

# Summary of Behavioral Health Care Recommendations from the Medicaid Redesign Public Hearings

February 2011

The New York State Medicaid Redesign Team, created by Governor Andrew M. Cuomo, conducted a comprehensive examination of New York's Medicaid system, holding six regional public hearings in January and February of 2011. The hearings were designed to solicit suggestions from the public and stakeholders on ways to eliminate waste and inefficiency while improving quality in the Medicaid program. The Medicaid Redesign Team invited public input directly in writing, via the web site, or during these hearings.

The Team received more than 800 recommendations, a number specific to mental health and behavioral care.

The following summary takes into account suggestions and recommendations related to behavioral health care that were elicited as part of the public hearing process. Across all regions, care coordination, service quality, service access, reimbursement setting and rates, and oversight and regulatory reform were the predominant themes related to behavioral health care to emerge. Specific recommendations include:

On February 24, 2011, Governor Cuomo accepted a report from the Medicaid Redesign Team, which met the Governor's Medicaid spending target contained in his 2011–2012 budget. The report included 79 recommendations to redesign and restructure the Medicaid program to be more efficient and get better results for people receiving care under Medicaid. More information can be found on the [Medicaid Re-design website](#) .

## Care Coordination

- Use other states' successful programs as models for New York.
- Implement behavioral/medical healthcare homes.
- Consolidate the oversight function of agencies.
- Reduce misuse of emergency department and other costly services.
- Provide incentives for care coordination the provision of integrated care.
- Include use of peer support services.
- Increase use of technology and tele-health services.
- Increase and improve the training and qualifications of providers and physicians by including education and pay incentives.
- Redefine the role of county involvement.

- Expand substance abuse integrated services.
- Incorporate the use of “health coaches.”

### **Service Quality**

- Use evidenced-based practices.
- Improve preventative care in the behavioral health and medical health sectors (diabetes care/tobacco cessation).
- Improve and increase family planning.
- Improve diversity, especially linguistic competence.
- Increase available housing within the most integrated setting.
- Improve self-directed, individualized consumer-driven care.
- Reduce needless, repetitive paperwork and reporting by treatment providers.
- Streamline paperwork requirements and develop a universal assessment tool.
- Review residency restrictions.
- Reduce waste and unnecessary services (e.g., readmissions, emergency department visits).

### **Service Access**

- Expand hours of service.
- Provide more day service options.
- Expand community-based care.
- Increase access to community based- housing.
- Increase waiver programs.
- Streamline paperwork requirements and develop a universal assessment tool.
- Increase case management services.
- Increase the timeliness of eligibility determinations.

### **Reimbursement Setting and Rates**

- Eliminate reimbursement disparities amongst different regions and providers.
- Do NOT carve in behavioral health services; rather, keep them in the carve-out.
- Decrease provider reimbursement rates.
- Reform nursing home system of care and reimbursement.
- Increase home, community-based and long-term care reimbursement rates.
- Consider regional difference when looking at ways to redesign the system.

- Incentivize long-term care insurance.
- Reinvest savings back into communities.

### **Oversight and Regulatory Reform**

- Increase audits and reduce waste and fraud.
- Allow greater transparency.
- Do NOT cut services; rather keep the safety net in place for vulnerable populations.
- Reform the pharmacology component by recycling medications and relying upon generic formulations.
- Institute regulatory reform to reduce the burden of unfunded mandates and provide regulatory relief for providers.
- End the spousal refusal loophole.
- Reduce and standardize provider paperwork requirements and eligibility standards.

### **Regional Differences**

Although there were commonalities throughout the five regional hearings, there were also recommendations for Medicaid Redesign made that more clearly took into account regional differences experienced by participants. Below are those more prevalent recommendations by region.

#### ***Buffalo Regional Hearing***

- Carry out a comprehensive redesign to reduce waste and inefficiencies (e.g., unnecessary visits, readmissions), streamline paperwork requirements, and improve care coordination.

#### ***Rochester Regional Hearing***

- Include nursing homes in the redesign of long-term care.

#### ***Long Island Regional Hearing***

- Implement regulatory reform, including reimbursement rates, waste and fraud.

#### ***New York City Regional Hearings***

- Avoid cuts, expand access, and maintain the safety net.

#### ***Queensbury Regional Hearings***

- Use behavioral health organizations and expand patient-centered medical homes.