New York Office of Mental Health
Ambulatory Restructuring Project Report

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Executive Summary

New York State's public adult mental health system is exceedingly complex including Medicaid, State, county and other funding for a broad array of community based services. It serves a huge number of individuals, the vast majority of whom have serious mental illness. The total system funding is $5.6 billion, with $1.4 billion in ambulatory and clinic based services, approximately half of which is delivered outside of a clinic setting. It faces a significant need for restructuring if it is to expand its recovery focus and achieve essential improvements in accountability and coordination. This need for systemic restructuring is made more urgent as a result of several proposed new federal Medicaid regulations. The rule changes threaten New York with the loss of up to $170 million in funding for the federal share of ambulatory, non-clinic services.

The compelling necessity of significant and far reaching change presents the State with a major opportunity. Modifications can and must be made that will preserve some of the threatened federal funds and simultaneously strengthen the service delivery system. This study documents the critical need for change, building upon the substantial and important work of the OMH clinic restructuring process, and having a more comprehensive scope. It concludes by presenting several options for the State to consider as it moves forward.

The many stakeholders interviewed for this study agreed that the system has a number of problems, although they naturally differed in their perceptions of the details. Their consensus view was that:

- The system's excessive complexity reduces efficiency and increases service fragmentation;
- Accountability is poor;
- There is an over-reliance on inpatient care;
- The State cost settlement process exhausts State, local and provider staff, has a multi-year backlog and does nothing to support recovery;
- Despite 5.07 Plan requirements, there is a need for a more systemic process to review the service system at a county or regional level, to identify areas for improvement or implement improvements through contracts with providers;
- County and State staff lack data on performance of providers, utilization and outcome data on individuals served under deficit financing; and, finally,
- Services are overly costly and unevenly distributed: expenditures per capita vary by more than 100 percent across regions. In other words, consumers' access to care, rather than being uniform across the State, differs significantly as a result of where they happen to live.

Thus stakeholders generally agree on the following goals:

- Increase the focus on recovery;
- Reduce fragmentation of services;
- Improve accountability and measure performance; and
- Increase the emphasis on providing services in the community.

To best achieve those goals, while recognizing that New York's size, diversity and complexity preclude the possibility of finding one statewide solution, we recommend consideration of several options for system redesign, including the following:

- Development of “recovery home” or “clinical home” models in which case managers coordinate care for, and bear responsibility for outcomes of, the consumers they serve.
- Under Medicaid 1915(b) waiver authority, consider pilot managed mental health care approaches (such as organized delivery systems) that cover one or more counties, or;

Within any of the above structures, the State can and should implement or expand upon the following strategies, which will likely improve the system’s ability to meet consumers’ needs:

- Person-centered planning
- Disease management approaches

Note that these options are not mutually exclusive, but rather can work together to transform the mental health system.

In order to help finance the implementation of the chosen approaches, the State should consider methods such as the 1915(b) waiver authority and the 1915(i) State Plan Option, as well as revisions to the existing rate structure.

New York’s approach to reform must recognize that significant changes are underway in restructuring and re-financing clinic services. Staging of change efforts must consider the capacity of providers to respond to and implement additional changes.

Transforming the system of care is a goal well worth seeking. It is our hope that this paper will provide a rational foundation that can support State officials and other stakeholders as they make critical decisions that will set the State on a new path.

Introduction

Funding for New York State's adult mental health system ranks second overall nationally and third on a per capita basis. Some of the nation's best mental health services research is funded through New York's numerous medical schools and the Research Foundation for Mental Hygiene. Westchester County has the highest per capita concentration of psychiatrists in the country. New York providers have developed nationally recognized innovations, especially in the area of recovery oriented services; for instance the Clubhouse movement began in New York. Moreover, most of the national leadership in managed care began their work in New York State.

Given these strengths in research, clinical practice and administration, as well as the expenditure of significant resources, it may seem surprising to uncover profound dissatisfaction among many mental health leaders with the organization, structure, and financing of the State's public mental health system. Yet that is what this study has found. The current financing approaches by Medicaid, the Office of Mental Health (OMH) and counties, consist of multiple "layered" strategies and rules that are unique to specific programs or populations. The result, when taken together, is a "system" that is extremely complex and fragmented.

While there have been previous efforts to reform the service delivery system in a systemic way, they have met with resistance from many stakeholders, compounding rather than solving the problems. Not only does the system continue to be fragmented and to lack accountability, but care has suffered. For example, an OMH and New York City (NYC) panel investigated several recent violent crimes in NYC.[1] That investigation: ". . . revealed poor accountability and weak integration or communication among mental health, substance abuse and correctional services, even in instances where individuals were assigned the highest intensity community-based service. . ."

The panel's findings underscore the urgent need for a more integrated, accountable and coordinated system of care in New York for adults with serious mental illnesses.

While inconsistent quality, fragmentation, lack of accountability and failure to focus on recovery provide more than enough reasons for change, revisions in the (Federal) Centers for Medicare and Medicaid Services (CMS) rules governing the Medicaid program have pressed the issue even harder. Hundreds of millions of dollars in mental health funding are threatened by potential changes in the CMS rules governing Targeted Case Management and Rehabilitation Option services. Despite their positive aspects, these changes threaten to undermine the current reimbursement methods for many of New York's outpatient mental health services and require a fundamental redesign of the system.

As Commissioner Michael Hogan recently stated:

> *"We currently have an over-reliance on inpatient care…access to low cost services is limited, services are not comprehensive, and excellence can be missing."*

To address these and other issues, OMH has undertaken a major planning and restructuring process. The present paper, which is part of that process, reviews the current structure,

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[1]New York State/New York City Mental Health – Criminal Justice Panel: Report and Recommendations, June 2008

financing, service patterns and challenges of the adult non-clinic, ambulatory mental health services in New York State; it identifies barriers to change and proposes some restructuring options. It draws on data obtained from OMH administrative data sets[2], information from several stakeholder meetings upstate and in New York City and interviews with selected providers across the State.

Adult ambulatory care includes a broad array of services and programs, at the heart of which lie community mental health clinic services. Clinic services were not included in the current project because in 2007 the Public Consulting Group (PCG) prepared a report summarizing the scope of services for Clinic, Continuing Day Treatment and Day Treatment programs licensed by OMH. That report sparked a clinic restructuring process that has been underway for approximately two years.

The overall recommendation in the PCG report was that:

> *"What is needed is a complete overhaul of the current payment system. However, no changes to the reimbursement methodology for outpatient mental health services can be done without considering New York State's overall health care policy goals."*[3]

Therefore, this report, the PCG report and the work that followed the PCG report need to be considered together as elements in an overall review of the State's mental health care system.

An Overview of New York's Ambulatory Mental Health System

This section provides a more in depth overview and introduction to New York's adult ambulatory mental health system[4]. We have excluded children's services where possible from the analysis.
New York's mental health system is programmatically and financially large. The overall mental health system serves more than 688,000 individuals.[5] More than 544,000 of these are adults and more than 80 percent of these have serious mental illness.[6]

Funding for the public adult mental health system is also exceedingly complex including Medicaid, State, county and other funding for a broad array of community based services. Total system funding is $5.6 billion (adults and children), with $1.4 billion in ambulatory and clinic based services.

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[2] Data for this report was drawn in May from the Consolidated Financial Report (CFR) database (including 2007 or the most recently filed financial statements from providers) and from Medicaid claims for calendar year 2007. For a more detailed discussion of the data used for this report please see Attachment A
[3] Public Consulting Group, *"Provider Reimbursement System"*. New York Office of Mental Health, June 2007.
[4] The term "ambulatory" mental health system is defined further below but includes all services provided in the community, outside of hospital or 24 hour facilities. It includes clinic and an assortment of "non-clinic" services.
[5] "Statewide Comprehensive Plan 2006-2010: 2008 Update" New York State Office of Mental Health, October, 2008, p.1.
[6] 84% of adults served in the mental health system 18 through 64 years of age and 78% of older adults (ages 65 +) have serious mental illness.

As a result of history, population, funding, and local priorities, the structure and content of mental health services vary considerably by region and county.

The Delivery System is Enormous and Complex

The adult mental health system in New York State consists of a complex array of programs, funding streams, and providers that are configured somewhat differently in each county. The complexity and variability are influenced by many factors including:

- **Rural and urban differences** that are as extreme as any found in the US – from New York City to Delaware County, from Monroe County to Chemung and Hamilton County.
- **The presence of State operated hospitals and community services**. State-operated hospitals and community based services are critical aspects of the service system and provide a significant portion of the community based services in communities where the psychiatric centers are located.
- **County resources and priorities**. Counties have statutory responsibility for planning and system oversight. Both counties and licensed providers have historically had a wide degree of latitude to develop services and programs that best meet local needs. Additionally, many counties have put up their own funding for local priority programs. As a result, there is a great deal of variation in the availability of and access to different services across the State.
- **Complexity and availability of State and local funds**. The system for financing public mental health services is extraordinarily complex; it includes Medicaid funding, county and State local aid funds, direct State contracts, and State hospital related services, including inpatient, ambulatory and prepaid mental health services.
- **The incremental and aggressive refinancing of many services onto Medicaid has profoundly skewed priorities in a fashion that was not intended or anticipated**. This "over-Medicaiding" of the system has sustained and in many cases increased the utilization of Medicaid reimbursable services and reduced the financing and utilization of local and State supported services, regardless of priority.

The **mental health system** in New York includes dually licensed (OMH/DOH) Article 28 hospital operated services, Article 31 outpatient and residential programs, State operated outpatient programs, and non-licensed community mental health services.

The **ambulatory mental health system** includes all mental health services that are provided in the community, (i.e., not including inpatient hospital services and other 24 hour care facilities). Approximately half of the ambulatory services are clinic based services. The analysis in this paper focuses on the ambulatory services for adults that are delivered outside a clinic setting. These services include (and we have reported on) expenditures in the following categories[7]:

- **Emergency Services:** Comprehensive Psychiatric Emergency Program (CPEP) and Crisis Intervention;
- **Day Rehabilitation Services:** Including Continuing Day Treatment (CDT), Intensive Psychiatric Rehabilitation Treatment (IPRT), Partial Hospitalization, Personalized Recovery Oriented Services (PROS);
- **Assertive Community Treatment** (ACT);

[7] See Attachment C for CFR definitions of the 39 different ambulatory, non-clinic services.

- **Support - Care Coordination:** Case Management (Intensive, Supportive and Blended), Transition Management Services, and Bridger Services;
- **Support - General supports:** Including Outreach, On Site Rehabilitation, Transportation, Pre Admission Screening, Recreation, Respite, Consumer Service Dollars (Non ICM, SCM/ACT), Multi Cultural Initiative;
- **Support - Vocational supports:** Sheltered Workshops, Assisted Competitive Employment, Ongoing Integrated Supported Employment Services, Transitional Employment, and Affirmative Business/Industry and Work Programs;
- **Support – Self Help:** Advocacy Support Services, Psychosocial Clubhouses, Drop-In Centers, Self Help, Peer Advocacy and Alternative Crisis Support; and
- **Support - Other services**.

The Ambulatory System Serves Almost 458,000 People Each Year

New York's public mental health system serves more than 688,000 people per year. Of these individuals, 458,000 people are served in outpatient or ambulatory settings[8].

According to the 2007 Patient Characteristics Survey conducted by New York's Office of Mental Health (OMH)[9]:

- Approximately 59 percent of all consumers were receiving SSI/SSDI benefits;
- Services received by those[10] with serious mental illnesses[11] were broadly distributed including:
  - 9.8 percent received some form of inpatient service;
  - 50.1 percent received clinic services; and
  - 25.5 percent participated in some form of non-residential community supports.
- Those reported as not having serious mental illness received a more limited range of services:
  - 81 percent were served in clinic; and
  - 16 percent participated in non residential community support programs such as outreach and advocacy services.
- For those adult consumers receiving ambulatory non-clinic services[12]:
  - 86 percent were reported to have serious mental illness;
  - 67 percent reported disability due to mental illness, while 20 percent reported a co-occurring alcohol or substance abuse disability;
  - Approximately 10 percent reported some kind of justice system involvement: 4.5 percent were State prisoners and 2.7 percent were parolees or probationers; and

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[8] These data were obtained from the 2008 Update to 2006-2010 Statewide Comprehensive Plan for Mental Health Services, New York State Office of Mental Health.

[9] Because individuals often receive more than one type of service, these percentages are duplicated.

[10] Note that these percentages also include children with serious emotional disturbance. The data did not separate these age groups.

[11] The OMH Patient Characteristics Survey definition of serious mental illness includes a current mental illness diagnosis and one of the following: SSI eligibility due to MI, extended impairment or low functioning or reliance on treatment and supports. It is outlined at http://www.omh.state.ny.us/omhweb/pcs/survey05/GUIDELINES_pcs2005.htm

[12] These data were from a special analysis of PCS data from adults receiving ambulatory, non-clinic services(B. Brauth communication on 8/12/08)

- Most received care through federally funded programs: 50 percent were eligible only for Medicaid; an additional 24 percent were dually eligible (Medicaid / Medicare); a very small proportion (fewer than 5 percent) had private insurance.

The Need for Change: Fragmentation, Lack of Accountability and Financing Challenges

Ambulatory, non-clinic services include traditional Medicaid Services like case management and continuing day treatment as well as some services perceived to be the most "recovery oriented" in the State's mental health system – advocacy and support services, self help, psychosocial clubs, and vocational support programs.

These services are not by themselves a "system," but are essential components of the overarching mental health system. They drive recovery and provide the foundation for the coordination of care. However, in recent years, sustaining State and local investments in these services has been increasingly difficult, defining appropriate service outcomes has been elusive, and no consensus exists on needed service models and capacities across the State.

There is, however, broad agreement on the need to change the system to better support recovery and to address financial pressures. More challenging are questions regarding what specifically to change and how to change it in order to foster improved services. Numerous stakeholders from across the State offered input on these questions during the course of the project. Virtually all of them acknowledged that the system is fragmented and lacks accountability. Not surprisingly, respondents' roles and values influenced their perspectives. They cited the following types of barriers to effectiveness:

"The whole is less than the sum of its parts . . .Incremental improvement and services aren't going

- Services are fragmented and care coordination is ineffective;
- Case management doesn't work; it needs to be reinvented;
- The system lacks accountability to consumers and funding sources;
- Treatment does not always have a recovery focus;
- Regulations create barriers to efficient care;
- There are gaps in the information available about services in the correctional system;
- The system is overly reliant on inpatient services; and
- Financial incentives are not properly aligned.

The sections that follow summarize the barriers reported, present data on the issues raised, and offer some recommendations that emerged during the discussions.

Services are Fragmented and Care Coordination is Ineffective

New York State is not alone in complaints about fragmentation in the health care system. Most of us as healthcare consumers have experienced the problems. We see symptoms of fragmentation in poor integration of care for individuals with multiple needs (e.g. health and behavioral health problems) and in high inpatient readmission rates. Additionally, the New York mental health system has seen periodic well publicized crises, particularly in the New York City area. As OMH Medical Director Lloyd Sederer's report on Clinical Care noted:

> *". . . we must address a core problem that was caused by New York's approach to mental health – namely its extreme fragmentation of care, with no one*

responsible for the overall well being and recovery of people with mental illness."[13]

In response, that report made the following recommendations:

- Promote county and provider-based recovery oriented innovation to serve defined recipient populations or specified geographies across all levels of care;
- Introduce screening for and care management of high prevalence, high burden and high cost disorders in primary and mental health care, targeting opportunities where current practices do not meet quality standards and which present clear opportunities for improvement;
- Shift to more person-centered planning (as in the Western NY Care Coordination Program); and
- Develop specialized and more evidence-based practices for discrete populations (as in Wagner's Chronic Care model[14]).

The recent violent incidents involving several individuals with mental illness in New York City sparked the City and State to convene a panel to review the cases and make recommendations. The New York State/New York City Mental Health-Criminal Justice Panel found:

"Poor coordination, fragmented oversight and lack of accountability in the mental health treatment system"[15]

As an initial step to fighting fragmentation, the Panel recommended establishing teams and better utilizing existing data to monitor the care being provided to high need adults and the programs that provide that care.

Case Management needs Reinvention

A new, or reinvented, approach to case management should be part of the solution. More than $152 million is spent on care coordination and $46 million on ACT. But no stakeholders cited evidence of the efficacy of case management services and the literature is mixed as to whether traditional case management approaches (especially targeted case management or "service broker" approaches) are successful.[16] According to many stakeholders, case managers frequently lack the training, technology and skills to effectively coordinate care for people in acute phases of their illnesses.

