

# 2012 Policy and Planning Activities Report from LGU Mental Hygiene Planning

August 2011

The Policy and Planning Activities Report section of this year's mental hygiene planning cycle provided localities with the opportunity to weigh in on substantive policy and planning issues affecting the mental hygiene disability areas at the State and local levels. Specifically, the Policy and Planning Activities Report this year sought feedback in three major areas—Medicaid redesign, mandate relief, and the integration of mental hygiene services—across the Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), and the Office of Alcoholism and Substance Abuse Services (OASAS).

In all, 36 counties responded fully or partially to questions 2 (Medicaid redesign), 3 (mandate relief) and 4 (integration of mental hygiene services) on the Planning Activities Report. Responses were considered largely within the geographic framework being used for the creation of the regional behavioral health organizations (BHOs), which will guide overall health care management and coordination for Medicaid beneficiaries in New York State.

The breakdown of these regions includes:

- **Central New York Region**

Broome, Cayuga,  
Chenango, Clinton,  
Cortland, Delaware, Essex,  
Franklin, Fulton, Hamilton,  
Herkimer, Jefferson, Lewis,  
Madison, Montgomery,  
Oneida, Onondaga,  
Oswego, Otsego, St.  
Lawrence

- **Hudson River Region**

Albany, Columbia,  
Dutchess, Greene, Orange,  
Putnam, Rensselaer,  
Rockland, Saratoga,  
Schenectady, Schoharie,  
Sullivan, Ulster, Warren,  
Washington, Westchester

- **Long Island Region**

Nassau, Suffolk



- **New York City Region**  
Bronx, Kings, New York, Queens, Richmond
- **Western New York Region**  
Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuylers, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates

Additionally, responses were considered in terms of the geographic nature of each county, using the OASAS epidemiological regions based on the U.S. Census classification of NYS counties.

- **New York City:** Bronx, Kings, New York, Queens, Richmond
- **Suburban Downstate:** Nassau, Rockland, Suffolk, Westchester
- **Suburban:** Dutchess, Ontario, Orange, Putnam, Saratoga, Sullivan, Tompkins, Ulster
- **Upstate Urban:** Albany, Broome, Erie, Monroe, Niagara, Oneida, Onondaga, Rensselaer, Schenectady
- **Rural:** Allegany, Cayuga, Chenango, Cattaraugus, Chautauqua, Chemung, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Orleans, Oswego, Otsego, St. Lawrence, Schoharie, Schuylers, Seneca, Steuben, Tioga, Warren, Washington, Wayne, Wyoming, Yates

Data tables used for the analysis, which are included with the report, detail the regional and geographic breakdown for each county. Counties had the option to answer any or all parts of the three survey questions. As Table 1 shows, 80 percent of all responses came from counties in the Central and Western New York regions. Question 4 drew the highest number of responses, reflecting in part the emphasis on integrated planning across the three mental hygiene agencies and impending changes under Medicaid redesign. It should be noted that, because the survey was optional and some large urban and suburban counties opted not to respond to some or all of the questions, findings should be viewed cautiously in light of their underrepresentation in the results.

**TABLE 1**  
**Breakdown of Survey Responses by Region**

Region	Question 2 Medicaid Redesign				Question 3 Mandate Relief	Question 4 Mental Hygiene Integration		
	2a	2b	2c	2d		4a	4b	4c
	Central New York	8	5	7	7	5	7	6
Hudson River	3	2	3	3	2	5	4	3
Long Island	0	1	0	0	0	2	1	1
New York City	0	0	0	0	0	0	0	0
Western New York	9	7	8	9	4	12	12	9
<b>Total</b>	20	15	18	19	11	26	23	21

The following analyses demonstrate that most of the concerns related to the planning, financing, delivery and evaluation of mental hygiene services center primarily on mental health/chemical dependencies (defined under Medicaid redesign as “behavioral health”) and physical health. Counties uniformly pointed out ways they wished to see tighter integration between the mental health and substance abuse systems of care and provided numerous recommendations for reducing regulatory and statutory barriers to effective care. Counties also highlighted areas where improved coordination and integration of care could occur between mental health and developmental disabilities.

Broadly, counties across the State, counties offered recommendations on the movement toward Medicaid managed care and ultimately toward the provision of the most effective services, while reducing costs and making the best investment of Medicaid funding. These priorities include:

- Implementing the integration of chemical dependence and mental health services and ultimately integrating behavioral health services with physical health services and related supports for successful community living
- Incorporating case management services and care management for people with complex conditions, while strengthening community linkages along the recovery continuum of care to reduce unnecessary inpatient care and detoxification admissions, as well as readmissions, among Medicaid beneficiaries who are identified as “high use/high cost”
- Providing integrated physical and behavioral health care based on the values of person-centered, recovery-oriented care, and utilizing models of co-located care that help to reduce stigma and improve the outcomes of care
- Engaging with the State agencies to identify areas for regulatory and statutory relief, enabling better alignment between the goals of Medicaid redesign and the on-the-ground operations (e.g., billing models that incentivize integrated care rather than

contribute to siloed care) as well as fostering implementation of integrated services and care management with the least administrative and clinical burden

- Implementing electronic medical records and having access to robust Medicaid data to better manage the care of Medicaid beneficiaries with the most serious and complex conditions, monitoring outcomes of care, identifying people who may need treatment but have been lost to care so providers may reach out and engage them in care, and examining indicators of overall system of care performance
- Having the ability to access flexible funding to provide critical support services (e.g., peer, housing, employment) not funded under Medicaid but proven by science to be essential to successful community life for individuals with serious behavioral conditions

What follows is a summary of recommendations and concerns in response to each question.

