

Recommendations from the Conference of Local Mental Hygiene Directors (CLMHD)

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Submitted to Commissioners Hogan and Gonzalez-Sanchez
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CLMHD welcomes the opportunity for positive changes to the behavioral healthcare system in New York under the proposals adopted by the Governor's Medicaid Redesign Team (MRT).

We are optimistic that through collaboration among the state, counties, providers and consumers, New York can meet its objective to redesign and integrate the delivery of mental hygiene and physical health services to consumers in a cost-effective way.

Enrolling consumers with serious persistent mental illness in Medicaid managed care in 2013 and including substance abuse services in managed care are cornerstones of the system redesign. Moving to managed care, coupled with the redesign of behavioral healthcare under the MRT, allows for a new of approaching treatment, services and recovery for consumers.

This effort will require modifications to the existing roles of all stakeholders, including providers, consumers, and the local governmental unit (LGU). From the local perspective, LGUS' responsibility for managing the local system for all consumers—not just those enrolled in Medicaid—will require new and enhanced core functions and responsibilities in a regional behavioral healthcare organization (RBHO) and managed care environment.

In this context, the following provides a broad framework for what the Conference views as the core functions and responsibilities of the LGU in advising and monitoring the impact to the system and consumers with mental illness and substance abuse disorders during Phase I.

The Conference will continue its discussions of the priority elements of the behavioral health organization (BHO), the redesign of the behavioral healthcare system and Medicaid managed care as additional information is available. We look forward to working with the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) to improve the treatment and services for consumers with mental illness and substance abuse disorders in the state.

The Role of the LGU in a Managed Care Environment

The role of LGUs/counties is an important component of managed care in other states, e.g., the counties in Pennsylvania, the local management entities (LMEs) in North Carolina, etc.

In New York State (NYS), local involvement provides a vehicle for determining the impact of statewide policy decisions and managed care operations on local systems of care. The core functions and responsibilities of the LGU in a BHO/managed care environment are anchored in Article 41 of Mental Hygiene Law (MHL), which vests in the LGU the responsibility to develop plans to meet the needs of people diagnosed with mental illness and alcohol or substance use/abuse conditions. What makes LGUs unique and an important change agent in the move to Medicaid managed care is that they are statutorily responsible to:

- **Plan for the needs of ALL LGU residents**, not just Medicaid managed care plan members. The LGU, not unlike the OMH/OASAS, is responsible for addressing the treatment and service needs of all individuals needing mental hygiene services, regardless of the payer source.
- **Plan for an essential array of services and supports** whether those services are a covered benefit in the managed care plan or the provider is in the network.
- **Facilitate forensic and court-ordered services** provided for under Criminal Procedure Law (CPL) and assisted outpatient treatment (AOT), including involuntary commitments, emergency admissions, and competency evaluations.
- **Finance services** through county tax levy and the approximately 20 percent Medicaid local share.

CLMHD Recommendations and Requests for LGU in Phase 1

Included within the authority conferred LGUs by Article 41 of MHL is an explicit role and responsibility for oversight of quality mental health and chemical dependency services. This oversight of the delivery system will require modification in a managed care environment wherein the locus of authority for Medicaid recipients is shifted to private entities. As such, CLMHD recommends and requests the following considerations for the role of LGUs as we move into Phase 1 of RBHOs:

- LGUs will participate in the development, with the state and BHOs, of mutually agreeable service access and quality measures, and will monitor adherence to such measures through the use of data reports provided by the BHOs to LGUs and State oversight entities. Monitoring will be done on quality issues related to timely and appropriate access, clinical outcomes, and quality of care of the managed care program.
- A role for regionally and demographically representative LGUs in each of the steering Committees of the BHO/Medicaid managed behavioral healthcare plans. Steering Committees (or similar governance structures) would comprise representatives of the plan, the State, LGUs, mental health and substance abuse providers, consumers and family members to monitor and oversee the project and bring the local perspective to the group.
- Facilitate access to timely and comprehensive data and information, including access to data and performance reports from the managed care organizations that reflect standards included in the managed care contract with the State

- LGU consultation and participation in BHO contract deliverables, via the CLMHD as the facilitator (except in New York City [NYC]) to convene and coordinate LGUs impacted by each regional contract.

Conceptual Design of LGU and BHO in Phase 1

The new responsibilities of LGUs in Phase I of the project in an RBHO model and ultimately managed care environment include:

- **Participation** in the definition of key elements of the design, implementation and redesign of managed care. This would include, but not be limited to providing advice on benefit plan design, network development to ensure that a comprehensive, responsive, recovery oriented behavioral health system of care is available to members
- **Monitoring quality** from the perspective of the LGU's overall system of care and the impact of managed care activities on all county residents in need of behavioral health services. Quality monitoring will include but not be limited to an active review of:
 - **System impacts:** Provide feedback to the state and the managed care company regarding the impact of managed care on the local service system and the people served by that local system including the plan members as well as the medically indigent, non-Medicaid recipients, etc.
 - **Member services:** Monitor data reflecting timely access to care, provider choice, appeals and member satisfaction for managed care plan members and provide feedback from a local perspective.

Each of these broad-brush elements includes several varied and important aspects of the system which require planning and focused implementation to meet the objectives the state is seeking from BHO and managed care models. The clinical outcomes, data, and other findings collected in Phase I under the RBHO will inform the foundation for the design of the full-risk managed care system in Phase II. It is crucial that stakeholders are equal partners in the process to design, implement and monitor a behavioral healthcare system that is effective in producing improved outcomes for consumers through access to clinically-appropriate services, and the cost-effective use of limited resources.

Steering Committees

The Conference strongly recommends that each RBHO be required to create a Steering Committee that is responsible for oversight and evaluation of if and how the RBHO with stakeholders is meeting the objectives of the project. The Steering Committee concept is an accepted model in other states with Medicaid managed care programs. The Steering Committee in each region would be comprised of representatives of:

- BHO
- OMH/OASAS

- LGU : The Conference would facilitate identifying a specific number of representatives to each RBHO region (except for NYC) to participate on the steering committee based on the number of counties in the RBHO and with consideration for urban/rural geographic differences.
- Mental health and substance abuse providers
- Consumers/families/peers

The Steering Committee would be responsible for oversight of various aspects of the RBHO project, such as:

- Identifying the population, i.e., outliers, underutilizers
- Monitoring inpatient hospitalization length of stay to identify appropriate utilization and outliers
- Overseeing the availability and access to community-based services. Are extended hospital lengths of stay caused by lack of appropriate community services?
- Quality of the services in the community
 - Are specific mental health or substance abuse community services more effectively preventing re-hospitalization?
 - How is care coordination working in the region?
- Reviewing mental health and substance abuse policy, financing or regulatory issues that may impact on the functioning of the RBHO
- Reviewing data provided by the BHO that is real time and actionable in order to monitor the project and make necessary adjustments or enhancements
- Identifying opportunities for better treatment integration for the co-occurring population and between behavioral health and physical health
- Developing and advising on indicators and outcome measures

The quality oversight component is a crucial piece of the Steering Committee activities as this portion will answer the question, “Is the RBHO meeting the objectives?” The LGU provides the boots on the ground perspective through planning, contracting, and knowledge of community providers and resources. Counties will work in partnership with the state, managed care companies/behavioral health organizations and stakeholders to build the local service systems that provide access, choice, person-centered planning, quality care, innovative treatment and supports, and overall oversight of the system.

Over the years the LGUs have worked as a partner with the State of New York to develop statewide behavioral health policies and implement them at the local level, a role that should continue in the move to managed care.