For many consumers, their case manager is their "clinical home" And their one reliable relationship with the care system. Case managers offer many consumers with serious mental

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[13] Sederer, Lloyd I. et al., *"OMH Assessment of Clinical Care, Professional Workforce, Research and Local Government Opportunities."* October 2007.
[14] Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. *Improving Chronic Illness Care: translating evidence into action.* Health Affairs. 20(6) 64-78. Nov-Dec 2001.
[15] New York State/New York City Mental Health – Criminal Justice Panel: Report and Recommendations, June 2008.
[16] See, for instance, Marshall M, Lockwood A, Green R, et al.: *Case Management for People with Severe Mental Disorders (a Cochrane review).* Oxford, England, Update Software (for the Cochrane Library),1998; and Ziguras, S J., Stuart, G.W., *"A Meta-Analysis of the Effectiveness of Mental Health Case Management Over 20 Years,"* Psychiatric Services 2000, 51: 1410-1421.

illness their most important contact with the mental health system. Consumers may receive multiple services such as medications, housing and vocational supports, and may participate in clubhouse or peer support programs. The case manager coordinates these services through assessment, treatment planning, referral, and monitoring of services. However case managers in New York, and in most states across the country, were reported by virtually all stakeholders to spend their time on a variety of more recovery oriented services including life skills training, counseling and sometimes providing assistance with transportation. These would not be eligible for Medicaid reimbursement under the new Targeted Case Management rules. Such services could be reimbursed under other Medicaid options, e.g. the rehabilitation option, if the relevant Medicaid state plan amendments can be constructed and approved.

Case Management Today

The current model of case management offers two levels of service intensity and a "blended" option. Reimbursement requires a minimum of two face to face contacts per month for adults receiving "supportive" case management and four face to face contacts per month for "intensive" case management. Providers bill on a monthly basis for recipients who receive these minimum service levels. Many consumers, however, need only telephonic contact, medication and peer support services unless they experience a setback, at which time they may need significantly more services. The reimbursement models therefore need to account for periodic variability in needs. Case management reimbursement provides incentives to retain compliant clients who are reliably available for scheduled visits. Stakeholders reported that many clients receive four visits each month when they do not need them so that providers can maintain their revenue levels. Meanwhile, case management is often not available to individuals who experience acute problems because it requires pre-approval and the supply is limited.

New CMS Definition of Case Management

CMS defines case management as including ". . . services that assist eligible individuals to gain access to needed medical, social, educational, and other services. . . . (it) does not include the underlying medical, social, educational and other services themselves."[17] In New York, case management activities are generally consistent with this definition. They include functions such as assessment, service planning, referral, and coordination of care. For instance, intensive case management is defined as ". . . services provided by a designated intensive case manager to promote managed care by coordinating all aspects of services needed by persons with a serious mental illness and enrolled for such services with a provider of services, for as long as necessary". One of the differences that will have to be reconciled is that the CMS definition has some implicit time limits, while, as noted, New York rules make the service available "as long as necessary."

The System and its Providers are Not Accountable

Over the last two decades, as Medicaid has been used to significantly expand service capacity, discretionary financial support for mental health services by counties and the State has diminished as a percent of total funding. Accompanying the increased dependence on Medicaid funding and the reduced State and county support has been a loss of program flexibility, county control and the ability to coordinate services across program types. It is clear from stakeholder

[17] Centers for Medicare and Medicaid Services, "*Technical Assistance Tool: Optional State Plan Case Management*" (CMS – 2237 – IFC).

interviews that this has reduced accountability - accountability to consumers, purchasers and taxpayers.

Absence of Coordination Sends Consumers to Emergency Rooms

> *"We have helped create a group of professional patients – save them from ourselves!"*

No single organization is responsible for coordinating the care of many consumers with serious and chronic conditions who are receiving ambulatory mental health services in the community. When a consumer experiences a crisis, should the outpatient provider respond? What is the role of the case manager in the evening? What resources can be deployed to provide for some stability and supports during the crisis? Far too often the only response to these issues is for the consumer to go to the emergency room. Yet the emergency room is rarely equipped to provide for diversion and support services; instead, if a bed is available, the consumer may be admitted to the hospital.

Increasing accountability of ambulatory providers to consumers or payers for clinical supports to prevent such a hospitalization might include the use of 24-hour response services, the adoption of advance directives, mobile response and the use of stabilization beds. As one example of the effective use of 24-hour response services, the Massachusetts Behavioral Health Partnership measures their emergency service providers for diversion rates and is beginning a re-procurement of the service to increase quality and cost effectiveness. Michigan's county-based Prepaid Inpatient Plans create clear financial incentives for county and community staff to divert consumers from inpatient services where possible.

Providers are not Accountable

The system does not hold providers accountable for their performance or for the outcomes their consumers achieve. Medicaid funded providers must meet certain service and quality standards as a part of their licensing. Far too often these standards are focused on physical plant characteristics or staffing qualifications rather than on quality of care. Even once providers are licensed, they experience little formal oversight of the services they provide. Regional offices of OMH and some counties monitor programs and services, but this monitoring consists mainly of licensing reviews, contract reviews or investigations.

Staff in county offices and OMH often lack the experience and tools needed for effective contract oversight. State finance officials are reported to be several years behind schedule in the cost reconciliation processes and some providers have had to modify budgets for program expenditures that are several years old in order to avoid recoupment of funds. As one person in our focus groups stated, "this is a sign of a truly broken system."

The agreements for COPs and CSP "add-ons" include terms governing provider performance and services to the uninsured. These include standards on access to services, timeliness of initial assessments, agreement to participate in annual planning with local government agencies, 24-hour coverage, etc. These provisions were intended to reduce fragmentation and increase accountability but they have not been completely successful, and there is little public follow up regarding the terms of the agreements. These provisions are not monitored routinely.

Data on Care, Satisfaction and Outcomes are Lacking

Accountability requires accurate information on the care consumers receive, the timeliness of that care, utilization of services, and satisfaction with and the outcomes of those services. Information is needed at all levels of the delivery system, by case managers, program management staff, counties and State administrators, to effectively coordinate care, manage staff and oversee contractor performance. Currently, the only comprehensive data available for tracking access to and utilization of services come from the eligibility and billing data in the Medicaid program. No comparable data are available for services Medicaid does not cover, or for individuals whose care Medicaid does not pay for. While the State has made many improvements over the last decade in the accessibility of Medicaid data for research and reporting purposes[18], timely Medicaid claims data are not readily available to be used for oversight purposes by staff at the regional or county level. While OMH provides aggregate Medicaid utilization data to counties, county and OMH field office staff need training and support in the effective use of these data. Data are not routinely provided at the individual consumer level to analyze episodes of care, practice patterns or consumer engagement in services.

The System Has Little Information on Consumer Outcomes

Little is known about the outcomes of mental health services in New York State, and for that matter elsewhere in the country. Although consumers are undoubtedly achieving improvements in their quality of life, and many are more able to live meaningful lives in the community, there is little data documenting those successes. Providers, advocates and administrators have long disagreed about the nature and types of measures that should be used within the public sector. Over the last several years, SAMHSA[19] has developed a set of National Outcome Measures based upon recovery principles. Mental health measures include retaining a job, reducing criminal justice system involvement, finding stable and safe housing, increased access to services and reduced symptomatology. Few states are able to report on any of these data across their system; some choose instead to report on small samples or demonstration projects. States that do have particularly effective data and outcomes tracking systems include Ohio, Connecticut, Oklahoma, and Washington.

In New York, administrative data on spending and the numbers of people served are available only for Medicaid funded services, and rarely for services supported by local assistance. The latter services are not reimbursed on an encounter basis and lack standardized eligibility and enrollment procedures. There is no systemic approach to link enrollment and utilization data with consumer outcomes and satisfaction. A one week snapshot of program recipients, the Patient Characteristics Survey (PCS), represents the primary source of data on the characteristics of New York's mental health consumers. The most recent PCS data available come from the survey done in 2007.

One key goal of a transformed service system is to increase consumers' rates of competitive employment. Mental illness is a disabling condition and low employment rates are likely for people who have mental illness; this is used as an excuse by many in the system. PCS data show that only 17.7 percent of adult consumers (18-64)[20] are now in competitive employment

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[18] E.g. the Aid to Localities Finance System

[19] U.S. Substance Abuse and Mental Health Services Administration

[20] 2007 PCS Data: Those reporting competitive employment (with and without supports) divided by (the total clients served less unknown and those not in the labor force because they are retired, in jail, students, etc.)

(with and without supports). If, however, the system were designed to focus on increasing the numbers who are seeking employment and improving employment rates for those who want to work, vocational services funding might be used differently and CDT programs might be used to focus on pre employment and coaching efforts. It is not hard to imagine that, as a consequence, the competitive employment rate might go up significantly even in a bad economy.

We do not know nearly enough about the actual outcomes of treating mental illnesses in the community. We need to support further research and yet also be prepared for small effect sizes. The controlled studies we do have show marginal benefits over no treatment – improvement rates of approximately 10 percentage points. These types of changes and outcomes are enormously difficult to measure and the measurable changes often take a long time to be realized. There is similar uncertainty about the effectiveness of new and existing drug treatments, the most widely researched area of mental health treatment. [21]

Blurred County/State Roles Hamper Oversight

Accountability can only be achieved if clear roles and responsibilities are assigned to county and State officials. The lines of responsibility and authority between State and county officials have, however, become blurred in recent years as the State has entered into more direct contracts with providers and county match requirements have been capped. Most respondents reported that State oversight was limited to licensing compliance and the burdensome cost settlement process. Counties seem to have few, if any, systemic processes in place to manage providers' performance or encourage competition.

The county role as purchaser is sometimes "handicapped" when counties are also major providers of case management and community services. To some extent this is also true of OMH. While private organizations are increasingly the major service providers in NYC and to a lesser degree in other urban settings, counties are generally the dominant ambulatory providers in more rural areas. Providers' perception of the conflict between counties' twin roles, as both purchasers and providers, has sometimes led to antagonism between county officials and providers.

These conflicting roles have led many states to require counties to create separate organizational structures for purchasing and providing services. Examples include Washington DC, North Carolina, and Michigan.

- Washington DC split up the Department of Mental Health and created two separate organizational entities. DMH oversees the services delivered by the public Community Service Agency and by contracted providers.
- Michigan created specific requirements for organizations to manage specialty services. In order to reduce conflicts, these rules encouraged counties to create or contract with Administrative Service Organizations to manage the Medicaid specialty services.
- North Carolina has tried to create the same differentiation at the county or regional level. The Piedmont Behavioral Health Authority is an example of how this can work; other counties have not been as effective.

[21] The Commission for Scientific Medicine and Mental Health, The Scientific Review of Mental Health Practice. "*Anti-Depressant Placebo Debate in the Media.*" Accessed online at http://www.srmhp.org/0201/media-watch.html. Last accessed on 8/22/08.

Improved Accountability Requires a Variety of New Activities

Accountability requires performance management activities, including routine and regular reporting by providers, monitoring by State or county officials, feedback to providers and quality improvement efforts. Data and regular communication are keys to success. As a recent report noted:

> *". . . while planning, funding, licensing, and regulatory decisions are concentrated at the State level, the counties are charged with providing local services according to population needs and knowledge of evidence based treatments, available providers, and available resources. Effective collaboration between OMH and county agencies is one of the best opportunities we have to improve services for consumers and their families."*[22]

One strategy would be to implement performance contracting approaches. Much has been written about this and the methods are promising but current State policies and State and county contracting methods would make this very hard to achieve.

It may also be possible to improve accountability by consolidating contracting and provider oversight under a lead agency, an organized health delivery system or a managed care organization. One of the attractions of this approach for public officials is that it requires them to oversee only one (or a few) large comprehensive contract(s), reducing their burden and clarifying the lines of accountability.

There is a belief among many that managed care entities or private agencies are more capable of performing the necessary functions because they have greater flexibility in recruiting qualified staff, disciplining staff for non-performance, and they are less subject to legislative interference. On the other hand, there have been situations in which managed care or private contractors have neither improved accountability nor reduced fragmentation. Whether public or private sectors are responsible, the key to successful implementation lies with the quality and dedication of staff, oversight and supervision.

The System Lacks a Recovery Focus

Achieving consensus on the need to transform our public mental health systems based upon recovery principles was a major accomplishment of the President's New Freedom Commission.[23] The gap between the current reality and the vision of the New Freedom Commission is significant in many public mental health systems; some have called it a chasm.[24] Some of the key elements of a recovery oriented system include person centered care and service planning, peer operated services and peer supports. These focus on helping consumers achieve their own goals for housing, meaningful work activities, and relationships;.

Many stakeholders we spoke to noted that the mental health system in New York was not recovery-oriented. While there are a number of recovery-based services in operation, spending is dominated by inpatient, State hospital and clinic services that have a more medical focus.

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[22] Sederer, Lloyd et al. Op. Cit.

[23] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

[24] Institute of Medicine, *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, Quality Chasm Series. The National Academies Press, Washington, D.C., 2006.

Indeed, in 2004, roughly $2.9 billion or almost 53 percent of total spending in New York's mental health system was devoted to inpatient services.

In community care, continuing day treatment services represent an approach that has been replaced in most states by alternatives that emphasize rehabilitation (like NYS' PROS model or clubhouses). Other states have also developed effective consumer operated "recovery centers". Examples include Value Options consumer-operated centers in PA, NM, CO, and FL. Tennessee, Alaska and California counties, and other states actively support and seek to expand the use of "Recovery Centers." New York should consider how to transition many of the existing day services to those that emphasize "in-situ", or in the community, recovery and rehabilitation.

As a recent New York State report said so meaningfully, "Recovery is the process of gaining control over one's life in the context of the personal, social and economic losses that may result from the experience of psychiatric disability. It is a continuing, nonlinear, highly individual process based on hope and it leads to healing and growth."[25]

> *"What helps a person recover? Reality is that a person needs a relationship with consistency. That will move the person through the system."*

One stakeholder pointed out that "relationships should be the foundation of care." However the New York system, including many of its regulations, makes it very difficult for individuals to maintain helping relationships as they recover. The impact of regulations on consumer care is further discussed below.

Many professionals find the shift to a recovery focus not only challenging but profound. It does not happen easily, nor does it happen overnight. After many years of trying to implement a recovery-focused system, the Western New York Care Coordination Program recognizes the continuous need to support and train professionals in person-centered planning practices.

The slow adoption rates of evidence based or recovery-oriented practices, despite clear evidence and consensus on the need for change, suggests that adjusting the incentives in the system may be the only way to realize significant change.

Regulations Present Barriers to Good Care

During the course of this review, the barriers created by licensing processes and requirements (not the people) became increasingly apparent. The regulations regarding services, Medicaid billing and the use of State Aid are thorough and extremely comprehensive, but they are also complex. While seeking to eliminate or minimize duplication of services and double billing (goals which they presumably achieve), they also curtail consumer choice and create programmatic "silos." They increase fragmentation and inhibit consumers' ability to move from one service to another. For example:

- Separate treatment plans are required for different programs, which leads to unnecessary paperwork and a duplication of effort.
- In clinics, the requirement for treatment plan review every three months means that cases are often closed when people do not access services for more than three months.

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[25] 2007 Update and Interim Report to the 2006-2010 Statewide Plan for Comprehensive Mental Health Services, New York Office of Mental Health

If they return for a medication or other visit, the case must be reopened. Cases don't have to be reviewed in primary care when people are healthy unless they move or change physicians; why then do we need this frequency of review in behavioral health services?

- In the effort to transform, and to develop an alternative to continuing day treatment (CDT) programs for adults, OMH developed an innovative new program, Personalized Recovery Oriented Services (PROS). However the challenge of providing highly individualized day services under Medicaid has led to what many providers reported to be very complex regulations and reimbursement rules that intimidated some providers. Many reported that they have decided to modify their CDT services to make them more recovery oriented rather than develop PROS. However, the long-term viability of the CDT model is uncertain and improvements have been made to the PROS funding model.
- Restrictions on billing for multiple services on the same day reduce access and increase travel costs. For example, reimbursement rules will not permit consumers to receive medication treatment and therapy on the same day.
- As a result of State regulations, consumers must often change case managers and therapists when they progress from one program to another. If relationships are, indeed, the foundation of care, this requirement is likely counter productive.