### **Question 2: Medicaid Redesign (optional)**

In January 2011, Governor Cuomo established the Medicaid Redesign Team. Its objective is to find ways to reduce costs and increase quality and efficiency in the Medicaid program. Part of this effort includes seeking ideas from the public at large, as well as experts in health care delivery and insurance, the health care workforce, economics, business, consumer rights and other relevant areas. These guidelines provide counties with an additional opportunity to provide input into this process. Resources you may find particularly helpful in completing this item include: [OASAS Detailed Medicaid Recipient Profiles \(2007-09\)](#), [OMH County Mental Health Profiles \(Adult Medicaid Expenditures\)](#).

- 2a. What specific *system or program reform/changes* have you enacted or are proposing to enact during the reporting period that will improve quality and reduce costs to the Medicaid program?
- 2b. What specific regulatory or administrative changes have you implemented locally (in partnership with Medicaid managed care companies or Local Commissioners of Social Services/Human Services) to lower costs and/or improve quality within the Medicaid program?
- 2c. What current elements of your local Medicaid program or system of care do you find have truly worked to control costs and enhance quality and that you feel should be preserved or expanded?
- 2d. What other recommendations do you propose to restructure the State Medicaid program that could "... achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure"?

In all, 24 counties across four regions responded to one or more parts of this question. Concerns expressed by counties often reflect their geographic nature. In this regard, with respect to counties responding to any part of survey question 2:

**2a. What specific system or program reform/changes have you enacted or are proposing to enact during the reporting period that will improve quality and reduce costs to the Medicaid program?**

Across three regions, counties described reforms and changes already enacted or being proposed in several major areas. The changes under way reflect attention on preparations for BHOs, integrated behavioral and physical health care, and health homes. Below are some of the common themes among those counties responding to this part of the survey question:

- Ensuring that services are medically necessary and of the right amount and duration
- Improving single-point-of-access (SPOA) processes so that intervention occurs early for persons identified as having high need and that care management strategies are employed to provide continuity of care during critical transitions in care
- Strengthening discharge planning, especially for individuals with high readmission rates, with “warm hand-offs,” accessible clinic hours, follow up for no-show appointments, care manager involvement in discharge planning)
- Fostering collaborations among hospitals, clinics, and providers across the mental hygiene systems of care to identify people whose service use and costs are high and to establish comprehensive treatment plans that will improve outcomes while at the same time lower costs associated with care for people with high risk and/or clinically complex conditions
- Improving the integration of primary and behavioral health care by providing behavioral health onsite consultation in primary care settings
- Providing training to improve care for persons with co-occurring mental illness and chemical dependency services (e.g., screening tools, motivational interviewing techniques, cognitive behavioral therapy, trauma-informed care)
- Utilizing peer-run and peer support services to help engage people with treatment needs who have dropped out of or who have become lost to care or to promote skills development that aids daily living (e.g., benefits counseling, employment support)
- Removing regulatory and statutory restrictions that impede the ability of localities to co-locate and effectively integrate services (e.g., substance abuse, physical health, mental health)
- Improving mobile and crisis services to address urgent needs more effectively and reduce the need for emergency department utilization
- Utilizing electronic medical records to improve the ability of clinicians to provide effective, integrated care

Regional examples of reforms include:

### ***Central New York Region***

Eight counties in Central New York responded to Question 2a. Seven of the eight affirmed that they are integrating physical health and behavioral health care. In some counties, primary care providers are in the same physical location as behavioral healthcare providers. Other counties have integrated substance abuse treatment with mental health services, providing screening for addiction and mental health disorders at the same time. Onondaga County is an active participant of the New York Care Coordination Project (NYCCP).<sup>1</sup>

Staff members in Otsego County are dually trained to participate in treatment courts and social services case conferences and evidence-based interventions such as motivational interviewing. Crisis intervention enhancements are in place in Clinton County and include using community residences as crisis respite, involving an intensive case manager at treatment team meetings and discharge planning, developing risk assessments and safety plans and using a “warm hand-off at discharge. Others are providing phone crisis intervention using trained clinicians, phoning “no-show” individuals, initiating phone contact with persons on wait lists, and developing evidenced-based group therapies to provide a greater diversity of services. One county simply declared the local governmental unit (LGU) has no say in enacting reforms because Medicaid is a federal/state program.

### ***Hudson River Region***

In the Hudson River Region, three counties responded to this question. Dutchess County is experiencing diminished bed capacity, with rising transportation costs. It formed a weekly “Community of Solutions” team involving all providers to move clients from inpatient to community care, which increases access to inpatient beds while helping people to receive services in their own communities. Greene County placed a mental health clinician in five primary care offices, which has reduced stigma and improved outcomes. The county involvement in the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) has also improved outcomes for individuals. Sullivan County is in the process of discussions with physical health providers to coordinate care for their common consumers. The introduction of Recovery Centers is also being discussed to assist individuals with housing, employment and illness/wellness management.

### ***Western New York Region***

A number of counties in this region are part of NYCCP (Chautauqua, Erie, Monroe and Wyoming). Chautauqua County implemented county-wide public health models to identify at-risk youth and intervene early. It is also a “System of Care” community and uses high fidelity wraparound services and evidence-based treatment models. Its clinics participate in PSYCKES to reduce polypharmacy and manage medications across providers. In addition, the county plans to redesign its behavioral health crisis model to avoid unnecessary emergency room visits.

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<sup>1</sup> NYCCP is a collaborative undertaking by county governments, providers and consumers who share interests in promoting recovery and conserving resources for the support of children with serious emotional disturbance and adults with serious mental illness. The web site address is [NYCCP](#) .

