Retrieved from https://www.omh.ny.gov/omhweb/News/2014/hcbs-manual.pdf
[52] NYS Office of Mental Health. (2014). NYS Office of Mental Health Statistics and Reports. Retrieved from https://www.omh.ny.gov/omhweb/statistics/index.htm
[53] New York State Department of Health. (2015). All Payer Database. Retrieved from https://www.health.ny.gov/technology/all_payer_database/
[54] NYS Department of Health. (2015). Medicaid Analytics Performance Portal (MAPP). Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_mapp.htm
[55] New York State. (n.d.). Health Commerce System. Retrieved from https://commerce.health.state.ny.us/public/hcs_login.html
[56] Salient HHS. (n.d.). Healthcare Data Analysis Software. Retrieved from http://www.salienthhs.com/