The answers to these problems do not lie in creating new regulations. In many ways, that has been New York's solution to date; and while necessary for Medicaid billing the result has not increased accountability or reduced fragmentation. The process of changing regulations to make needed improvements is too burdensome and time consuming to be effective. It also increases the administrative costs of the system. The answers lie in creating clear lines of accountability in local provider systems for the organization, administration and oversight of the system for most of the consumers.

Information is Limited on the Mental Health Treatment of Individuals in the Correctional System

National estimates are that the prevalence of serious mental illness in prison and jail is more than three times that in the general population[26]. New York State has a comprehensive and elaborate system of services in State correctional facilities. However, little is known systemically about treatment of mental illnesses in jails. Many in our prisons and jails have undiagnosed mental illness and others go untreated or have no access to medications. Most studies have found that the correctional system has a limited capacity to handle serious illness and acute episodes without resorting to physical and/or chemical restraints. While there are excellent criminal justice and diversion programs in some communities, there is a general consensus that many people with mental illnesses end up in the criminal justice system simply because other alternatives are non existent. This is particularly likely in rural areas. New York State should continue to promote diversion of non violent mentally ill offenders to supervised treatment using the sequential intercept model[27].

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[26] National GAINS Center (1997). *The Prevalence of Co-occurring Mental and Substance Abuse Disorders in the Criminal Justice System*. Just the Facts Series. Delmar, NY: National GAINS Center.

[27] For a description of the sequential intercept model see Munetz, Mark and Griffin, Patricia, 'Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness". Psychiatric Services, 57: 544-549, 2006

Inpatient Utilization is More than Twice the National Average

Stakeholder meetings and feedback from many consumers and advocates reported excessive reliance on inpatient services. Though utilization varies significantly by location, in 2001-2002 New York State had more than twice the national average of psychiatric inpatient days per thousand in State and general hospitals. [28] In 2007, overall daily inpatient bed use in New York State was 60 per 100,000 individuals[29].

At its peak in 1955, New York had more than 90,000 people housed in State-operated psychiatric centers. In 2008, the State psychiatric center census was approximately 4,800 beds reflecting significant drops in utilization. In comparison, general hospital bed capacity was approximately 5,700; private psychiatric hospital bed capacity was 1058[30].

While some of the above data are old, the conclusions of everyone we spoke with were the same; the system remains too reliant upon inpatient services.

Recent efforts to continue reducing psychiatric inpatient use at State-operated psychiatric centers have had limited effect thus far. Utilization of State operated psychiatric center beds is of concern both because of the long length of stay of these individuals, the high capital costs required to renovate the facilities, and because inpatient care in State-operated psychiatric centers is not eligible for federal match. OMH efforts to increase accessibility and reduce overuse have shown promise. This should be continued and closely monitored.

Private inpatient expenditures (Article 28 and 31) represent a significant portion of mental health spending. In 2004, State-operated inpatient expenditures were $1.197 billion and expenditures for private psychiatric hospitals, residential treatment facilities (RTFs) and Article 28 hospitals were $1.695 billion, a total of almost 53 percent of total mental health expenditures[31]. New York State should develop inpatient reimbursement methods that set goals for access to care while reducing incentives for long lengths of stay.

OMH should also engage in a dialogue with local communities about the needs, models and effectiveness of the outpatient services provided by staff of the State psychiatric centers. With well over 2500 FTEs devoted to community care, this resource must be carefully prioritized.

As the data on regional variation in inpatient care demonstrates (see Attachment F3), the demand for inpatient services is highly elastic; it is influenced by a large number of external factors rather than being determined by the nature of the illness itself. Outside NYC, inpatient spending ranges from 19 percent to 29 percent of total Medicaid spending. In NYC, however, a startling 51 percent of total Medicaid spending occurs in inpatient settings. Most attribute the high use of inpatient services to the lack of available housing (people with no place to go cannot be discharged). NYC Medicaid penetration rates for inpatient services are below average suggesting that length of stay and rates are the factors contributing to the very high costs of

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[28] Statewide Comprehensive Plan for Mental Health Services 2004-2008, Appendix 5, New York State Office of Mental Health, Table 2: 2001 Adult Average Daily Bed Usage. Includes Article 28, 31 and State Psychiatric Centers

[29] Data calculated by OMH from DOH SPARCS, Medicaid, and OMH data sets.

[30] Data comes from OMH Concerts data system as well as OMH data on state operated inpatient beds.

[31] New York State Office of Mental Health Finance Group, Op Cit (New York Times Data)

inpatient. However, the availability of community services, the effectiveness of case management and access to housing supports also play a huge role in reducing the demand for inpatient services. While CPEP services are an important vehicle to divert consumers from inpatient care, New York State should explore alternatives to acute inpatient services that can be accessed prior to admission to a CPEP.

Financial Incentives are Not Properly Aligned

The mental health system operates relatively "risk free" in New York, from a financial perspective (no capitation payments and limited use of case rates). Because the system uses fee-for-service and grant-based financing in all but a few demonstration initiatives, the provider's incentive is to maintain high rates of Medicaid encounters and to minimize the number of consumers funded by State and county grants. As a result, some providers are reported to hold onto consumers as their needs improve, rather than helping them move to less intensive levels of care.

The significant county variation in the services and financing of the mental health system is a direct result of the historical role that counties have had in funding services, particularly the county match requirements for Medicaid. The county Medicaid match is now capped, however, and so county risk for excess Medicaid spending is limited. But counties are not just purchasers of service. They (and the State in the psychiatric centers) are also service providers that have employees on payroll and need revenue to support their operations. Thus, complex and competing incentives drive the relationships among the State, counties and providers.

"We can't assume integration just because one agency has all the pieces. We have created the impediments through all the discrete regulatory standards. We get nervous about shared space, shared staff, shared treatment plans and services on the same day."

The one area of the Medicaid system where there is some risk is in the health maintenance organization (HMO) benefit. However, the risk is minimal for Medicaid managed care plans because their liability has been capped at 20 outpatient and 30 inpatient visits. This cap encourages Medicaid managed care organizations (MCOs) to transfer high cost recipients over to the public fee-for-service system. While there are some safeguards in place to protect against this cost shifting, any policy changes must take it into account.

For SSI eligibles, the mandatory enrollment that is taking place across the State excludes mental health services but will increase pressure on the MCOs and public mental health system to coordinate health services for consumers with serious mental illness.

If the general premise is accepted that to truly change practice patterns financial incentives should be placed as close to providers as possible, then vertically integrated provider systems[32], also known as organized delivery systems (ODS), might be one solution. Many areas, however, may not have the provider capacity or scope of services necessary to develop them. Another approach might involve the development of county or regional "systems of care." Many states with county mental health programs have shifted the risk down to the county or regional level in order to encourage the development of such systems. Examples include

[32] Vertically integrated delivery systems are provider systems that include a full array of services from outpatient and peer support services through Continuing Day Treatment, partial hospital and in some systems, inpatient services.

California, Washington, Colorado, Florida, Michigan and Pennsylvania. Wherever the risk is placed, the system's financing model should encourage movement between levels of care, and ultimately to less costly levels. These various options are discussed further in the recommendations section of this paper.

Financing Models Must Change

Based on numerous interviews and our analysis of the data, (see appendices B, E, F, G) it is clear that changes are needed in the financing and regulation of New York's public mental health system. Many of these changes have been needed for the last decade. They have been made more urgent by continuous changes to federal CMS regulations and the fiscal challenges facing the State, counties, and providers.

Medicaid add-ons to clinic reimbursement like Community Support Program (CSP) and Comprehensive Outpatient Program (COPs) payments also need to be eliminated. Documentation for treatment and rehabilitation plans need to be clearer to comply with new CMS rules and avoid audit recoveries. The local assistance distribution and reconciliation process needs review.

In sum, changes are needed in the way providers are organized, financed and deliver services.

Medicaid Reimbursement Rules are in Flux

New York's non-clinic ambulatory Medicaid reimbursement is currently based on unit billing, per diem payments or monthly rates, depending on the service. Proposed changes in federal Medicaid rules and changing interpretations of existing rules may require New York State to change how it defines and pays for these services. (These proposals are currently being reviewed by the Obama administration.)

As noted above, changing Medicaid regulations constituted one of the motivations for this review of ambulatory services. Previous efforts over the years to restructure the financing and delivery systems have not succeeded. Now, however, the 2005 Deficit Reduction Act (DRA) and other proposed and enacted revisions to CMS rules mean that system change is essential. These changes place over $170 million in federal funding for Targeted Case Management, CDT, ACT and numerous other services at risk. The temporary federal moratorium on the implementation of these regulations gives New York an opportunity to restructure its systems of care in a thoughtful manner[33].

Several key provisions in the Deficit Reduction Act and the new CMS rules may have a significant impact on New York's federal revenue. These include:

- Changes in Targeted Case Management and Rehabilitation Option rules to require new billing procedures for services using approved CPT and procedure codes. New York has perfected the science of bundled rates. If the regulations are enacted as they stand, many of the rates and reimbursement methods for CDT, Targeted Case Management and others services will need to be revised. Rates need to be unbundled.

[33] In June 2008, in response to a veto-proof bill from the Senate and consistent with previous House language, President Bush signed a Congressional Moratorium on 6 Medicaid regulations, including targeted case management., rehabilitation services and school based services. The moratoria are due to expire April 1 2009.

- Requirements that Targeted Case Management activities be limited to: 1) assessment; 2) the development of a treatment plan; 3) referral for services; and 4) monitoring of the plan. Documentation of covered activities will likely need to be more specific for case managers in the treatment plans and case records. Because the value of "case management" is driven by personal relationships, a person-centered approach and timely interventions, New York must find a way to retain the value of our current case manager services under a financing approach that complies with the new regulations.
- Rehabilitation Option rules clarify what Medicaid will cover and how the services must be documented and billed. Under the proposed rule, there must be a specific written Rehabilitation Plan that identifies the covered services, their goals and the specific conditions they are designed to address. These are to include recovery goals, involve the individuals and families, and provide a timeline for the services and when they will be reviewed. The timeline must not be longer than one year. These rehabilitation plans, including their required level of specificity, documentation and periodic review, impose additional requirements on mental health providers.

Services Affected by New Federal Rules

Medicaid rules for reimbursement of services and the changes needed under new rules are summarized in table 4 below:

Service and Description	**Brief Summary of Current Reimbursement Methods**	**Changes Needed**
Case Management (ICM, SCM, Blended)	Case management services are reimbursed with a fixed regional monthly fee. Payment is based on the level of service provided (Intensive, Supportive and Blended). Clients must receive a minimum number of face-to-face contacts per month (two or four) for providers to receive payment. Number of contacts varies based on level of case management provided.	Shift to billing in discrete service units; services limited to assessment, treatment planning, referral and monitoring of services.
Assertive Community Treatment (ACT)	ACT services are reimbursed with a monthly, fixed fee per client. Clients must receive a minimum number of face-to-face contacts per month for provider to receive payment.	Potentially this service will have to shift to an encounter driven system with team members responsible for their own billing. Service documentation will have to be clearly linked to a rehabilitation plan.
Continuing Day Treatment and Partial Hospital	There are regional fees based upon 3 regions. Hourly fees for Partial Hospital and half day/full day fees for CDT. The payments are based upon the cumulative visits and hours for consumers in each program. For CDT, the average hourly payments are	The service is billed in hourly increments; however selected CDT services may have to be unbundled to specifically identify rehabilitation services. Service documentation will have to be clearly linked to a rehabilitation plan. Partial Hospital rates will

Service and Description	Brief Summary of Current Reimbursement Methods	Changes Needed
	lower for providers that provided more service hours per client per month (volume adjustments). Visits are for direct, collateral and group collateral visits.	have to be reviewed but do not involve rehabilitation option rules, since they are hospital based services. The need to document progress toward rehabilitative goals and move away from long term "maintenance" treatment will further drive change.
IPRT	Regionally determined hourly fees for non-state operated Intensive Psychiatric Rehabilitation Treatment (IPRT).	Service documentation will have to be clearly linked to a rehabilitation plan.
Personalized Recovery Oriented Services (PROS)	PROS are reimbursed using 5 different monthly rates determined by a combination of program participation and service frequency. These are accumulated for the day and then the month to determine the monthly rate that is paid. A minimum of two PROS units are required each month for the monthly base rate.	Service documentation will have to be clearly linked to a rehabilitation plan. Monthly billing may have to be unbundled to specifically link to services.
Comprehensive Psychiatric Emergency Program (CPEP)	CPEP services are reimbursed according to a statewide fee schedule	Current services meet medical necessity criteria. Changes are not likely to be necessary.

Table 4 - Ambulatory Reimbursement Methods

As is evident, the reimbursement methods differ significantly for the various services; each method was created in the effort to simplify billing, avoid cost shifting and contain costs. Case management and ACT services are paid to providers through monthly bundled[34] rates, adjusted by level of service (contacts) during the month. Case management is reimbursed under the targeted case management (TCM) rules of Medicaid. ACT is an evidence based practice combining clinical, rehabilitation and case management services. CDT is reimbursed under the clinic option. CPEP services are reimbursed using encounter rates. All of the services except perhaps CPEP are affected in some way by the new CMS regulations and will require restructuring or changes in billing procedures and documentation.

New York's current Medicaid payments for clinic and Continuing Day Treatment include base rates (that generally vary by region) and certain supplemental payments ("add-ons") for Comprehensive Outpatient Programs (COPs) and for Community Support Programs (CSP). These funds are used to pay for a variety of Medicaid ambulatory mental health programs and the methodology is part of New York State's approved Medicaid State Plan. There is universal agreement that these "add-on" payments need to stop. They were a creative approach to

[34] A bundled rate is a rate that provides reimbursement for multiple services or multiple incidents of the same service within one rate.

increasing federal revenue for the mental health system, but Medicaid rules and policies under the DRA have specifically targeted these kinds of payments for elimination. The Clinic Restructuring process currently underway is recommending a method of eliminating COPs payments and making adjustments in the methodology for other clinic services to help compensate for the loss of COPs. A similar process is needed for CSP payments to Clinics, IPRT, Partial Hospital and Continuing Day Treatment providers.

Community Support Program (CSP) Payments

The supplementary payments known as Community Support Program (CSP) payments, are intended to provide clinic, CDT and Day Treatment (for children) providers with supplemental funding to support the greater needs of individuals with serious mental illness (SMI) in the community. These payments are "added to the Medicaid rate of certain OMH outpatient programs in proportion to the amount of community support program State and local assistance previously replaced by CSP. This Medicaid revenue is regulated in 14NYCRR Part 588" [35] .

Certain clinic and continuing day treatment programs receive CSP supplemental Medicaid rates for services they provide according to a provider specific formula that is based upon the amount of State Aid a provider received in 1997-98 and their Medicaid eligible population at that time. The rate is adjusted by the volume of services provided by each organization. Table 5[36] summarizes the range of CSP supplemental rates.

CSP Rates			
	Min.	Avg.	Max.
CDT	$11.10	$53.38	$170.73
Clinic Treatment	$0.62	$42.45	$300.00
Day Treatment	$4.24	$25.70	$117.47
*Minimum rates and averages do not factor in zeros			

Table 5: CSP Rates

These supplemental payments, developed in the late 1990s, provide more than $50 million[37] a year in annual support to clinic providers for their non clinic outreach and related activities. Each provider has a threshold cap for CSP revenue. Providers must track receipts and set aside CSP revenues in excess of the threshold in a reserve account for recovery by OMH in the cost settlement process. Because CSP rates are bundled and are not directly linked to services, CSP payments will have to be revised under the new CMS regulations.

Local Assistance is Essential to Protect the Safety Net but Accounting and Reconciliation Methods are too Complex

"The requirement to revise budgets from years past is irrational and a symptom of a broken system"

State and county non Medicaid funding, known as Local Assistance funding, support services that are either:

- Not Medicaid reimbursable because they are not considered

[35] New York State Consolidated Budget and Claiming Manual. Appendix A, Glossary, Section 25. May 2007.
[36] Public Consulting Group, Provider Reimbursement System, New York Office of Mental Health, June 2007.
[37] NY Office of Mental Health, Office of Financial Management, N. Brier by phone.

"medically necessary" (for example, advocacy, some housing and vocational services); or
- Medicaid covered services delivered to individuals who are not eligible for Medicaid (such as CDT or case management services to adults whose income is above the Medicaid threshold in New York). Counties vary in the extent to which they provide this type of coverage.