Monroe and Erie Counties are planning to improve their SPOA processes for better care of high-cost, high-need individuals. Erie County will implement Critical Time Intervention (CTI) to enhance continuity of support for persons with serious mental illness during periods of transition. The county has also partnered with the Department of Senior Services to provide services to older adults to avoid placements in nursing homes or institutions. Monroe County plans to simplify access for high-need individuals, provide outreach and engagement, and use short-term intensive care management for people with physical and behavioral health needs, develop level of care guidelines for mental health and chemical dependence services, and analyze Medicaid data to identify high-need/high-cost individuals to inform health home planning and physical and behavioral health integration. Wyoming County is using a Co-occurring Disorders Task Force to track people with dual diagnoses to better integrate care.

Cattaraugus County plans to strengthen discharge planning for individuals with high readmission rates. The county will provide co-occurring services training to its providers across services. Engagement of people lost to services will be assisted through the use of peers.

Several counties are identifying high need/high cost individuals either through using Medicaid data or collaborating with physical, behavioral, and substance abuse providers. Chemung County is encouraging provider groups to assess medical necessity at intake and via utilization review. It is also working to improve outcomes while shortening lengths of stay in case management and to identify people with co-occurring disorders to establish comprehensive plans of care while improving outcomes. Niagara County is shifting from long-term outpatient treatment to a model that provides episodic care as needed. Wayne County is employing a clinical operations team to conduct a risk review and identify consumers who have potential for relapse. Seneca County is conducting a mental hygiene cross-disability assessment to better understand how physical, behavioral and developmental disability services are being delivered and plans to offer primary medical services (e.g., physicals) within the mental health and substance abuse clinics upon approval of the Centers for Medicaid and Medicare Services.

**2b. What specific regulatory or administrative changes have you implemented locally (in partnership with Medicaid Managed Care companies or Local Commissioners of Social Services/Human Services) to lower costs and/or improve quality within the Medicaid program?**

Counties in four regions outlined regulatory and administrative changes they have implemented to improve the quality of care for Medicaid beneficiaries, while reducing costs. Common changes cited across regions include:

- Participating in NYCCP to integrate physical healthcare and behavioral healthcare through its complex care coordination functions that are helping to reduce emergency department use and inpatient stays
- Relying upon proven quality improvement initiatives (e.g., Six Sigma) that enhance care processes and lead to better outcomes and pilot projects, such as the Rapid Engagement Demonstration, which are successfully linking at-risk individuals with substance abuse disorders to services and supports (e.g., housing) and ongoing care coordination

- Establishing collaborations with Medicaid managed care companies to address the high Medicaid costs associated with treating physical and behavioral health issues, and with local Social Services to reduce residential youth placements and address community living needs of youth in transition
- Strengthening collaborations across the systems of care so that care is more holistic and better integrated
- Improving access to and engagement in care through enhanced SPOA processes (e.g., data-informed decision making)
- Monitoring data trends and implementing clinic restructuring

Regionally, counties described regulatory or administrative changes that have led to cost-effective quality care, including:

### ***Central New York Region***

Across the Central Region, most of the changes implemented by the five counties responding to this question have been administrative. Four counties have been concentrating on strategies aimed at concurrent care for persons with co-occurring disorders and staff training, a greater emphasis on recovery-oriented services and supports, strong collaborations between adult and child-serving agencies (e.g., breaking down silos through good communications), and management of resources (e.g., improving access to housing services for youth in transition, reducing no-show rates for appointments through outreach, improving SPOA and hospital communications to reduce inpatient and crisis services utilization). St. Lawrence County notes that regulatory relief at the State level across the mental hygiene agencies will be crucial in the development of fully integrated physical and behavioral health services.

### ***Hudson River Region***

In the Hudson River Region, Greene County identified making administrative changes like examining Medicaid costs in conjunction with the Social Services Department and looking at specific costs like the financial impact of housing youth in motels. Sullivan County is focusing on care coordination using wraparound services to allow individuals to remain at home and calls for data sharing and cross-systems care coordination.

### ***Long Island Region***

Nassau County points to the need for timely high-need, high-cost client data to help the county manage care coordination for this population.

### ***Western New York Region***

Chemung County is on the leading edge of health care reform among the seven counties responding, having already formed a medical care home model to enhance care for individuals with co-morbid conditions. The county is monitoring outcomes and anticipates cost savings from reductions in hospitalization and readmissions. Counties participating in NYCCP (Chautauqua, Erie, Monroe, and Wyoming) describe a successful collaboration with a managed care organization to implement complex care management strategies (reductions in inpatient stays) for individuals identified as utilizing high amounts of inpatient and emergency services.

Other changes include shifting from an “individual meets admission criteria” orientation to single point of access reforms in Erie County that focus on assessment and triage to appropriate services. Of note is the implementation of a rapid engagement demonstration project in Monroe County, where at-risk individuals with substance abuse problems are being linked quickly to services and ongoing care coordination.

**2c. What current elements of your local Medicaid program or system of care do you find have truly worked to control costs and enhance quality, and that you feel should be preserved or expanded?**

Those elements that work to control costs and enhance quality most commonly cited by counties in three regions include:

- NYCCP
- Complex care management
- Substance Abuse and Mental Health Services Administration (SAMHSA) supported Systems of Care for children, youth and families.
- SPOAs
- Person-centered planning and recovery-oriented care
- Accessible Medicaid data to inform planning, evaluation and performance management efforts
- Co-occurring Disorders Task Force
- Cross-systems collaboration and planning

By region, counties described those elements they believed should be preserved or expanded as follows:

***Central New York Region***

Of the seven counties responding to this question, Clinton County indicated that case review to determine treatment dropout and readmission trends as well as emergency department psychiatric assessments appear to be having a positive effect, with fewer hospital admissions, more emergency room assessments, and more outpatient admissions. The county advocates for Medicaid data to monitor care for high-need, high-cost individuals and expansion of SPOA monitoring for lengths of stay in case management and housing and for doing community outreach. Otsego County reports that it is also exploring ways to follow up with people who use crisis services but do not keep appointments; this population is of concern because case management, SPOA and housing make a significant difference in preventing hospitalizations and promoting recovery. Onondaga County is an active participant in NYCCP and points to the value of the program in delivering services efficiently and effectively.