Local assistance supports many recovery oriented and innovative services. These services have generally been funded through a mix of State Aid and county contributions. Both funding categories have increasingly been constrained. Providers receive funds primarily through county contracts. The contracts are either direct contracts for specific services or "deficit funding" for programs. Deficit funding fills gaps in financing after all other revenue is received. Providers receiving these funds are subject to annual budgeting requirements, revenue reconciliation, and cost settlement provisions with the State.

Across all mental health services in 2007, local assistance totaled $488 million almost half of which ($200 million) covered ambulatory non-clinic services (CFR Data). According to CFR data, approximately $66 million in deficit funding, compared to $117 million in Medicaid funds, is received by programs for the care coordination services covered by this study (case management, ACT, transition management and bridger services). These same care coordination programs also report almost $12.7 million in losses for the most recent operating year.

The funding methods for these State and county contracts are very complex. Until recently, counties had the responsibility both for providing the local share of the Medicaid State match (about half) and for the local share of deficit funding for providers. Counties supported this through their own tax levies. The county role in financing has changed somewhat as counties' obligations for the Medicaid match have been capped and a number of new services have been funded through direct State contracts. These changes have added to the complexity of funding streams and fragmentation of programs.

State procedures for budgeting, cost reporting and settlement of deficit funding contracts further compound the complexity of the system. The rules governing budgeting and cost reconciliation processes require providers to prepare annual budgets, make revisions during the year, and undertake cost settlements with the State. The settlement process has been taking several years to finalize – even in the best of situations. A careful study of the costs and benefits of the reconciliation process would be important to determine whether the amount of the recovered or reallocated funds justifies the administrative costs of the process. Numerous stakeholders and State staff reported on the inefficiencies and ineffectiveness of these procedures.

Recommendations: A Framework for Change

The need for change is clear. Maintaining the status quo is not an option. As this paper has explained, changing interpretations of Medicaid rules will likely require significant modifications to several programs such as unbundling of rates, new service definitions for some services, revisions to State and provider billing systems, and a clearer focus on rehabilitation plans and monitoring of these plans.

These dramatic adjustments have the potential to stress an already fragile system while doing nothing to reduce fragmentation or change the underlying dynamics in the system. Making

changes that reduce fragmentation, increase accountability and lead to a stronger, more recovery oriented system, will require vision, consensus, commitment and coordinated action.

Stakeholders made numerous recommendations during the interviews and in the focus groups. Some of the most salient are outlined in Attachment H. These formed the basis for the recommendations outlined below. Indeed, the recommendations in this paper touch in one way or another on most of the recommendations of stakeholders.

> *"We need a system that is transformative; that facilitates recovery, improves accountability and is consistent with federal standards"*

The overall recommendations are grouped in four general areas: Case Management, Programmatic, Organizational and Financial. Many of these are interrelated; for instance, implementing Recovery Homes (see definition below) will require changes in financing and, under certain conditions, will require a 1915(b) waiver, similar to Primary Care Case Management programs. The general areas are:

- **Case management redesign** must include changes in rates and improved documentation;
- **Program and management recommendations** include the implementation of Recovery Homes, person centered planning and performance contracting;
- **Organizational changes** include building local or regional systems of care, implementing Organized Delivery Systems, and disease management strategies;
- **Financing options** include changes in TCM and rehabilitation rates, 1915(b) waiver approaches and 1915(i) state plan options.

These options are related and they are not mutually exclusive; they provide a framework for thinking about different strategies that counties as well as the State could consider.

Case management redesign

Providers and other stakeholders report that in addition to assessment, treatment planning and referral services, case managers often provide life skills, service navigation, escort, life coach services and targeted interventions designed to increase motivation and engagement with services and community supports. These functions may have to be unbundled from the case management procedure code in order for providers to meet Medicaid requirements. Thus, the new CMS rules will require redefined services, increased levels of documentation by providers and changes in billing and rates.

It is essential to develop a system that is capable of providing several levels of care coordination so service can vary based on acuity of the illness, natural supports, housing, vocational situations, and other factors. Coordination of care is most important during transitions between services and during acute phases of care. For example, during:

- The first three weeks following hospital discharge;
- Changes in housing; and
- Changes in treatment.

It is much less important during periods of stability. This kind of flexible response capacity requires technologies, specialization of staff and functions that most case management services do not have access to.

The specialization of staff, the use of clinical guidelines and the intensity and nature of contacts between staff and consumers should be flexible enough to respond to these different levels of need. The functions that should be considered include administrative case management, targeted case management and disease management strategies.

To reduce fragmentation and increase meaningful coordination of care, elements of each of these three types of care coordination should be adopted. For instance, although New York counties provide little, if any, administrative case management service as defined above, the case monitoring recommendation of the Mental Health /Criminal Justice Panel seem to call for just these services. Similarly, the use of clinical guidelines, technology support, and consumer education and self-management approaches that are found in disease management are important tools for the State to use to reduce regional and inter-county variation and improve outcomes. These tools would help to reduce practice variation and maximize the use of available resources.

Program Recommendations

New York State should consider expanding the use of what we have called "Recovery Homes" and person-centered planning. Each is discussed further below.

Recovery Homes

A "Recovery Home" is similar in many ways to a Primary Care Case Management (PCCM) model in Medicaid though, like the Medical Home concept, Recovery Homes are intended to be more comprehensive and provide more than just PCCM gate-keeping (service authorization) services. Recovery Home clinicians would authorize and coordinate all behavioral health care services and many aspects of physical health care for people with chronic conditions. These clinicians must have a health information system that allows them to track compliance with clinical guidelines, follow up on referrals and monitor health status. They would anticipate consumers' needs and use consumer and person centered planning tools that encourage self management of the chronic illness. A Recovery Home approach can be implemented as a part of several different financing options.

The model builds on Wagner's Chronic Care Model[38] for the integration of services to disabled and other individuals with chronic needs. Wagner's model has been widely tested with positive outcomes and there are numerous states developing similar approaches for behavioral health care coordination. Wagner's model identifies six fundamental areas of practice that need change: 1) increasing self management; 2) improving decision support; 3) redesigning the delivery system for increased accountability; 4) implementing a patient registry or clinical information system; 5) improving the organization of health care; and 6) involving local communities in the change process.

In a Recovery Home, individuals meeting "enrollment" criteria select a primary mental healthcare provider or organization as their primary provider, their "Recovery Home." Enrollment should target those individuals who require a more intensive level of coordination – these might be people currently eligible for targeted case management. They would have access through that "Recovery Home" to a core set of services such as medication, individual, family or group treatment, case management and peer support services. Consumer education,

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[38] Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. *Improving Chronic Illness Care: translating evidence into action*. Health Affairs. 20(6) 64-78. Nov-Dec 2001.

self-management skills, employment and life skills would also be taught through PROS or a similar service. Care would be tightly coordinated among service providers. Most likely, each of these "homes" would be a mental health clinic or a comprehensive ambulatory provider in partnership with a clinic. The current functions of targeted case management would be embedded in, or integrated with, the Recovery Home provider.

The Recovery Home would be responsible for developing the treatment and rehabilitation plan, referring the consumer to appropriate services and monitoring the outcomes of those services and making any needed adjustments to the plan. A key principal would be "one person, one plan;" this single treatment plan would cover all services the enrolled individual receives. Performance would be measured. Reimbursement could be on a fee-for-service basis, using a supplemental monthly enrollment rate (similar to PCCM approaches), or it could be through more complex monthly case rates.

Person Centered Planning and Self Direction

Person centered planning principles should be at the heart of New York's system redesign. They constituted a cornerstone of the recommendations of both the President's New Freedom Commission[39] and the Institute of Medicine's (IOM) "Crossing the Quality Chasm"[40] reports. The proposed CMS Rehabilitation Option rules also specifically mention and recommend the implementation of services that are recovery oriented and that are governed by a person centered plan (PCP). The proposed regulations state:

> *We are proposing to require in §440.130(d)(3)(iii) that the written rehabilitation plan include the active participation of the individual (or the individual's authorized health care decision maker) in the development, review, and reevaluation of the rehabilitation goals and services. We recommend the use of a person centered planning process. Since the rehabilitation plan identifies recovery oriented goals, the individual must be at the center of the planning process. (emphasis added)*[41]

Perhaps the best example of the implementation of Person Centered Planning in New York is the multi year effort of the Western New York Care Coordination Program that is being implemented in a number of counties in Western and Central New York. In fact, their effort is arguably the most comprehensive and most mature attempt in the country to alter treatment and treatment planning. Managers of that program are keenly aware of the challenges involved and time it takes to make these kinds of transformative changes.

Self-directed care (SDC) extends the practices of person centered planning to include the management of a budget. SDC is "a method of delivering services that is based on giving each consumer control of an individual budget with which to purchase goods and services to meet his or her needs. It is frequently also referred to as consumer direction . . ."[42] In addition to being cited by the President's New Freedom Commission and the IOM's Crossing the Quality Chasm

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[39] New Freedom Commission on Mental Health (2003), Op. cit.
[40] Institute of Medicine (2006), Op. cit.
[41] Centers for Medicare and Medicaid Services, "Medicaid Program; Coverage for Rehabilitative Services, Proposed Rule. CMS 2261-P: RIN 0938-A081, Page 18.
[42] Alakeson, Vidhya. "*The Contribution of Self-Direction to Improving the Quality of Mental Health Services*." Office of the Assistant Secretary for Planning and Evaluation, DHHS. November 2007.

report for behavioral health services, self directed care has been at the heart of two recent regulatory changes from CMS. These include the new rules for what are referred to as 1915(i) state plan amendments and 1915(j) rules for the implementation of self directed personal care assistance.

PCP differs from SDC since the latter generally enables the consumer to "direct" funds toward more flexible services than may be available through state plans.[43] Use of PCP can be increased within existing financing structures and also through waivers and other rule changes that would be required under Medicaid. In some sense, PCP is the first step in pursuing self direction; it is necessary but not sufficient. While it helps fulfill the aims of the IOM's Crossing the Quality Chasm series, it involves huge changes in providers' culture and practice. According to recent research supported by the Office of Mental Health, and reviewed for this paper, the Western New York Care Coordination Program has demonstrated some promising results.[44]

CMS has actively encouraged the pursuit of self-direction through its Home and Community Based waivers, Independence Plus waivers and the new state plan amendment option enacted through the Deficit Reduction Act (DRA). CMS defines self ("participant") direction as the following:

> *Participant direction of waiver services means that the waiver participant has the authority to exercise decision making authority over some or all of her/his waiver services and accepts the responsibility for taking a direct role in managing them. Participant direction promotes personal choice and control over the delivery of waiver services, including who provides services and how they are delivered.*

Many stakeholders, particularly consumers and consumer advocates, expressed considerable interest in the development of SDC in New York State. While it is not a panacea, SDC could be an option for consumers receiving continuing care services and supports. It can be implemented with considerable flexibility using state deficit funding or pursuant to CMS guidelines under 1915(b) waiver or 1915i state plan amendment authority[45]. The State should consider using pilot grants to spark and spread the development of these programs.

Organizational Options

Build Local or Regional "Systems of Care"

A single statewide solution is neither optimal nor a very viable approach in New York State. The State is too large and too diverse. The data on regional service penetration and utilization suggest the need to develop new, more coordinated, systems of care, building upon the existing base of services, providers and practice. A comprehensive local or regional planning process that is informed by data and that drives service delivery is needed. The State's 5.07 planning

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[43] For a good overview of both these practices please see Judith Cook (2005). "*Patient Centered*" and "*Consumer Directed*" Mental Health Services. Prepared for the Institute of Medicine, Committee of Crossing the Quality Chasm -- Adaptation to Mental Health and Addictive Disorders."
[44] Western New York Care Coordination Program: Results, July 2008.
[45] In addition CMS allows the implementation of self-directed care under 1915j authority, which covers personal care assistance services. These services are of limited utility for mental illnesses however under NY's existing state plan.

process provides a useful framework for this; the plans should address the need for services and gaps in these services. Service effectiveness and opportunities for efficiencies should be documented in the planning process. However, planning is necessary but not sufficient. Systems need the ability and willingness to change the allocation of funding and/or utilization when new funds are not available.

One approach that might work is the use of a single regional entity or system of care to coordinate the implementation, financing and delivery of services provided to consumers. This entity could be a governmental (county) or a private organization. Generally such initiatives operate under a 1915(b) waiver of freedom of choice, enabling consumers to be enrolled in the entity, permitting selective contracting of providers and providing a structure for financing through a capitation or case rate methodology. They require mandatory enrollment and are a carve-out approach.

In many states, regional care coordinating entities work within a single county's geographic boundary and are contracted by the state to provide a full or partial (e.g., ambulatory care only) array of services to enrolled consumers. Some counties may be able to assume this role themselves; in other areas counties should work together to jointly share resources, as the Western New York Care Coordination Program has done. Counties in Pennsylvania, Florida, Washington State, Colorado, Michigan, California, and regions in Arizona and elsewhere demonstrate how systems of care can be implemented directly by a county, by a county with an administrative service organization or through a private organization. The feedback from consumers and advocates in most of these states has been very positive; the notable exception might be Florida, which has had a number of funding and structural changes.

Once fully operational, each regional system of care entity would contract with the state and then administer subcontracts with a network of service providers. It would finance and deliver services that meet state and local standards, addressing most of the Program and Management recommendations described in the previous section. Financing from the state could be on a financial risk or non risk basis. Developing capitated or case rates based upon historical costs might avoid some of the rate setting and regulatory issues associated with changes to the case management and rehabilitation option regulations.

Use Organized Delivery Systems (ODS)

Medicaid rules permit the development of so-called Organized Delivery System (ODS) for the provision of health services. These are legal entities that contract with the state to provide a comprehensive array of services[46]. A waiver is not required if consumers have a choice of providers and enrollment is voluntary. A 1915(b) waiver of freedom of choice is required, however, if enrollment is mandatory. The ODS option is optimal in an urban setting where the scale is sufficient to allow competing providers to enroll consumers. With sufficient scale for enrollment and relatively low cost barriers to entry, an ODS could be implemented without a waiver. Most areas find that a waiver is preferred to ensure that the ODS will have sufficient enrollment to break even on its required administrative costs.

New York officials should consider developing standards and a performance contracting strategy for ODSs. Requirements should include the provision of a full array of ambulatory

[46] Note that we have differentiated between Regional Systems of Care and Organized Delivery Systems to distinguish a single regional delivery system from the use of more than one delivery system operating in a region.

services with an emphasis on recovery services. Services should build on the foundation of the Recovery Home concept described above; the ODS could in fact provide the centralized clinical record that would enable the individual provider to track consumers' services and progress.

The contract needs to include provisions regarding the ODS's responsibilities for oversight of the provider network, reporting standards and performance incentives. The ODS should include fully integrated ambulatory and specialty services provided either by their own staff or through subcontractors.

Reimbursement to ODSs is generally on a prepaid, capitated or case rate basis though it can be through fee-for-service methods also. Initially, the ODS should exclude inpatient and emergency services; however, performance incentives should be developed to reward reduced hospital usage and cover the costs of the increased community services that consumers need. Incentives should also be developed for the coordination of physical health services.

Disease Management Strategies

CMS defines disease management as "a **direct service** offered either through a managed care organization, a primary care case manager, or individual practitioners. It is a coordinated package of care comprised of preventive, diagnostic and/or therapeutic services to a specific group of individuals who have, or are at risk for, a chronic illness or condition and does not include the same components to meet the definition of case management."[47]

The State should consider using disease management strategies in rural areas. In areas that offer voluntary enrollment, the State might encourage use of disease management programs for consumers who do not choose to enroll in either a Recovery Home or an ODS. Disease management could be used to guide professionals and paraprofessionals in the treatment of individuals with serious mental illness to support review of care plans and to improve access to consumer education and service referrals. The approach could be structured to incorporate many of the functions envisioned in the "case monitoring organization" recommended by the Mental Health/Criminal Justice Panel.[48]

Disease management in Medicaid has generally been initiated for chronic physical conditions such as diabetes, congestive heart failure and asthma. Many disease management firms have also included depression as one of the conditions "managed," but these efforts have generally been aimed at the primary care physician rather than at the specialist. APS Healthcare has developed some small programs in the Wyoming and Georgia Medicaid agencies, but in general little has been done to address schizophrenia, bi-polar disorder or other serious mental illnesses. While few state Medicaid agencies have implemented programs aimed at individuals with SMI, these programs potentially have great importance to state Mental Health Authorities such as OMH.

Reimbursement could be through some form of case rate, or blended per diem rate, or the State could contract with the organization using a non risk administrative service contract. Most disease management programs do not include the assumption of risk for other services, though they are likely to have performance incentives if certain targets are met.

[47] CMS Technical Assistance Tool, Ibid.
[48] New York City/New York State: Mental Health/Criminal Justice Panel, op.cit.

Certain functions that are generally included in disease management programs might also be eligible for reimbursement as administrative case management under Medicaid. These would include identification of high cost or high risk individuals, case review, telephonic support to providers and oversight of the treatment plan.

Financing Options

Accomplishing any or all of the modifications outlined above will require changes in the way the State and counties purchase Medicaid and general fund services. Rates and reimbursement methods will need to change for several current Medicaid services. The COPs and CSP clinic add-ons will need to be eliminated and changes will be needed in the monthly rates currently billed for targeted case management and ACT. In addition, IPRT rates may have to adapt to billing in different increments more closely tied to service encounters. All of these changes will require more careful attention to treatment planning and documentation.

If the system were to adapt to these regulatory changes without other more fundamental changes, it would be reasonable to estimate that New York would initially experience a $170 million loss of federal Medicaid match. Many programs would likely close and there would likely be increases in hospitalization rates and the use of more restrictive services. Although New York is not the only state confronting this problem, it is probably unique in its use of the COPs and CSP add-ons. Little is known about the magnitude of the problems other states anticipate.

There are a number of Medicaid financing options available that are consistent with the recommendations proposed for consideration in this paper and that might minimize the lost revenue. Fully describing and discussing the advantages and disadvantages of each of these approaches is beyond the scope of this paper and will require more detailed analysis and planning. However, there are two that are important to consider at this time.

1915(i) State Plan Amendment

The Deficit Reduction Act (DRA), P.L. 109-171, was passed by Congress and signed by the President on February 8, 2006. The law creates new options under the Medicaid program that allow states greater flexibility to furnish community based services. For example, Section 6086 of the DRA gives states the ability to provide home and community based services (HCBS) to elderly individuals and people with disabilities without receiving a waiver or demonstrating the cost neutrality generally required under a 1915(b) or 1115 waiver. Services approved under this option are intended to help individuals delay or avoid institutional stays or other high cost out-of-home placements. The initiative has become known as a 1915i State Plan Amendment (SPA).

Section 6086 gives states, at their option, the opportunity to offer HCBS to elderly individuals and people with disabilities who have incomes up to 150 percent of the federal poverty level (FPL). A state need only amend its Medicaid plan to provide any of the services now covered under HCBS waivers. There is no need to document current Medicaid institutional costs, which helps to avoid the problems created by the IMD exclusion[49]. Section 6086 expands the

[49] This is the exclusion of costs and reimbursement for individuals between the ages of 21 and 64 residing in Institutions for Mental Disease (IMDs). An IMD is any organization with more than 16 beds, licensed or operating as a psychiatric facility, or where more than 50% of the population has a primary diagnosis of mental illness. The exclusion was specifically designed to exclude state mental health hospitals from Medicaid coverage.

populations eligible for HCBS waivers: adults from ages 22 through 64 who have a mental disorder are now covered.

Only Iowa and Nevada have an approved 1915(i) SPA. Iowa's new benefit will provide statewide HCBS case management services and habilitation services at home or in day treatment programs that can include such things as support in the workplace.

Some states see the 1915(i) as an opportunity to contain program expenditures by limiting the number of individuals that can participate. In addition, the 1915(i) also provides consumers with the opportunity to self direct their care-an opportunity that is not afforded for regular state plan services.

However, some states have expressed concerns regarding eligibility for the 1915(i) program such as:

- Limited eligibility. Individuals must be Medicaid eligible and have incomes less than 150 percent of the FPL. States that have expanded their eligibility for children beyond 150 percent are particularly concerned that the 1915(i) will exclude many children who need these services.
- Limited benefit package. CMS will only allow a 1915(i) to cover the statutory services discussed above. States have indicated that the additional statutory services do not meet the needs of the target population. For instance, many statutory services such as adult day health, personal care and homemaker services are not relevant for children. Other statutory services, such as rehabilitation, day treatment and clinic services can be included as regular state plan services and do not require a 1915(i).
- Cost of implementation. Implementation requires the development of a costly independent assessment and treatment planning process.
- Ability to target intended recipients. The eligibility criteria for the 1915i program must be based upon financial need rather than on diagnoses or illness. As a result those need based criteria must be carefully defined.

These last two issues may create problems for many states seeking to implement the program, including New York. In the end, the 1915(i) option is likely to be part of but not the entire solution.

In addition, and of particular concern, the submission of a 1915(i) application may "open up" for CMS review the current state's Medicaid plan for rehabilitative services. CMS is currently reviewing many states' Medicaid rehabilitative services plan. Based on this review, CMS is requesting that certain services that do not appear to be rehabilitative (e.g., group home services) be removed from the plan. In addition, CMS is reviewing the states' rate setting methodologies for rehabilitative services and is requiring that all rates for rehabilitative services be reimbursed in 15 minute increments. This is hugely problematic for services that are currently priced on a monthly or per diem basis.

1915(b) Freedom of Choice Waiver

CMS allows states to develop and operate waivers to implement managed care delivery systems, or otherwise limit individuals' choice of providers under Medicaid. States may request Section 1915(b) waiver authority to operate programs that impact the delivery system for some or all of the individuals eligible for Medicaid in a state. Under a 1915(b) authority, states are

permitted to waive “state wideness”, comparability of services, and freedom of choice. Section 1915(b) waiver programs may be implemented in regions. Recipient eligibility must be consistent with the approved state plan. States also have the option to use savings achieved through managed care to provide additional services to Medicaid beneficiaries. Some 1915(b) waivers create voluntary programs and some have the option for fee for service or managed care. Every Medicaid recipient should have a choice of at least two providers.

There are nearly 100 1915(b) waivers in operation with most states having one or more. There are four types of 1915(b) Freedom of Choice waivers:

- 1915(b)(1) mandates Medicaid enrollment into managed care;
- 1915(b)(2) utilizes a "central broker;"
- 1915(b)(3) uses cost savings to provide additional services; and
- 1915(b)(4) limits the number of providers for services.

States that have 1915(b) waivers often contract with a Prepaid Inpatient Health Plan (PIHP) or a Prepaid Ambulatory Health Plan (PAHP) to implement and administer their managed care programs. A PIHP is an entity that provides, arranges for, or otherwise has responsibility for medical services, including the provision of inpatient or institutional services for its enrollees. A PAHP does not provide or arrange for (and is not otherwise responsible for) the provision of any inpatient hospital or institutional services for its enrollees.

PIHPs and PAHPs often receive pre-paid capitation payments or other payment arrangements for providing services to enrollees. PIHPs and PAHPs are generally private companies; they may be for-profit or non-profit. However, some PIHPs and PAHPs are administered by state or local governments. This can include county operated plans if the funding flows from the state through the county as in Pennsylvania. Behavioral health PIHPs and PAHPs are either developed as “carve-ins” (behavioral benefits are included with physical health plan benefits), “carve-outs” (a separate contract is developed for behavioral benefits) or a combination. Any 1915(b) waiver model in NY will have to be some form of combination, since TANF MCO benefits include limited mental health benefits (20/30 rule).

The use of pre-paid capitation payments based upon historical costs could help the State retain some of the federal support that would come unbundled otherwise – historical costs under the approved plan can be included in a the capitation rate. A 1915(b) waiver would allow the State to reinvest savings into the mental health system. However, under CMS rate setting rules for the 1915(b), savings can only be reinvested in services that are part of the current state plan in order to be included in future capitation rates. This is an important distinction: while savings can be used to pay for services not currently approved in the state plan, future rates will be established on the basis of utilization of state plan approved services. This will result in lower capitation rates in future years of the 1915(b) waiver.

States that have implemented 1915(b) waivers have generally had two sometimes competing goals: increasing the effectiveness of services, and controlling expenditures for behavioral health services. In their waiver applications, states must provide information to CMS on their goals for maintaining or increasing access to services, while maintaining or reducing costs. They must also outline their strategies for achieving these goals. The solution to this apparent conflict lies in increasing access to outpatient and support services while reducing the use of inpatient, residential and other costly services.

Implementing managed care with a 1915(b) waiver of freedom of choice may provide some challenges for New York State. The history of New York's Special Needs Plans may make any future waiver approach difficult to implement. The split in mental health benefits between the limited benefit in managed care plans (20-30) and the more comprehensive benefit available to those with serious mental illness is another confounding factor. Nonetheless, managed care waivers can provide OMH with a great deal of flexibility to design a delivery system that is less fragmented and more accountable, while improving outcomes and controlling costs.

Conclusion

The keys to reducing fragmentation and increasing the effectiveness of care in New York's mental health system include the improvement of care coordination activities, increased focus on recovery, improved data systems, increased accountability through contract oversight and performance management, redesign of the overall financing system, and increased focus on improving outcomes. These have been the vision for the mental health system in New York for years, but the needed changes have been elusive. The crisis brought on by the new CMS regulations and the dissatisfaction with the status quo provides a window of opportunity transform the system. Consensus on the need for change, as we heard from all the stakeholders interviewed, is essential to moving forward.

As this paper has documented, consumers in different regions vary dramatically in their access to and utilization of services. Each region is starting from a different place in the reform of its system. If transformation of our mental health system is ultimately about changing practice, the solutions must be adapted to current local practice and to the strengths of the local delivery system. No single approach is optimal statewide; New York must develop strategies that build on the expertise of local staff, their organizations and county officials, and that allow the flexibility for local innovation.

Solutions must be regional because many counties lack adequate scale for most reform efforts. The success of Western New York counties in increasing access to services, keeping costs low, reducing inpatient rates and increasing care coordination services suggests that their regional approach to coordinating care and developing person centered planning should continue. Other counties may want to follow a similar approach. The ideal approach for New York City, given the large number of recipients, the role of hospital systems and the scale of services should probably be the development of recovery homes or some form of ODS that can be chosen by consumers and include a comprehensive array of services with enhanced performance measurement and monitoring.

Care monitoring and disease management strategies should be adopted for individuals who do not enroll in one of the other options and for localities that do not undertake or participate in any larger reorganization. The financing system needs to be adapted to suit these different options. Changes in the existing rules will be necessary for those recipients or counties that do not enroll or participate in the changes. For them, there are likely to be reduced levels of federal support and restrictions on the availability of services.

As the announcement of the President's New Freedom Commission report states:

> *"Overall . . . the system is not oriented to the single most important goal of the people it serves the hope of recovery. Many more individuals could recover from even the most serious mental illnesses, if they had access to treatments tailored to their needs, to supports and to services in their communities. State-of-the-art*

treatments, based on decades of research, are not being transferred from research to community settings. Meanwhile, many outdated and ineffective treatments are currently being actively supported. The barriers to effective mental health care can and must be overcome . . .”

New York has the opportunity now to create the kinds of changes envisioned by the President’s Commission.

New York Office of Mental Health
Ambulatory Restructuring Project Report
Appendices

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Attachment A – Data Used for this Report
Primary data sources used in the course of this project include:

- OMH Consolidated Financial Report (CFR) data set for the most recent years filed by providers.
- OMH Patient Characteristics Study
- Medicaid Claims Data for MH diagnoses, sorted by Service and by county
- Statewide Planning and Research Cooperative System (SPARCS) Inpatient Admissions data
- Various OMH reports

In addition, the study collected information through interviews with:

- Staff leadership of the Office of Mental Health
- Stakeholders from upstate and downstate
- State and county officials, advocates, providers and recipients of services.
- Programs and Counties were visited in New York City, Westchester, Middletown, Madison County, Utica, and Rochester.

Unless otherwise indicated, the quotations that appear in text boxes throughout this report come largely from these interviews and focus groups.

CFR data include filings for calendar year 2006 while data for New York City providers cover the period from 7/1/2006 to 6/30/2007. The CFR data summarize all revenue sources and costs for mental health programs across all providers. Financial data reported by county or region are based upon the location of the agency filing the report. Service and facility locations may vary from the reporting location but the county locations were deemed reliable for analysis purposes.

For this analysis, out of 89 OMH program types, the following services were excluded: Inpatient; FEMA Crisis; Clinic Treatment; Residential; Special Demonstrations; LGU Admin and programs specifically designed for children.

At the time the present study was initiated, a separate process was begun to restructure children's mental health services. Since the children's system had previously been engaged in strategic planning efforts and has been expanding the population served under its Home and Community Based Services waiver, a separate planning process was created for children's mental health ambulatory services. However, there is significant overlap in many of the data sources for child and adult services. CFR data for many of the ambulatory services, for example, cannot be separately reported for adults and children. Other services are specifically targeted to adult or child populations and they have been excluded. Day Treatment and certain family support services are clear examples of services specifically focused on children. Other services such as emergency and case management cannot be as easily separated.

As a result, in the data that follow we have generally indicated whether programs serve just adults or children as well.

Adult Medicaid claims data were reviewed for calendar year 2007. Data included claims by service, unduplicated adult (18+) recipients for each service type and units of service. Medicaid data allow for analysis of per capita service costs, penetration rates, client use of multiple services and client movement and transition between services.

Data from the 2007 Patient Characteristics Survey were also reviewed to provide demographic and other summary information on the people served in New York's ambulatory non-clinic mental health system. These data are from a survey of providers during a one week period in "snapshot" in 2007 and have been sorted to report only on adults who were not in clinic or inpatient services.

Attachment B: How Are Mental Health Dollars Distributed in New York State?
In this section, data are summarized from three distinct and potentially overlapping sources to help to define the size and scope of the ambulatory mental health system in New York State.

1. Total 2004 spending data assembled by OMH from multiple sources, often referred to as the New York Times data set. These sources include Medicaid claims, CFR reports and State agency expenditures; they describe the entire $5.5B publicly funded mental health system.
2. The most recently filed Consolidated Financial Reports (as of late April, 2008) summarizing $1.4B in expenditures for ambulatory programs.
3. 2007 Medicaid billing data for all levels of care and for ambulatory services.

As is often the case with different data sets, the data do not always "cross-walk" between the sets. We have reviewed areas of difference and are confident that, taken together, they help to provide a comprehensive picture of the State's mental health system.

Total 2004 Spending on Public Mental Health Services is more than $5.5 Billion

It is important to understand how the ambulatory system fits within the total public mental health system in NYS. In 2004, total spending for non State operated adult and child mental health services was more than $3.9 billion (Table 1). [50]

2004 Hospital and Community Mental Health Expenditures						
Service	**Private Psych**	**Residential TX Facilities**	**Article 28 Hospitals**	**OMH Non- Article 28 CFR Filers**	**Family Care**	**Total**
Emergency			$187	$23		$210
Inpatient	$180	$86	$1,429			$1,695
Outpatient	$5		$515	$550		$1,070
Support			$32	$430		$462
Residential			$15	$447	$23	$485
Total	**$185**	**$86**	**$2,178**	**$1,450**	**$23**	**$3,922**

Table 1 – Mental Health Spending (millions)

In addition to the $3.9 billion in hospital and community services summarized above, spending for State operated services in 2004 totaled an additional $1.64 billion. State operated services are primarily inpatient ($1.2 billion), but also include emergency, outpatient, support, residential and research services (see Table 2).[51] These services are principally funded from $1.25 billion in State general funds and $406 million in Medicaid funding (for individuals under 21 and over 65 years of age). Thus, all told, 2004 spending in New York's mental health system totaled $5.564 billion.

2004 State Operated Service Expenditures (Research Spending has been allocated to Program Costs)	
Service	**$**
Emergency	$24,438,837
Inpatient	$1,196,936,343

[50] New York State Office of Mental Health, Finance Group. *"Summary of State Mental Health Expenditures, Fiscal Years: 1995 to 2004"* (New York Times Data)
[51] Ibid.

2004 State Operated Service Expenditures (Research Spending has been allocated to Program Costs)	
Service	**$**
Outpatient	$200,240,887
Support	$139,674,275
Residential	$80,952,406
Total	**$1,642,242,747**

Table 2 – Spending (millions)[52]

Adult Ambulatory Mental Health Program Spending Totals Almost $1.4 Billion

Adult ambulatory services include $651 million in clinic spending and $724 million (Figure 1) in non clinic expenditures according to 2007 CFR data.[53] Thus non clinic ambulatory expenditures are slightly more than 13 percent of the total system expenditures.[54] These services include virtually all of the recovery oriented services that have been developed over the last two decades, including clubhouse, self help services, vocational supports, and ACT. They are described in Attachment B and C in greater detail.