The other counties responding to this question indicated that they would like to see the following to help control costs:

- Establishing clinical profiles and trends to monitor outcomes and costs

- Establishing a countywide care coordination model for people with behavioral conditions
- Having a close-knit provider community that communicates frequently around client needs, coordinates individualized services, and is granted waivers from burdensome regulations
- Providing person-centered, recovery-oriented care
- Shifting toward reimbursement for peer services, implementing options for step-down care for people who have had long institutional stays, and focusing on training in evidence-based treatments

Montgomery County indicates that it is simply trying to survive in a system of care it does not own, but rather is owned by the federal and state governments.

### ***Hudson River Region***

Putnam County explained that case management serves to reduce repeat hospitalizations and connects consumers with supports, treatment, and additional services such as housing. The county also noted the value of Section 8 programs, additional housing assistance programs, and access to a safe house for a person in supporting his or her recovery. It also called for allowing providers to flexibly serve people with needs who may or may not be Medicaid eligible (e.g., pay offline for prescriptions when Medicaid benefit cards are not available or to ensure payment for medications when a non-Medicaid eligible person lacks funds to pay for those medications). Dutchess County also points to the success of its Community of Solutions group to increase inpatient capacity and provide community services.

### ***Western New York Region***

Of the eight counties in the region that responded to the question, three were involved in NYCCP (Chautauqua, Erie, and Monroe). The three point to a number of successes in controlling costs and preserving quality through adherence to utilization management, quality improvement practices, a prescribed matrix and benchmarks. Among these are SPOA for adults and children as a gatekeeper to high-end services through triaging and prioritizing access to services; practice to outcome models / fidelity to practice; quality improvement mechanisms; utilization management performance; accountability; access to real-time data that is used to monitor outcomes, quality improvement, utilization management and performance accountability; and the sharing of aggregate data and data dashboards with partners. Under the NYCCP complex care management program, a more intensive, short-term care management approach, counties are showing promising results. Moving forward under care management and Medicaid redesign, the counties have requested Medicaid managed care encounter data, data to identify individuals on a trajectory to high use, an ability to drill down OMH data by race and ethnicity and an ability to drill down to OASAS data by provider; and expansion of care coordination for high risk/high cost consumers with addictions.

Chemung County is monitoring the effect of the health home in reducing readmissions and improving care. Livingston County is has adopted a team concept for addressing each individual's needs, with identified points of access and more collaborative care. Wayne County

reported that child and adult SPOAs, the Coordinated Children’s Services Initiative (CCSII) Tier 2, Co-occurring Disorders Task Force, cross-systems planning, and a leadership group are all working.

**2d. What other recommendations do you propose to restructure the State Medicaid program that could “... achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure”?**

Across three regions, counties offered suggestions for restructuring State Medicaid programs. Among the common recommendations are:

- Implementing utilization management and quality improvement practices that provide the right treatment in the right amount at the right time
- Ensuring strong vendor networks and use of electronic medical records
- Providing regulatory review and relief, where possible, between OASAS and OMH that leads to more integrated treatment (e.g., single treatment plan, New York State Clinical Records Initiative [NYSCRI])
- Taking into account that the cost of providing services in rural counties, while relatively small in comparison to most counties, is significantly higher per individual and making certain that such counties are given regulatory flexibility to the degree possible
- Ensuring alignment between Medicaid billing requirements and the structure of care (e.g., treatment options limited for people with dual diagnosis because Medicaid billing does not recognize this as a “primary diagnosis”)
- Facilitating county access to Medicaid managed care data that enables effective systems management
- Supporting Medicaid reimbursement of treatment that focuses on the health needs of the “whole person” such as recovery-oriented, peer support and offsite services
- Being certain that the people with the most serious behavioral health conditions do not fall through the cracks

Within each of the regions, specific recommendations include:

***Central New York Region***

Two of the seven counties responding to this portion of the question called for more effective and efficient service provision between OMH and OASAS. Clinton County called for the establishment of a single treatment plan template along with a relaxation of some of the more stringent OASAS requirements that are difficult to master, particularly with a co-occurring population; the establishment of a sound "harm reduction" model (e.g., less rigidity with abstinence); the development of medication clinics that provide maintenance rather than clinical care relaxing the accompanying documentation needed to maintain that level of care for those who cannot be referred back to a primary care physician for follow up; and the provision of off-

site visits (e.g., in physicians' offices) without establishing satellite sites has the potential for much better integrated behavioral and physical health care. Franklin County asked for more streamlined regulations and consolidation, particularly consolidation of documentation procedures via NYSCRI.

Hamilton County added that it would like to see the rural nature of counties considered in regulatory reform. The county noted that the key to maximizing efficiency in such settings is having the flexibility to continually right size staffing configurations to target populations through combinations of mobile staffing and contracting staff on an as needed basis. Otsego County, on the other hand urges a "warm hand" linkage to providers and services. Rather than spending time on the phone trying to manage outpatient services, it recommends that we think locally and remember that systems work together because of the relationships people have and act upon the importance of support services a (e.g., housing, transportation, employment) because they matter when it comes to outcomes.

Lewis County recommended an expansion of the use of information technology, which is essential to enhance the coordination of care, reduce the duplication of services, and assist the flow of information to the benefit of the treatment for clients. The county also calls for the certification of peer service providers to ensure proper reimbursement of these services.