Figure 1 – Statewide Ambulatory Non-Clinic CFR Data

CFR Expenses by Category: Statewide		
Emergency-Comp. Psych. Emergency Program	$61,475,009	8.5%
Emergency – Crisis	$36,512,007	5.0%
Total Emergency	***$97,987,016***	***13.5%***
Total Day Rehabilitation	***$185,770,558***	***25.7%***
Total ACT	***$45,572,105***	***6.3%***
Support – Care Coordination	$152,858,509	21.1%
Support – General Support	$67,985,623	9.4%
Support – Self-Help	$100,950,992	13.9%
Support – Vocational	$71,931,572	9.9%
Support – Other	$1,115,492	0.2%
Total Support	***$394,842,188***	***54.5%***
Total Expenses	**$724,171,867**	**100.0%**

Funding from Medicaid provides more than 54 percent of financial support for non clinic, ambulatory services according to the CFR data. The balance is net deficit funding (32.7%) from State and local revenues, Medicare, and third party revenue (11.6% combined).

- More than one quarter of this spending is for day rehab services, the vast majority for Continuing Day Treatment.
- Care coordination services account for an additional 21 percent of spending or $153 million.
- ACT services represent more than six percent of total spending.

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[52] Ibid.
[53] Note that CFR data includes all reported revenue and expenditures for different services. We have not included services that are restricted only to children; however some services in Figure 1 (such as emergency and care coordination) include costs of services for children and adults. These numbers do not include expenditures by several hospital and DTCs that do not report expenditures on the CFR
[54] Based upon 2004 NY Times Data set

- Self help services account for approximately 14 percent of service spending for a total of $101 million.

Adult Medicaid Funding Totals almost $1.8 Billion

Total Medicaid Spending for all adult mental health services in 2007 was almost $1.8 billion (shown in Figure 2). This total includes the following:

- Almost 40 percent of this ($696M) was spent on ambulatory and clinic services. Clinic and non clinic services were almost equally split at $347 million and $349 million respectively.
- Partial hospital services ($6.4M) were a very small 0.4 percent.
- Hospital inpatient claims ($669M) were 38.1 percent of total Medicaid funding[55].
- An additional 12 percent of total Medicaid billing was for State operated services. This includes State hospitals[56] and the Prepaid Mental Health Plan).

Thus, over 50 percent of adult Medicaid mental health spending supported hospital based inpatient, partial hospital and State operated services.

Figure 2 – 2007 Adult Medicaid Mental Health Spending

Statewide Medicaid MH Adult Services Total		
Services	**Statewide Medicaid**	**%**
Ambulatory	$348,944,245	19.9%
Residential	$168,761,937	9.6%
Hospital Inpatient	$669,128,784	38.1%
Partial Hospitalization	$6,379,884	0.4%
State Hospital	$90,165,465	5.1%
PMHP	$125,587,318	7.2%
Clinic	$347,133,425	19.8%
Total	**$1,756,101,058**	**100.0%**

Of the 39 ambulatory non clinic services tracked through the CFR (see Attachment C), Medicaid pays for only 7 - CPEP, CDT, PROS, IPRT, ACT, Targeted Case Management (TCM) and Partial Hospital services[57]. However, Medicaid funding for these seven services equals 50 percent of the funding for all of the 39 services combined. PROS spending was not reported for 2007.

As shown in Table 3 below, Medicaid funding for CDT and TCM was approximately $160 million and $116M respectively. This is almost 78 percent of total non clinic Ambulatory Medicaid spending.

Large Variation in Per Person Cost Per Service:

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[55] Note: Hospital Inpatient claims include all private inpatient settings including Article 28 facilities who may not file a CFR.
[56] Medicaid only covers state hospital services for Medicaid eligible youth under 21 and individuals over 65 years of age. No services for children under 18 are reported.
[57] Note these CFR services are primarily adult services, but some cover adult and child services. Medicaid spending reported in this study is for adults only.

Medicaid funding varies greatly on a per person per service basis.

- CPEP serves 13,333 individuals at a cost of $622 per consumer;
- Continuing Day Treatment serves 20,531 people at a cost of $7,784 per consumer;
- ACT serves 4,330 people at a cost of $11,904 per consumer;
- TCM expenditures averaged $4,991 per person
- IPRT averaged $4,775 per consumer.

Overall spending per consumer served for Medicaid ambulatory non clinic mental health services (Table 3) was $5,249.

2007 Medicaid Ambulatory Services

Ambulatory Services	**Statewide Claims**	**$ per Individual Served**
ACT	$51,542,791	$11,904
CDT	$159,807,146	$7,784
CPEP	$8,295,211	$622
IPRT	$13,151,190	$4,775
TCM	$116,147,907	$4,991
Partial Hospitalization	$6,379,884	$1,836
Total Ambulatory Non-Clinic	**$355,324,129**	**$5,249**
Ambulatory Clinic	**$347,133,425**	**$2,010**

Note: Medicaid CY 2007 Claims divided by unduplicated recipients served

Table 3 – 2007 Medicaid Ambulatory Services

Regional Variation in Service Patterns:

Patterns of spending vary by program type and region. Access to and utilization of Medicaid mental health care are also widely divergent throughout the State (see Attachment E). Overall adult Medicaid penetration rates[58] vary significantly by region; rates range from 9.5 percent to 17.6 percent. Medicaid recipients in Western New York have the highest penetration rate, almost double the rate of NYC and almost four percentage points higher than the next closest region, Central New York.

Western New York has a dramatically higher overall penetration rate (primarily due to clinic access rates), and relatively low per capita and per recipient costs (in comparison with other regions). New York City has low penetration, low overall per capita costs, the lowest ambulatory costs and highest inpatient hospital costs.

Variations in service access, cost and utilization are the result of historical distribution of State funding and the choices made by individual counties in budgeting, staffing and contracting for mental health services in New York. Ultimately, the factors that drive these differences need to be studied further. Most importantly, local planning must incorporate these data, developing strategies to reduce unwanted variation.

[58] The Medicaid penetration rate is the unduplicated number of Medicaid recipients who received at least one mental health service in a year divided by the total unduplicated number of individuals who are Medicaid eligible in the population during the same year.

Attachment C - CFR Definitions

0320 – On site Rehabilitation (Non Licensed Program)
The objective is to assist individuals disabled by mental illness who live in adult congregate care settings, supervised or supported living arrangements to achieve their treatment and community living rehabilitation goals. Services include one or a combination of: (1) consumer self help and support interventions: (2) community living; (3) academic and/or social leisure time rehabilitation training and support services. These services are typically provided either at the residential location of the resident or in the natural or provider operated community settings which are integral to the life of the residents. These on site rehabilitation services are provided by a team that is either located at the residential site or which functions as a mobile rehabilitation team traveling from site to site.

> **Units of Service**:
> Brief Day Visit: less than 3 hours.
> Half day visit: 3 but less than 5 hours.
> Full day visit: 5 hours or more.
> Total Units of Service: Add weighted visits by category to calculate a total.

0340 - Sheltered Workshop/Satellite Sheltered Workshop (Non Licensed Program)
The objective is to provide vocational assessment, training, and paid work in a protective and non integrated work environment for individuals disabled by mental illness. Services are provided according to wage and hour requirements specified in the Fair Labor Standards Act administered by the Department of Labor.

> **Units of Service**:
> Brief day visit: Less than 3 hours
> Half day visit: 3 but less than 5 hours
> Full day visit: 5 hours or more
> Total Units of Service: Add weighted visits by category to calculate a total.

0380 - Transitional Employment Placement (TEP) (Non Licensed Program)
The objective is to strengthen the individual's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. TEP's provide time limited employment and on the job training in one or more integrated employment settings as an integral part of the individual's vocational rehabilitation growth.

> **Direct staff hours**: The number of staff hours spent by staff in providing case management services face to face or by telephone directly to Consumers or collaterals.
> **Indirect staff hours**: The number of staff hours spent by staff in providing case management services on behalf of Consumers other than face to face or by telephone directly with Consumers or collaterals.
> **Units of Service**: Count the total number of staff hours (combine direct and indirect).

0670 – Transportation (Non Licensed Program)
The provision of transportation to and from facilities or resources specified in the Consumer's individual treatment plan as a necessary part of his/her service for mental disability. This includes all necessary supportive services for full and effective integration of the Consumer into community life. A Consumer trip is the one way transportation of a Consumer from one place to another. For example, transportation of one Consumer from home to the facility and back is counted as two trips; transportation of two Consumers to and from is counted as four trips.

Units of Service: Count the number of trips.

0690 – Outreach (Non Licensed Program)
Outreach programs/services are intended to engage and/or assess individuals potentially in need of mental health services. Outreach programs/services are not crisis services. Examples of applicable services are socialization, recreation, light meals, and provision of information about mental health and social services. Another type of service within this program code includes off site, community based assessment and screening services. These services can be provided at forensic sites, a consumer's home, other residential settings, including homeless shelters, and the streets. This program code should **not** be used for services that are provided by a licensed outpatient program. For unlicensed crisis type services use program code 2680 Crisis Intervention.

Units of Service: Total the number of contacts.

0770 - Psychosocial Club (Non Licensed Program)
The objective is to assist individuals disabled by mental illness to develop or reestablish a sense of self esteem and group affiliation, and to promote their recovery from mental illness and their reintegration into a meaningful role in community life through the provision of two or more of the following: (1) consumer self help and empowerment interventions; (2) community living: (3) academic; (4) vocational and/or (5) social leisure time rehabilitation, training and support services.

Units of Service: Count each Consumer visit as one unit (no more than one unit of service per Consumer per day unless the Consumer returns for a planned evening program in which case count as two (2) units).

0800 - Assertive Community Treatment (ACT) Program (Licensed Program)
ACT Teams provide mobile intensive treatment and support to people with psychiatric disabilities. The focus is on the improvement of an individual's quality of life in the community and reducing the need for inpatient care, by providing intense community based treatment services by an interdisciplinary team of mental health professionals. Building on the successful components of the Intensive Case Management (ICM) program, the ACT program has low staff outpatient ratios; 24 hour a day, seven day per week availability; enrollment of consumers, and flexible service dollars. Treatment is focused on individuals who have been unsuccessful in traditional forms of treatment.

Units of Service: Intensive Program Full Payment: Six or more face to face contacts per individual per month (may include 3 collateral visits) count as one unit.
Intensive Program - Partial Payment: Between 2 and 5 face to face contacts per individual per month count as one unit. **Supportive Program**: 2 or more face to face contacts per individual per month count as one unit.
Total Units of Service: Total the number of contacts.

0810 - Case Management (Non Licensed Program)
Activities aimed at linking the Consumer to the service system and at coordinating the various services in order to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case specific advocacy. Linking: The process of referring or transferring a Consumer to all required internal and external services that include the identification and acquisition of appropriate service resources. Monitoring: Observation to assure the continuity of service in accordance with the consumer's treatment plan. Case Specific Advocacy: Interceding on behalf of a Consumer to assure access to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by a therapist. Case management services are provided to enrolled Consumers for whom staff are assigned a continuing case management responsibility. Thus, routine referral would not be included unless the staff member making the referral retains a continuing active responsibility for the Consumer throughout the system of service.

Direct staff hours: The number of staff hours spent by staff in providing case management services face to face or by telephone directly to Consumers or collaterals.
Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of Consumers other than face to face or by telephone directly with Consumers or collaterals.
Units of Service: Count the total number of staff hours (combine direct and indirect).
Note: Use Program Code 2100 (Clinic Treatment) if the Case Management services are affiliated with a licensed Clinic Treatment program. Please refer to Codes 1810, 6810 and 0820 for more Case Management service codes for applicability.

0820 – Blended Case Management (Non Licensed Program)
This program will facilitate a team approach to case management services by combining the caseloads of multiple Intensive Case Managers (ICMs) and/or Supportive Case Managers (SCMs).

Units of Service: Two face to face contacts per individual, per month (may include 1 collateral visit for children per month) counted as one unit. Count the total number of contacts.

0910 – Crisis Residence (Licensed Program)
A licensed residential (24 hours/day) stabilization program, which provides services for acute symptom reduction and the restoration of patients to pre crisis level of functioning. These programs are time limited for persons until they achieve stabilization (generally up to 30 days). Crisis residences serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting.
This program is licensed for adults as defined in 14NYCRR589 and for children and adolescents as defined in 14NYCRR594.

Units of Service: One resident day.

1310 - Continuing Day Treatment (Licensed Program)
A continuing day treatment program shall provide active treatment and rehabilitation designed to maintain or enhance current levels of functioning and skills, to maintain community living and to develop self awareness and self esteem through the exploration and development of patient strengths and interests. A continuing day treatment program shall provide the following services: assessment and treatment planning, discharge planning, medication therapy, medication education, case management, health screening and referral, psychiatric rehabilitation readiness development, psychiatric rehabilitation readiness determination and referral and symptom management. The following additional services may also be provided: supportive skills training, activity therapy, verbal therapy, crisis intervention services and clinical support services.

> **Units of Service**:
> Regular: shall be at least one hour and up to five hours
> Collateral: shall be at least 30 minutes but not more than 120 minutes.
> Group Collateral: shall be at least one hour and up to two hours.
> Count the total number of service hours.

1340 - Enclave in Industry (Non Licensed Program)
The objective is to provide vocational assessment, training, and transitional or long term paid work for individuals with severe disabilities in an integrated employment environment. An enclave consists of a small group of approximately five to eight individuals who work in an industrial or other economic enterprise either as individuals or as a crew. Individuals in enclaves are provided with training, supervision and ongoing support by a job coach/supervisor assigned to the work site by the rehabilitation service agency.

> **Direct staff hours:** The number of staff hours spent by staff in providing case management services face to face or by telephone directly to Consumers or collaterals.
> **Indirect staff hours:** The number of staff hours spent by staff in providing case management services on behalf of Consumers other than face to face or by telephone directly with Consumers or collaterals.
> **Units of Service:** Count the total number of staff hours (combine direct and indirect).

1380 - Assisted Competitive Employment (Non Licensed Program)
The objective is to assist individuals in choosing, finding, and maintaining satisfying jobs in the competitive employment market at minimum wage or higher. When appropriate, ACE provides these individuals with job related skills training as well as long term supervision and support services, both at the work site and offsite.

> **Direct staff hours**: The number of staff hours spent by staff in providing case management services face to face or by telephone directly to Consumers or collaterals.
> **Indirect staff hours**: The number of staff hours spent by staff in providing case management services on behalf of Consumers other than face to face or by telephone directly with Consumers or collaterals.
> **Units of Service**: Count the total number of staff hours (combine direct and indirect).

1400 Single Point Of Access (SPOA) (Non Licensed Program)
A SPOA is a process, *led by a SPOA Coordinator*, that helps Local Governmental Units achieve community based mental health systems that are cohesive and well coordinated in order to serve those individuals most in need of services. There are three types of SPOAs: Children's, Adult Case Management and Adult Housing. The SPOA process provides for the identification of individuals most in need of services, and manages service access and utilization.
This program code should not be used for services that are provided by a licensed outpatient program.

Units of Service: Not applicable.

1410 - Geriatric Demo Gatekeeper (Non Licensed Program
The Gatekeeper Program is designed to proactively identify at risk older adults in the community who are not connected to the service delivery system. Gatekeepers are non traditional referral sources who come into contact with older adults through their everyday work activities. They are specifically trained to look for signs and symptoms that may indicate the older adult is in need of assistance. The program increases public awareness of the needs of the older adults before a crisis occurs. Upon identification of an older adult in need, a trained Gatekeeper makes a phone call to trained staff which initiates the individual's assessment and a variety of in home supportive services. The program is designed to keep at risk seniors in their own homes, and prevent premature out of home placement. This program code should not be used for services provided by a licensed outpatient program, or for services provided by another active OMH funded program.

Units of Service: Count the total number of contacts.

1680 – CPEP Crisis Outreach (Non Licensed Program - Associated with a Licensed CPEP Program)
A mobile crisis intervention component of the CPEP offering crisis outreach and interim crisis service visits to individuals outside an emergency room setting, in the community in natural (e.g. homes), structured (e.g., residential programs), or controlled (e.g., instructional) environments. Crisis outreach service visits are emergency mental health services provided outside an emergency room which include clinical assessment and crisis intervention treatment. Interim crisis service visits are mental health services provided to individuals who are released from a CPEP for the purpose of facilitating the individual's community tenure while waiting for the first post CPEP visit with a community based mental health provider.

CPEP crisis outreach and interim crisis service visits are Medicaid reimbursable. This program is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: CPEP Crisis Intervention (3130), CPEP Extended Observation Beds (1920) and CPEP Crisis Beds (2600).

Units of Service:
Crisis Outreach Visit
Interim Crisis Visit.
Count the total number of visits.

1760 – Advocacy/Support Services (Non Licensed Program)
Advocacy/support services may be individual advocacy or systems advocacy (or a combination of both. Examples are warm lines, hot lines, teaching daily living skills, providing representative payee services, and training in any aspect of mental health services. Individual advocacy assists consumers in protecting and promoting their rights, resolving complaints and grievances, and accessing services and supports of their choice. Systems advocacy represent the concerns of a class of consumers by identifying patterns of problems and complaints and working with program or system administrators to resolve or eliminate these problems on a systemic, rather than individual basis.

Units of Service: Count the total number of contacts.

1770 – Drop In Center (Non Licensed Program)
The objective of a Drop In Center program is to identify and engage persons who may choose not to participate in more structured programs or who might not otherwise avail themselves of mental health services, and to provide services and supports in a manner which these individuals would accept. These programs are low demand, flexible and relatively unstructured, and responsive to individual need and circumstance.

Units of Service: Count the total number of units. Count each Consumer visit as one unit (no more than one unit of service per Consumer, per day, unless the Consumer returns for a planned evening program, in which case, count as two (2) units).

1810 - Intensive Case Management (Non Licensed Program)
In addition to the program description for Case Management (Code 0810), ICM services are services which are operated under a fidelity structure defined in 18 NYCRR, Section 505 and a memorandum of understanding between OMH and the NYS Department of Health. Federal Individuals with Disabilities Education Act Funds

Units of Service: Four or more face to face contacts per individual per month (may include 1 collateral visit for children per month) count as one unit. *Note:* If the service provider chooses the "Flexible ICM Model" as defined in Section 8 of the New Initiative Guidelines, a minimum of two (2) face to face contacts per individual, per month count as one unit.

Count the number of total units.

1920 – CPEP Extended Observation Beds (Non Licensed Program - Associated with a Licensed CPEP Program)
Beds operated by the Comprehensive Psychiatric Emergency Program which are usually located in or adjacent to the CPEP emergency room, are available 24 hours per day, seven days per week to provide extended assessment and evaluation as well as a safe and comfortable environment for up to 72 hours for persons, who in the opinion of the examining physicians, require extensive evaluation, assessment, or stabilization of their acute psychiatric symptoms. Extended observation bed services are reimbursed at the inpatient psychiatric rate of the hospital where the CPEP is located. This program is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: CPEP Crisis Intervention (3130), CPEP Crisis Outreach (1680) and CPEP Crisis Beds (2600).

Units of Service: One (psychiatric) inpatient day.

1970 – Transition Management (TM) Services (Non Licensed Program)
Transition Management Services (discharge planning) programs provide support for improved community service linkages and timely filing of Medicaid applications for seriously and persistently mentally ill (SPMI) consumers being released from local correctional facilities. The TM focus will be in obtaining post release services for these consumers. TM can only be used with funding source code 170B.

Units of Service: The number of staff hours.

1990 – Bridger Services (Non Licensed Program)
Health service to a less restrictive mental health service. The services provide supports to link consumers to appropriate community services and to ease their transition from, inpatient care.

Units of Service: The number of staff hours.

2070 - Transient Housing (THP, Some PHP and some S+C) (Non Licensed Program)
Housing and Urban Development (HUD) funds: Several federally funded programs contribute housing assistance specifically targeted to the homeless mentally ill. When funds do not flow through OMH, but are sent directly to the provider, the funds are reported under this program code and funding code 090 (non funded) on the DMH-3. Federal Programs which fall into this category are Transitional Housing Program (THP), Supported Housing Demonstration Program (SHDP), and some Shelter Plus Care grants. Funds may be used for: the acquisition and/or rehabilitation of a program site; operating expenses; support services; and administrative expenses. These funds flow directly to the not for profit provider agencies from the federal agency; organizations in receipt of these funds report the funds in a separate program column with the program code indexed if necessary. These grants are made for five years at a time.

Units of Service: Not applicable.

2320 - Intensive Psychiatric Rehabilitation Treatment (IPRT) (Licensed Program)
An intensive psychiatric rehabilitation treatment program is time limited, with active psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies, to overcome functional disabilities and to improve environmental supports. An intensive psychiatric rehabilitation treatment program shall provide the following services: psychiatric rehabilitation readiness determination, psychiatric rehabilitation goal setting, psychiatric rehabilitation functional and resource assessment, psychiatric rehabilitation service planning, psychiatric rehabilitation skills and resource development and discharge planning.

Units of Service: Total service hours.

2340 - Affirmative Business/Industry (Non Licensed Program)
The objective is to provide vocational assessment, training, transitional or long term paid employment, and support services for persons disabled by mental illness in a less restrictive/more integrated employment setting than sheltered workshops. Affirmative programs may include mobile contract services, small retail or wholesale outlets, and manufacturing and service oriented businesses.

Units of Service: Count the total number of Consumer hours.

2600 – CPEP Crisis Beds (Non Licensed Program)
A residential (24 hour/day) stabilization component of the CPEP, which provides supportive services for acute symptom reduction and the restoration of patients to pre crisis level of functioning. These programs are time limited (up to five days) for patients until they achieve stabilization. Crisis beds serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting. CPEP crisis bed services are *neither* funded by OMH *nor* Medicaid reimbursable, but are purchased from the facility operating these beds. This program is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: CPEP Crisis Intervention (3130), CPEP Crisis Outreach (1680) and CPEP Extended Observation Beds (1920).

Units of Service: One resident day.

2680 Crisis Intervention (Non Licensed Program)
Crisis intervention services, applicable to adults, children and adolescents, are intended to reduce acute symptoms and restore individuals to pre crisis levels of functioning. Examples of where these services may be provided include emergency rooms and residential settings. Provision of services may also be provided by a mobile treatment team, generally at a consumer's residence or other natural setting (not at an inpatient or outpatient treatment setting). Examples of services are screening, assessment, stabilization, triage, and/or referral to an appropriate program or programs. This program type does not include warm lines or hot lines. Use Advocacy/Support 1760 for such services. This program code should not be used for services that are provided by a licensed outpatient program.

Units of Service: Count the total staff hours.

2770 - Self Help Program (Non Licensed Program)
To provide rehabilitative and support activities based on the principle that people who share a common condition or experience can be of substantial assistance to each other. These programs may take the form of mutual support groups and networks, or they may be more formal self help organizations that offer specific educational, recreational, social or other program opportunities.

Direct staff hours: The number of staff hours spent by staff in providing case management services face to face or by telephone directly to Consumers or collaterals.
Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of Consumers other than face to face or by telephone directly with Consumers or collaterals.
Units of Service: Count the number total number of staff hours (combine direct and indirect)

2810 – Intensive Case Management (ICM) Services Dollars Management (Part of the Intensive Case Management Program)
Direct costs of support provided by the county or agency for contracted management expenses.

Units of Service: Not applicable.

2820 – Consumer Service Dollars (Non ICM/SCM/BCM/ACT) (Non Licensed Program)
Consumer Service Dollars (also known as "wrap around" dollars) may be used for any service(s) that address a consumer's basic needs and assist the consumer in living, working and/or socializing in a community environment. Authorizations and the detail of use for Consumer Service Dollars must be kept and available for field audit. Providers must have internal controls in place to limit the use of these funds. Examples of eligible expenses include: food, security deposits, lodging, respite, clothing, payment of a utility bill to prevent shut off, medical care, transportation, crisis specialist, educational services, vocational services, leisure time activities, homemakers and escorts. A fuller description of the uses and requirements for these funds is located in the annual "Contracting and Policy Guidelines." This definition does not apply to ICM, SCM or ACT teams.

Units of Service: Each authorization to use these funds.

2830 - Intensive Case Management/Supportive Case Management/Blended Case Management Emergency and Non Emergency Service Dollars (Non Licensed Program)
Services consistent with a consumers treatment plan, designed to be flexible and responsible to current individual needs. These services may include emergency services, both immediate and not immediate. The emergency dollars aimed at meeting immediate basic needs of the consumer to include transportation, medical/dental care, shelter/respite/hotel, food/meals, clothing, escort and other. Service dollars may also include furnishings, utilities, tuition, job related costs, job coaching, education, vocational services, leisure time services and others. This program does not include agency administration. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

3130 – CPEP Crisis Intervention (Licensed Program)
This licensed, hospital based psychiatric emergency program establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Brief and full emergency visit services are Medicaid reimbursable.
CPEP Crisis Intervention is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP), and the code to which the license is issued. The other program components of the CPEP are: CPEP Extended Observation Beds (1920), CPEP Crisis Outreach (1680) and CPEP Crisis Beds (2600).

Units of Service:
Brief Emergency Visit
Full Emergency Visit
Count the total number of visits.

3340 - Work Program (Non Licensed Program)
The objective is to provide vocational assessment, training and transitional or long term paid work in institutional or community job sites for individuals disabled by mental illness. Paid by the vocational services provider.

Units of Service: Count the total number of staff hours.

3990 - Multicultural Initiatives (Non Licensed Program)
Funds will support activities related to the development and operation of outreach interventions in underserved communities and to address disparities based upon culture, ethnicity, age, or gender. Efforts by service providers will include the cultural and linguistic competence of their programs, management and staff.

Units of Service*:* Count the total number of staff hours.

4340 - Ongoing Integrated Supported Employment Services (Non Licensed Program)
These funds are intended for ongoing job maintenance services including job coaching, employer consultation, and other relevant supports needed to assist an individual in maintaining a job placement. These services are intended to complement VESID time limited supported employment services.

Units of Service: Count the total number of staff hours.

6340 - Comprehensive PROS with Clinic (Licensed Program)
Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. There are four service components" in the program: Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and Clinical Treatment.

Units of Service: Count the number of direct care hours.

6810 - Supportive Case Management (SCM) (Non Licensed Program)
In addition to the program description for Case Management (Code 0810), SCM services are services which are operated under a fidelity structure defined in 18 NYCRR, Section 505 and a memorandum of understanding between OMH and the NYS Department of Health.

Units of Service: Count two or more face to face contacts per month as one unit. Report total contacts.

7340 - Comprehensive PROS without Clinic (Licensed Program)
Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. There are four "service components" in the program: Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and Clinical Treatment. This program does not include the optional Clinic Treatment component.

Units of Service: Direct Care Hours.

8810 – Assertive Community Treatment (ACT) Program Service Dollars (Associated with the licensed Assertive Community Treatment (ACT) program, Program Code 0800)
Individual services aimed at meeting basic needs of the consumer. These services may include emergency services as well as job coaching, education, leisure time services and others. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

Attachment D – Total CFR Expenditures by Service and Category

Program Code	Adult, Child or Both	Program Name	Program Category Description	Program Subcategory Description	Statewide Total CFR Spending
1680	Both	CPEP Crisis Outreach	Emergency	CPEP	$10,201,116
1920	Both	CPEP Extended Observation	Emergency	CPEP	$12,524,539
2600	Both	CPEP Crisis Beds	Emergency	CPEP	$826
3130	Both	CPEP Crisis Intervention	Emergency	CPEP	$38,748,528
Total Emergency-Comprehensive Psychiatric Emergency Program					**$61,475,009**
130	Both	Emergency Unit Clinic Treatment	Emergency	Crisis	$5,916,381
680	Both	Mobile Treatment Team/Crisis Outreach	Emergency	Crisis	$1,750,662
910	Both	Crisis Residence	Emergency	Crisis	$1,517,782
1600	Both	Crisis/Respite Beds	Emergency	Crisis	$327,261
2680	Both	Crisis Intervention	Emergency	Crisis	$26,999,921
Total Emergency - Crisis					**$36,512,007**
1310	Adult	Continuing Day Treatment	Outpatient	Continuing Day Treatment	$153,817,556
2320	Adult	Intensive Psychiatric Rehabilitation Treatment	Outpatient	Intensive Psychiatric Rehabilitation	$13,813,675
2200	Both	Partial Hospitalization	Outpatient	Partial Hospitalization	$16,399,301
6340	Both	Comprehensive PROS with Clinical Treatment	Outpatient	Personalized Recovery-Oriented Services	$1,708,895
7340	Both	Comprehensive PROS without Clinical Treatment	Outpatient	Personalized Recovery-Oriented Services	$31,131
Total Day Rehabilitation					**$185,770,558**
800	Adult	ACT	Outpatient	Assertive Community Treatment	$44,214,358
8810	Adult	Assertive Community Treatment-Service Dollars	Outpatient	Assertive Community Treatment	$1,357,747
Total ACT					**$45,572,105**
1410	Adult	Geriatric Demo Gatekeeper	Support	Care Coordination	
5990	Adult	MICA Network	Support	Care Coordination	$4,345,610
810	Both	Case Management	Support	Care Coordination	$26,130,862

Program Code	Adult, Child or Both	Program Name	Program Category Description	Program Subcategory Description	Statewide Total CFR Spending
820	Both	Blended Case Management	Support	Care Coordination	$49,280,234
1810	Both	Intensive Case Management	Support	Care Coordination	$27,557,840
1970	Both	Transition Management Services	Support	Care Coordination	$1,998,942
1990	Both	Bridger Services	Support	Care Coordination	$3,613,604
2810	Both	Intensive Case Management, Services Dollars	Support	Care Coordination	$1,815,885
2830	Both	ICM/SCM/BCM Emergency and Non-Emergency	Support	Care Coordination	$7,877,447
6810	Both	Supportive Case Management (SCM)	Support	Care Coordination	$30,219,266
7810	Both	Supportive Case Management (SCM) Service	Support	CM Service Dollars	$6,273
4810	Both	Intensive Case Management (ICM), Non-Emerge	Support	Service Dollars	$12,546
Total Support – Care Coordination					**$152,858,509**
320	Adult	On-Site Rehabilitation	Support	General Support	$16,767,638
510	Both	Pre-Admission Screening	Support	General Support	$128,107
610	Both	Recreation	Support	General Support	$3,052,531
650	Both	Respite Services	Support	General Support	$3,398,915
670	Both	Transportation	Support	General Support	$10,418,627
690	Both	Outreach	Support	General Support	$29,293,678
2820	Both	Consumer Service Dollars (Non ICM/SCM/ACT)	Support	General Support	$3,237,473
3990	Both	Multi-Cultural Initiative	Support	General Support	$1,688,654
Total Support – General Support					**$67,985,623**
660	Both	Alternative Crisis Support	Support	Self-Help	$31,664
770	Both	Psychosocial Club	Support	Self-Help	$38,694,484
1760	Both	Advocacy/Support Services	Support	Self-Help	$53,975,735

Program Code	Adult, Child or Both	Program Name	Program Category Description	Program Subcategory Description	Statewide Total CFR Spending
1770	Both	Drop In Centers	Support	Self-Help	$5,519,923
2760	Both	Peer Advocacy	Support	Self-Help	$30,139
2770	Both	Self-Help Programs	Support	Self-Help	$2,699,047
Total Support – Self-Help					**$100,950,992**
340	Adult	Sheltered Workshop/Satellite Sheltered Workshop	Support	Vocational	$31,309,981
380	Adult	Transitional Employment	Support	Vocational	$3,490,820
1340	Adult	Enclave in Industry	Support	Vocational	$1,323,500
1380	Adult	Assisted Competitive Employment	Support	Vocational	$13,417,316
2340	Adult	Affirmative Business/Industry	Support	Vocational	$9,290,698
4340	Adult	Ongoing Integrated Supported Employment Service	Support	Vocational	$9,596,231
3340	Both	Work Program	Support	Vocational	$3,503,026
Total Support - Vocational					**$71,931,572**
5340	Both	Supported Education	Support	Education	$1,115,492
Total Support - Other					**$1,115,492**
Total Ambulatory Non-Clinic					**$724,171,867**