### ***Hudson River Region***

Columbia County called for regulatory reform to permit integrated care of individuals with dual diagnoses (mental health disorders/chemical dependency issues or mental health disorders/ developmental disabilities). The county also noted that current Medicaid billing parameters that focus on a "primary diagnosis" do not recognize such persons and arbitrarily limit treatment options. Dutchess County stressed the need for protections and a safety net for people with the most serious mental illness so they do not fall through the cracks as the system orients toward integrated health and mental health care.

### ***Western New York Region***

Chautauqua County would like to see genuine collaboration among the agencies. It points out that under NYSCRI, the integrated approach of using unified forms is being threatened by the OASAS approach of developing its own forms. "Time wasted, dollars wasted. Providers could be back to separate forms." The county also would like to see family and peer services as reimbursable under Medicaid, and suggested that off-site services be covered under Medicaid, as they are proven to be effective in improving outcomes at a lower cost. Monroe County recommended that regional BHOs be established in a way that recognizes the need for local county oversight and allows for the designation of regions that local counties believe to be the best configuration to achieve the desired results. The county also noted that the simultaneous establishment of health homes for those with serious mental illness and serious substance use disorders would present an opportunity to better organize the system of care and provide care management and care coordination within a structure that maintains oversight at the local level. Among the four NYCCP counties responding to this question, Wyoming recommended accountability for each individual with high needs that takes into account a partnership between managed care organizations and the locality so that community integration can truly occur. The county also points out the importance of regional attention to specific

county needs in system design (e.g., needs of large counties vs. unique needs of small counties).

Seneca County suggested allowing OASAS-licensed treatment clinics to provide treatment for nicotine dependence to Medicaid clients. Livingston County recommended dual licensure for OMH and OASAS providers, while Cattaraugus County requested that localities have some local controls when it comes to BHOs.

**Question 3: Mandate Relief Redesign (optional)**

In January, Governor Cuomo established a Mandate Relief Redesign Team to review unfunded and underfunded mandates imposed by the New York State government on school districts, local governments, and other local taxing districts. Unfunded and underfunded mandates drive up costs of schools, municipalities, and the property taxes that support them. The team is looking for ways to reduce the costs of mandated programs, identify mandates that are ineffective and outdated, and determine how school districts and local governments can have greater ability to control expenses.

Given the objectives of the Mandate Relief Redesign Team described in these guidelines and the categories in which it is soliciting recommendations, identify potential mandate relief actions that you would like passed on to the team for consideration. For each recommendation, indicate whether the recommendation is for statutory or regulatory relief.

The State Mandate Relief Redesign Team includes representatives from private industries, education, labor, and government and will look for ways to reduce the costs of mandated programs, identify mandates that are ineffective and outdated and determine how school districts and local governments can have greater ability to control expenses. The team is charged with looking for ways to reduce the costs of mandated programs, reasons for State delays in reimbursements, and the practice of cost shifting of mandated programs. It is also charged with identifying opportunities for eliminating or reducing unfunded and underfunded mandates imposed by State government on local governments and local school districts.

Eleven counties responded to the Mandate Relief Redesign question. In the Central New York Region, all five counties reporting (Chautauqua, Chemung, Hamilton, Lewis and Montgomery) are rural counties. In the Hudson River Region, Columbia County is rural, while Sullivan County is classified as a suburban county. Two of the four counties in the Western New York Region are upstate urban counties (Erie and Niagara), while the other two are rural in nature (Seneca and St. Lawrence).

**Given the objectives of the Mandate Relief Redesign Team described in these guidelines and the categories in which it is soliciting recommendations, identify potential mandate relief actions that you would like passed on to the team for consideration. For each recommendation, indicate whether the recommendation is for statutory or regulatory relief.**

The counties responding to this question recommended potential mandate actions for consideration by the Mandate Relief Redesign Team that fell into several areas: criminal justice (public safety), local government operations, professional practice, quality of care, State/federal compliance, and supported housing. By region, specific recommendations are described by content area:

### ***Central New York Region***

#### **Criminal justice**

- Pass the Chargeback Bill, which would control the costs to counties related to those found incompetent to stand trial. The costs to the counties, which come with no county control or input, can be in the hundreds of thousands of dollars.
- Develop an infrastructure that supports every county's ability to provide intensive sex offender treatment programs to meet the demands of Article 10 civil confinement cases<sup>2</sup> for discharge to communities, rather than placing these individuals primarily in those communities that have created such capacity, thereby overburdening these communities because a comprehensive infrastructure is absent statewide.
- Support legislation that permits social workers and other appropriately licensed clinicians to conduct 730 and 330.2<sup>3</sup> evaluations.

#### **Local government operations**

- Remove redundant and ineffective legislative mandates that require children and adult SPOA committees, while not entrusting them with decision-making authority and funding to assure access.
- Eliminate the pre-approval certification committee (PACC), and the need for agency specific intake/admissions processes, and support SPOA in a more uniform manner in both regulatory and fiscal manner.

#### **Professional practice**

- Provide relief to scope of practice regulations that restrict service delivery by requiring specific licensed personnel to deliver treatment services. Reimbursement rates do not adequately compensate the required licensed professionals,

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<sup>2</sup> The Sex Offender Management and Treatment Act (SOMTA), enacted as Chapter 7 of the Laws of 2007, became effective April 13, 2007. The centerpiece of the legislation was the creation of a new Article 10 of the Mental Health Law.

<sup>3</sup> Criminal Procedure Law (CPL), Section 730, covers "not competent to stand trial as a result of mental illness," while CPL Section 330.20 covers "not responsible for criminal conduct by reason of mental disease or defect."

effectively discouraging individuals from pursuing professional careers in human services.

### **Quality of care**

- Look at the proliferation of evidence-based practices (EBPs), which are primarily proprietary, and the profit motive costs to everyday practice.

### **State/federal compliance**

- Fund fingerprinting compliance officers and their training; make sure reciprocation of this requirement occurs across systems.
- Modify the Office of the Medicaid Inspector General (OMIG) requirement to screen new employees and contractors to determine if they have been excluded or terminated from participation in federal health or State Medicaid programs; and reduce the burden associated with monthly re-screening of all employees, vendors, and referral sources.
- Reduce the burden associated with the Department of Labor guidelines for written notice for rate of pay and pay date (Wage Theft Prevention Act 4/9/11).
- Relieve burdens from Health Care Reform that require employers to provide all employees with notices of updated information and federal employee Health Plan Required Notices.
- Eliminate the impending change to the W-2 form that is being instituted to add the reporting of cost to the employer.

### **Supported housing**

- Provide more flexibility in the use of this resource (not just for downsizing State psychiatric units).

### ***Hudson River Region***

#### **Criminal justice**

- Support the bill proposing mandate relief pertaining to Criminal Procedure Law 730 to include licensed certified social workers and nurse practitioners in the definition of "psychiatric examiners."

#### **Professional practice**

- Examine intent of new OASAS regulatory requirements covering the qualifications of medical directors in 822<sup>4</sup> outpatient clinics in relation to the physician shortage.

#### **Quality of care**

- Ease 42 CFR, which serves as a barrier to identifying and engaging high-use people in integrated care management.

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<sup>4</sup> Part 822 refers to general service standards for chemical dependence outpatient and opioid treatment programs.

**State/federal compliance**

- Support regulatory restriction of the degree to which OMIG can extrapolate take backs.
- Support the right of providers to correct some errors before fines are assessed against them.

**Western New York Region****Criminal justice**

- Support mandate relief for the provision of mental health services in the local correctional facility.
- Address the demand for mental health services in correctional facilities while reimbursement continues to decrease.

**Local government operations**

- Shift payment of Medicaid entirely to the State and require its agencies to work together on the care of people with multiple disabilities.
- Eliminate CBRs, CFRs, CCR, quarterly claims, budget approvals, MHPD, petty review of certificates.
- Address issues unique to rural counties that impact the cost of care (e.g., lack of mass transit, high unemployment).

**Quality of care**

- Address underpayment by insurance companies to outpatient treatment providers for treatment services vitally needed to help people avoid costly care and to live successfully in their communities.

**State/federal compliance burdens**

- Allow no regulatory changes without first obtaining the appropriate funding to support them.
- Provide regulatory relief that reduces silos between state agencies to truly provide person-centered planning changes are needed (e.g., OPWDD regulatory issues are causing delays in the implementation of respite care for children).

#### **Question 4: Integration of Mental Hygiene Services (optional)**

Given the current fiscal climate and dire budget projections for the years ahead, and given the ongoing efforts of LGUs to find more efficient and effective ways to meet the needs of people with co-occurring disabilities or to meet common needs across the different mental hygiene service systems, and given the priority of the governor to reduce the cost of needed services, identify potential strategies that will meet these objectives.

- 4a. Identify efforts the county has undertaken, or plans to undertake, that will lead to efficiencies and improved quality of care.
- 4b. Identify strategies for service integration and for care coordination.
- 4c. Identify potential strategies beyond the Medicaid redesign and mandate relief strategies covered in the two previous questions that can or should be employed at the state government level that will create a more favorable environment for the county and providers to provide more efficient and quality services.

Overall, 29 counties responded to one or more portions of the question focused on the integration of mental hygiene services. The majority of responding counties in the Central New York Region are rural, while Onondaga County is an upstate urban county. In the Hudson River Region, three of the counties are designated as suburban (Dutchess, Putnam, and Sullivan), while Albany and Rensselaer are designated as upstate urban counties and Columbia County is rural. Nassau and Suffolk Counties in the Long Island Region are considered suburban counties. Three counties in the Western New York Region are upstate urban counties (Erie, Monroe and Niagara), while the other eight are rural.

#### **4a. Identify efforts the county has undertaken, or plans to undertake, that will lead to efficiencies and improved quality of care.**

Efforts leading to efficiencies and improvements in the integration of care commonly described by the counties in the four regions include:

- Co-locating, sharing, and merging services and integrating services functionally rather than by disability, particularly in rural counties
- Developing focused collaborations with mental hygiene (e.g., co-occurring disorders task forces) and other agencies serving people with disabilities
- Seeking expert guidance and support from entities with experience in care management and care coordination for people with complex conditions
- Strengthening the workforce to provide integrated physical and behavioral health care, as well as evidence-based treatment and support for co-occurring mental illness and substance abuse disorders, through education, training and expert consultation and educational opportunities

- Redesigning systems of care so they are “integrated” in a fashion that supports integrated care for the people and families being served.
- Beginning to develop networks of care that draw on the expertise of individual providers in an integrated care setting, including recovery centers and peer providers (e.g., peer respite)
- Conducting screening, brief intervention, referral and treatment (SIBRT) in emergency and primary care settings and participating in medication supported recovery training opportunities

Specific efforts toward integrated physical and behavioral health care among the counties include:

### ***Central New York Region***

Four of the seven counties responding to question 4a described efforts under way to improve care efficiencies and quality of care for people with co-occurring mental illness and chemical dependency disorders. Cortland County has created a co-occurring mental illness and chemical dependency taskforce to address service needs, capacity and related issues, encourages educational opportunities aimed at best practices for integrated care, and looks for grant-funded projects to foster integrated care. Hamilton County is striving for integrated treatment plans and noted how helpful it would be to have OASAS waive the application process for the provision of chemical dependency services in an OMH-approved mental health site. Otsego requests regulatory relief (e.g., requirements related to staffing, documentation, physical plant, safety) to help it better achieve integrated care. Of note, the North Country Directors from St. Lawrence, Franklin, Essex, Clinton, Jefferson, Lewis and Hamilton counties are beginning to engage in discussions with the NYCCP to determine the benefits of partnering with the coalition to better manage Medicaid costs.

### ***Hudson River Region***

Dutchess County noted how difficult it is to plan and prepare budgets in an environment of such uncertainty, one in which parts of the clinic restructuring effort are still not settled at the federal level, BHO activities are under way, and movement from a fee-for-service to capitated system and the introduction of health homes are to occur. Albany County is finding that consultation by the CEIC, in conjunction with the FIT curriculum, is leading to improved retention in services and outcomes for people with mental illness and chemical dependency disorders. Putnam County is also working on the integration of care for co-occurring disorders and preparing for the introduction of managed behavioral health and physical health services; preliminary planning is in progress for the development of a health home that provides behavioral, physical, crisis services, peer respite, and joint provider meetings focused on cross-system cases.

### ***Long Island Region***

Nassau County is focusing on sharpening staff skills and knowledge in assessing and identifying the services needs of individuals with co-occurring substance abuse and mental illness conditions. Building from lessons learned in a pilot co-occurring disorders treatment

program, administrative leadership is ensuring the success of ongoing integration efforts using integrated dual disorder treatment (IDDT) protocols and performance monitoring. In Suffolk County, the community mental hygiene system and Pilgrim Psychiatric Center have been working on the treatment and management of depression in primary care settings, using the Patient Health Questionnaire.

### ***Western New York Region***

Chemung County is continuing its work to integrate services across systems (e.g., expand beyond the three mental hygiene disabilities and bring in the Office of Aging and Long-Term Care into efforts to integrate and manage care). It is now setting up a memorandum of agreement between mental health and developmental disability entities that focuses on doing the right thing for the individuals being served rather than assuming that all services can be provided in any one system; activities have begun and are inclusive of county, not-for-profit agencies and State-operated administrators. The CEIC and Community of Solutions initiative have also aided the county in evaluating the degree of integration being achieved for people with co-occurring mental health and substance abuse disorders.

Erie County is strategically advancing care for co-occurring disorders under the direction of a Dual Recovery Coordinator, who is helping the department to reframe mental health and chemical dependency dual recovery services to include assessment and utilization of research informed practices, fidelity measures to practices, development of standardized performance measures and quality improvement planning/management related to the integration of care. In 2010, the Monroe County Office of Mental Health began reorganizing its structure to align with the core functions of the LGU— policy and planning, contract management, quality and accountability and priority services. Within these areas, all disability and age-related services are combined into a system that enables comprehensive, integrated approaches to care. Most other counties in the region are also attending to the integrated of care for dual disorders. Tioga County points to the need to not have regulatory requirements impede the integration of care for behavioral disorders and notes that the paperwork required of primary care providers is far less than that for behavioral health providers.

#### **4b. Identify strategies for service integration and for care coordination.**

Across four regions, counties responding to this part of question 4 described a number of strategies that are similar:

- Co-locating services, particularly for co-occurring mental illness and chemical dependency disorders, and integrating related functions such as treatment planning, case reviews, quality assurance, and staff training
- Participating in local discussions and planning for BHOs and health homes
- Utilizing shared educational resources to strengthen staff skills to provide care management and integrated behavioral and physical health care
- Tapping into care management resources to strengthen integrated care and related support activities (e.g., dual recovery coordinators, SPOAs, NYCCP)

- Considering what is necessary to meet the needs of adults and children with the most serious behavioral health issues and their families

Examples of strategies aimed at service integration and care coordination are:

### ***Central New York Region***

Counties responding to this part of the survey question are primarily working on the integration of co-occurring mental health and substance abuse disorders, with a number looking toward integrated care management under a health home model. In Otsego County, for example, county-operated mental health and addiction services are co-located, with integrated quality assurance activities, staff training, incident review and billing; discussions are taking place about integrated care under health homes and behavioral health homes and shared medical staff is being considered as a bridge across systems.

### ***Hudson River Region***

Similar strategies are being employed in the Hudson River Region, where, in Columbia County, the local government is pursuing a co-located mental health and chemical dependency treatment clinic, while a dual recovery coordinator is promoting the use of the FIT web-based training curriculum. Other approaches to integration in Columbia County include partnerships between human services and the Office of Children and Family Services to better serve youth at risk of detention or placement and co-locating a satellite clinic licensed for mental health and chemical dependency services. Putnam County, on the other hand, is striving to improve communications and strengthen integrated care through conferences for complex cases and monthly provider meetings.

### ***Long Island Region***

Nassau County is taking several steps to improve treatment for co-occurring disorders. It is collaborating with CEIC to evaluate and enhance integrated care and to overcome barriers to care coordination; identifying training needs and addressing them through a partnership with the Nassau County Mental Health Association, OASAS and OMH to deliver relevant training (e.g., motivational interviewing, cognitive behavioral therapy, stage-wise interventions).

### ***Western New York Region***

Much work in the Western New York Region focuses on improving care under BHOs and preparing for the transition to capitated care management through health homes and behavioral health homes for people with serious mental illness. Erie County, for instance, is working with NYCCP to design and implement a specialized health home services program for children with serious emotional disturbance and adults with serious mental illness. The County and NYCCP have a documented record of success implementing person-centered service planning and care coordination programs in diverse service environments, with improved individual outcomes and significantly reduced Medicaid and other government costs. The specialty health homes the County is considering would be a critical structural support for any managed care program that serves children with serious emotional disturbance or adults with serious mental illness. (Other Western New York counties responding to this question are taking similar actions.)

As with the other regions, counties responding to the survey question in the Western Region are concerned with improving care for persons with dual diagnoses and exploring improved care models that provide primary care services and other essential supports for recovery.

**4c. Identify potential strategies beyond the Medicaid redesign and mandate relief strategies covered in the two previous questions that can or should be employed at the state government level that create a more favorable environment for the county and providers to provide more efficient and quality services.**

Twenty-one counties, mostly large rural, responded to Question 4c, which asked what other strategies than those mentioned in parts a and b of the question would counties recommend they State address to create a more favorable environment for successful care management and integrated care.

Strategies recommended across the three regions fall into several categories; collaboration, fiscal, flexibility, information/technology/data, regulatory, and workforce. In the collaboration category, a number of counties asked for greater involvement of counties in the design, implementation, and evaluation of managed care initiatives. Additionally, among counties responding, a number acknowledge the importance of consolidating functions and operations wherever possible, thereby freeing up dollars for reinvestment in critically needed services. The recommendations include:

***Central New York Region***

**Collaboration**

- Clear communications with stakeholders about new initiatives, regulatory requirements and policy changes.
- Seek local input as part of the monitoring and evaluation of Medicaid redesign.
- Involve providers and practitioners in discussion of SAGE, mandate relief and Medicaid redesign.
- Consolidate the disability agency administrative, planning, and fiscal operations to better serve high-cost, high-need individuals with dual disorders and those in correctional settings.
- Consolidate mental health and chemical dependency system operations.

**Fiscal**

- Streamline reimbursement procedures to allow co-location/integration of mental health services and reimbursement in primary care settings.

**Flexibility**

- Ensure that the unique needs of rural counties are taken into account during the development of regional behavioral organizations.

**Information technology/data**

- Provide technical support and financial incentives for the adoption of electronic medical records in behavioral health settings.

- Support the adoption of electronic medical records that are simple, flexible, and not redundant.

### **Regulatory**

- Streamline licensing procedures to allow co-location/integration of mental health services in primary care settings.
- Reduce regulatory barriers across the systems of care so that integrated care may be realized (x3).
- Continue to consolidate State-operated psychiatric centers and reinvest savings into community programs that enable people with serious behavioral conditions to live successfully in their communities.

### **Workforce**

- Provide technical and financial support for training of medical and mental hygiene (all three disabilities) staff for provision of integrated services.
- Address scope of practice issues that impede the delivery of quality care.

### ***Hudson River Region***

#### **Collaboration**

- Ensure that OMH and OASAS synchronize system management so they do not work against each other and create more work for providers, ultimately compromising the quality of care.

#### **Housing support**

- Assure special housing options for people with disruptive behavioral disorders.

#### **Regulatory**

- Invest in federally qualified health centers.

### ***Long Island Region***

#### **Collaboration**

- Create strong local-State partnerships by including LGU personnel in decisions affecting local service delivery systems and fully utilizing their knowledge of community needs and priorities.

### ***Western New York Region***

#### **Collaboration**

- Provide flexibility to providers at the county level in determining eligibility for OPWDD services in the same manner as the OMH system, eliminating state barriers to access.
- Provide directors of community services with more opportunities to plan for change before major policy changes are instituted.
- Ensure clarity in responsibilities of field offices and DDSOs in relation to LGUs to avoid duplication and/or gaps.

## **Fiscal**

- Support consistent/common practices across mental hygiene agencies that permit counties to allocate funding in a more flexible manner (current practice of some state agencies is to allocate funds by provider/by program).
- Ensure the success of managed behavioral health care by enabling counties to manage resources while maintaining fidelity to clinical standards of care and other indicators of performance.
- Support consistent consolidated budget review practices and timely consolidated fiscal report closeouts.

## **Flexibility**

- Be sure to fund those necessary recovery services and supports not covered under Medicaid, thereby keeping health care costs down through the provision of supports essential for healthy community living.

## **Information technology/data**

- Make data compiled by the State available to counties to assist them in planning and services oversight, management, and quality improvement activities.

## **Regulatory**

- Consolidate operations wherever possible to save dollars (e.g., human resources, information technology) and reinvest savings so that individuals obtain only the care needed to maintain health and well-being.
- Allow for the dual licensure (OMH and OASAS) of all staff within an agency such that all staff are part of the OMH and OASAS clinic, eliminating the need for separate waiting rooms, case conference rooms, data bases (servers), support staff, record storage and all the other duplicative things that agencies with both a substance AND mental health clinics now have to do.
- Support consistent/common practices across mental hygiene agencies for county involvement in certification review processes.
- Reduce unfunded mandates and burdensome regulations.

## **Conclusion**

The statewide policy questions included in the local services plan guidelines provide the counties with an opportunity to influence State policy by offering their opinions, experiences and knowledge on important topics regarding the mental hygiene service system. The three policy questions that cut across all disabilities focused on Medicaid redesign, mandate relief and the integration of mental hygiene services. Responses to the policy questions were not mandatory and most reflected the views of Western and Central Region counties, with some responses from counties in the Hudson River and Long Island Regions. The 36 counties that answered the statewide policy questions provided valuable information to the OASAS, OMH and OPWDD. Given the changes to Medicaid and the mental hygiene system, this portion of CPS may be

required in future years so the county perspective is sufficiently represented in State policy decisions.

The most consistent theme throughout the responses was the need for the ability to integrate mental hygiene services to realize improved service quality and cost efficiencies. Successful implementation of NYCCP, Complex Care Management, SPOA, PSYCKES, CTI model, and Rapid Engagement Demonstration pilot are all examples of the counties incorporating the integrated care service model by using techniques such as person-centered care, enhanced case management, complex care coordination, peer recovery services and the employment of off-site services.

Most county recommendations centered on having State agencies provide more efficient access to Medicaid managed care data, integrated electronic medical records and more regulatory relief.