Programs Excluded from the Analysis: Non-Ambulatory or Child Specific

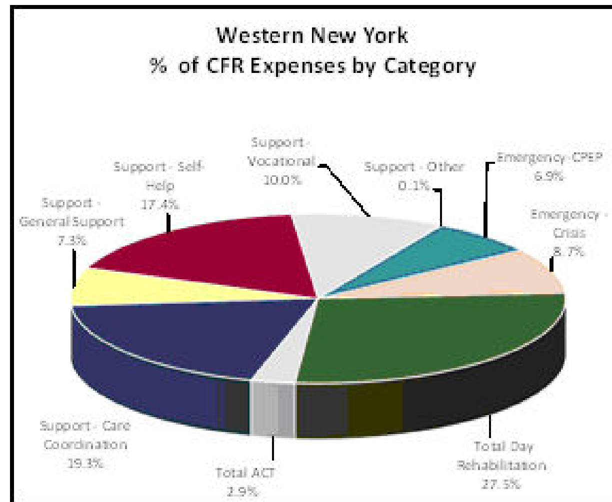
Code Not Included	Adult, Child or Both	Program Name	Program Category Description	Program Subcategory Description	Statewide Total Spending
0040	Adult	Family Care	Residential	Support Program	$748,069
1070	Adult	Permanent Housing (PHP)	Residential	Other Housing	$657,740
2070	Adult	Transient Housing - THP, some PHP and some S+C	Residential	Other Housing	$5,384,371
2780	Adult	Compulsive Gambling Treatment	Support	General Support	$152,560
2790	Adult	Compulsive Gambling Education, Assessment & Referral	Support	Education	$62,749
3070	Adult	Shelter Plus Care Housing	Residential	Other Housing	$3,584,687
5070	Adult	Supported/Single Room Occupancy (SRO)	Residential	Unlicensed Housing	$25,760,346

Code Not Included	Adult, Child or Both	Program Name	Program Category Description	Program Subcategory Description	Statewide Total Spending
6050	Adult	Supported Housing Rental Assistance	Residential	Unlicensed Housing	$64,277,945
6060	Adult	Supported Housing Community Services	Residential	Unlicensed Housing	$61,619,763
6070	Adult	Congregate/Treatment	Residential	Treatment Program	$171,510,937
6080	Adult	Congregate/Support	Residential	Support Program	$1,962,020
7070	Adult	Apartment/Treatment	Residential	Treatment Program	$103,422,025
7080	Adult	Apartment/Support	Residential	Support Program	$461,251
8050	Adult	SRO Community Residence	Residential	Support Program	$39,795,780
0010	Both	Inpatient Psychiatric Unit	Inpatient	Inpatient MH Facility	$17,052,352
1400	Both	Single Point of Access (SPOA)	Support	Care Coordination	$9,556,857
1690	Both	FEMA Crisis Counseling Assistance and Training	Emergency	Crisis	$756,316
2100	Both	Clinic Treatment	Outpatient	Clinic Treatment	$651,040,131
3010	Both	Inpatient Psychiatric Unit of a General Hospital	Inpatient	Gen Hosp Psych IP Unit	$301,396,419
Subtotal					**$1,459,202,318**
0200	Child	Day Treatment	Outpatient	Day Treatment	$32,021,390
0790	Child	Clinic Plus Outreach and Screening	Support	General Support	$199,817
1080	Child	Residential Treatment Facility - Children & Youth	Inpatient	Resid Treatment Fac.	$82,384,534
1320	Child	Vocational Services - Children & Family (C & F)	Support	Vocational	$3,538,330
1510	Child	School Program Co-located with Clinic Treatment Program	Support	Education	$2,111,619
1520	Child	School Program without Clinic	Support	Education	$7,342,549
1650	Child	Family Support Services - Children & Family	Support	General Support	$16,597,308

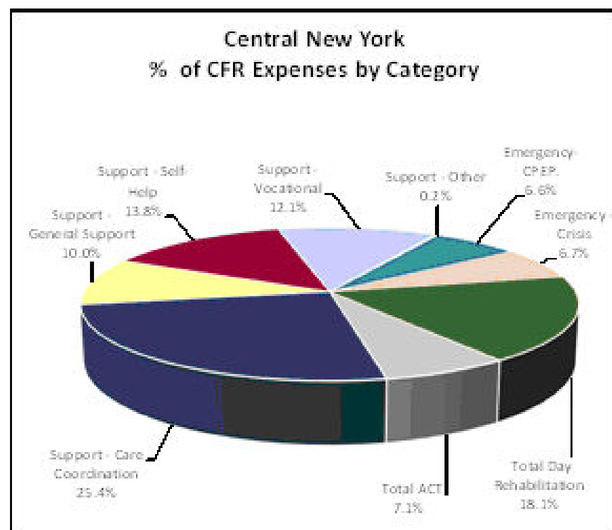
Code Not Included	Adult, Child or Both	Program Name	Program Category Description	Program Subcategory Description	Statewide Total Spending
2040	Child	Family Based Treatment	Residential	Treatment Program	$14,871,726
2230	Child	HCBS Waiver Individualized Care Coordination	Support	Care Coordination	$15,423,969
2240	Child	HCBS Waiver Respite Care	Support	Care Coordination	$1,096,136
2250	Child	HCBS Waiver Family Support	Support	Care Coordination	$346,185
2260	Child	HCBS Waiver Crisis Response	Support	Care Coordination	$35,536
2270	Child	HCBS Waiver Skill Building	Support	Care Coordination	$962,259
2280	Child	HCBS Waiver Intensive Home Care	Support	Care Coordination	$380,160
2880	Child	Residential Treatment Facility Transition Coordinator – C X	Support	Care Coordination	$926,026
2990	Child	Coordinated Children's Service Initiative	Support	Care Coordination	$7,018,219
3040	Child	Home Based Crisis Intervention	Emergency	Crisis	$6,662,990
4040	Child	Teaching Family Home	Residential	Treatment Program	$2,399,293
7050	Child	Children & Youth Community Residence	Residential	Treatment Program	$17,875,554
0860	NA	Local Governmental Unit (LGU) Admin. OMH Reinvest	Administration	LGU Funding	$4,595,091
0870	NA	Monitoring and Evaluation, CSS	Administration	LGU Funding	$4,096,128
0880	NA	Subcontract Services	Administration	LGU Funding	$2,220,121
0890	NA	Local Governmental Unit (LGU) Administration	Administration	LGU Funding	$13,617,804
0990	NA	Special Demo/Other	Support	General Support	$477,876
1190	NA	Special Legislative Grant	Administration	LGU Funding	$4,197,385
Subtotal					**$241,398,005**

Attachment E - CFR Expenditures by Regions

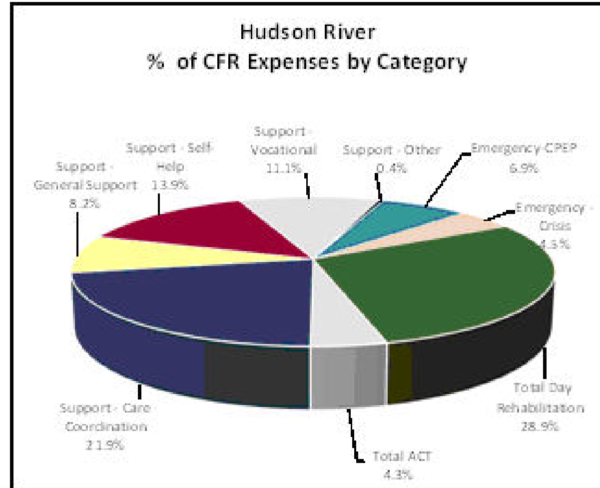
CFR Expenses by Region: Western		
Emergency-Comp. Psych. Emergency Program	$9,255,820	6.9%
Emergency - Crisis	$11,625,999	8.7%
Total Emergency	**$20,881,819**	**15.7%**
Total Day Rehabilitation	**$36,640,324**	**27.5%**
Total ACT	**$3,819,365**	**2.9%**
Support - Care Coordination	$25,706,091	19.3%
Support - General Support	$9,717,581	7.3%
Support - Self-Help	$23,143,863	17.4%
Support - Vocational	$13,319,892	10.0%
Support -Other	$77,167	0.1%
Total Support	**$71,964,594**	**54.0%**
Total Expenses	**$133,306,102**	**100.0%**



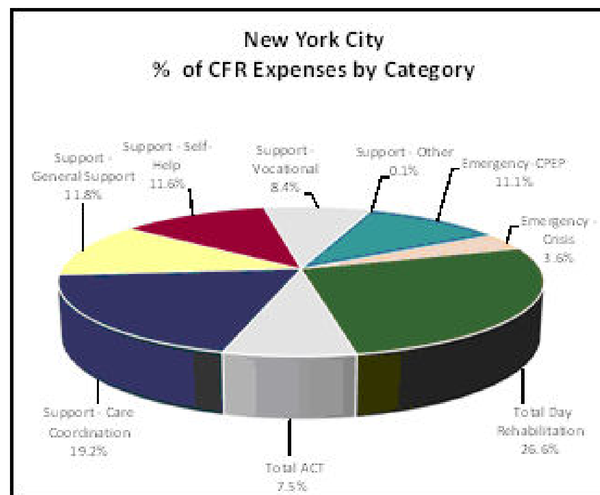
CFR Expenses by Region: Central		
Emergency-Comp. Psych. Emergency Program	$7,550,097	6.6%
Emergency - Crisis	$7,656,855	6.7%
Total Emergency	**$15,206,952**	**13.3%**
Total Day Rehabilitation	**$20,603,492**	**18.1%**
Total ACT	**$8,145,559**	**7.1%**
Support - Care Coordination	$28,997,106	25.4%
Support - General Support	$11,409,042	10.0%
Support - Self-Help	$15,696,034	13.8%
Support - Vocational	$13,754,308	12.1%
Support -Other	$212,753	0.2%
Total Support	**$70,069,243**	**61.5%**
Total Expenses	***$114,025,246***	***100.0%***



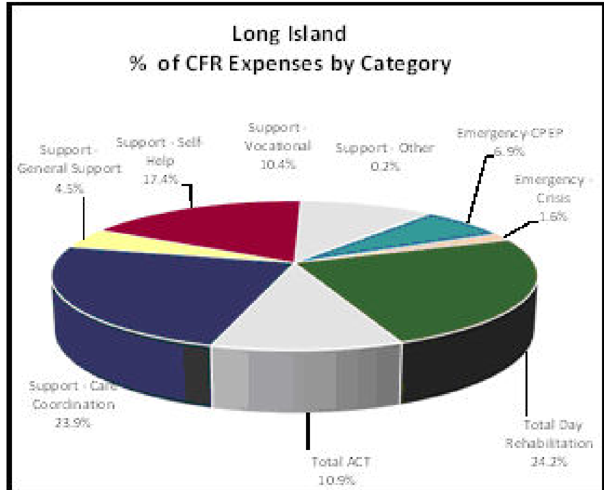
CFR Expenses by Region: Hudson River		
Emergency-Comp. Psych. Emergency Program	$9,291,126	6.9%
Emergency - Crisis	$6,027,467	4.5%
Total Emergency	**$15,318,593**	**11.4%**
Total Day Rehabilitation	**$38,950,709**	**28.9%**
Total ACT	**$5,841,521**	**4.3%**
Support - Care Coordination	$29,510,721	21.9%
Support -General Support	$11,012,315	8.2%
Support - Self-Help	$18,779,912	13.9%
Support-Vocational	$14,901,425	11.1%
Support - Other	$479,061	0.4%
Total Support	$74,683,434	55.4%
Total Expenses	***$134,794,257***	***100.0%***



CFR Expenses by Region: New York City		
Emergency-Comp. Psych. Emergency Program	$31,125,392	11.1%
Emergency - Crisis	$10,208,293	3.6%
Total Emergency	**$41,333,685**	**14.7%**
Total Day Rehabilitation	**$74,709,894**	**26.6%**
Total ACT	**$21,101,152**	**7.5%**
Support - Care Coordination	$54,027,576	19.2%
Support - General Support	$33,106,275	11.8%
Support - Self-Help	$32,626,503	11.6%
Support-Vocational	$23,556,109	8.4%
Support -Other	$215,974	0.1%
Total Support	**$143,532,437**	**51.1%**
Total Expenses	***$280,677,168***	***100.0%***



CFR Expenses by Region: Long Island		
Emergency-Comp. Psych. Emergency Program	$4,252,574	6.9%
Emergency - Crisis	$993,393	1.6%
Total Emergency	**$5,245,967**	**8.5%**
Total Day Rehabilitation	**$14,866,139**	**24.2%**
Total ACT	**$6,664,508**	**10.9%**
Support - Care Coordination	$14,666,809	23.9%
Support -General Support	$2,740,410	4.5%
Support - Self-Help	$10,704,680	17.4%
Suport-Vocational	$6,399,838	10.4%
Support -Other	$130,537	0.2%
Total Support	**$34,642,274**	**56.4%**
Total Expenses	***$61,418,888***	***100.0%***



Attachment F - Regional Variation: CFR Spending and Medicaid Utilization by Service

Data collected for this study reveal that the patterns of access to and utilization of mental health care are widely divergent throughout the State. Variation is shown most clearly through a review of penetration, per capita and per recipient expenditures and claims. We collected this information from the CFR and from Medicaid claims data.

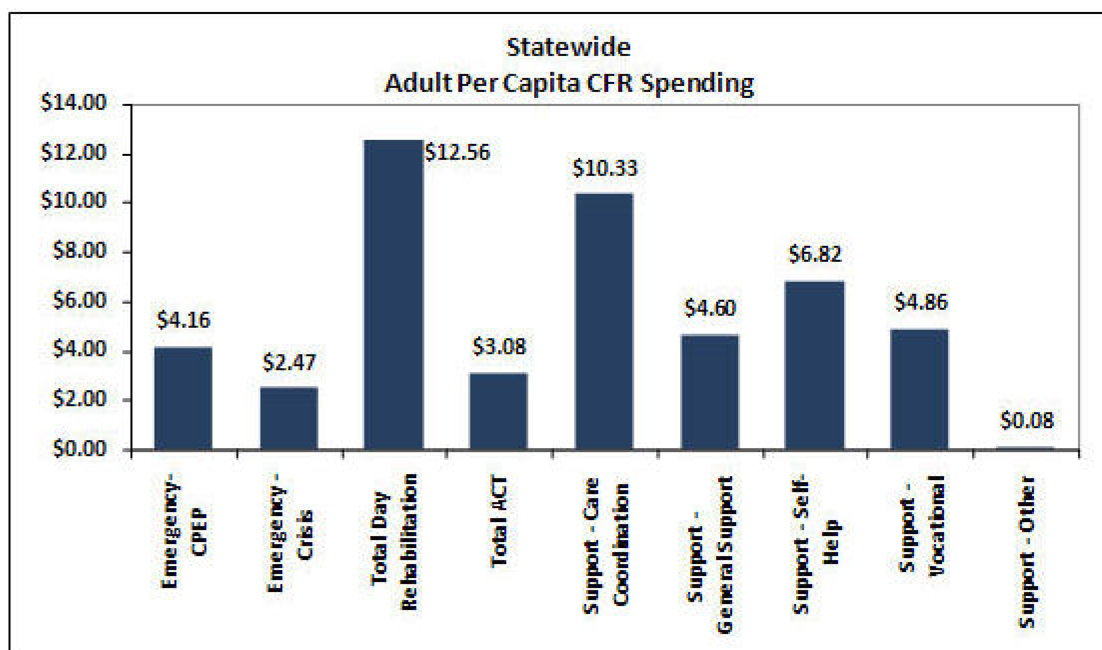
Proportion of Expenditures Devoted to each Type of Service

We reviewed the proportion of CFR expenditures devoted to each type of service by region (see Attachment D). While there were differences between regions, the variation was not extreme. For example, expenditures on care coordination as a proportion of expenditures on all services ranged from 19.2 percent in New York City to 25.4 percent in Central New York. Day Rehabilitation services showed slightly higher variation, accounting for 18.1 percent of expenditures in Central New York and 28.9 percent in Hudson River.

Per Capita Spending

More interesting information is found by looking at CFR spending on a per capita basis (total CFR spending[59] divided by the adult population as shown in the 2006 U.S. Census). Statewide adult per capita CFR spending data are presented in Figure F-1, below.

Figure F-1 Statewide Adult Per Capita CFR Spending



In order to better understand provider capacity and the supply of services in each region, we also analyzed regional per capita spending levels based on provider location and service type (see Figure F-2).[60]

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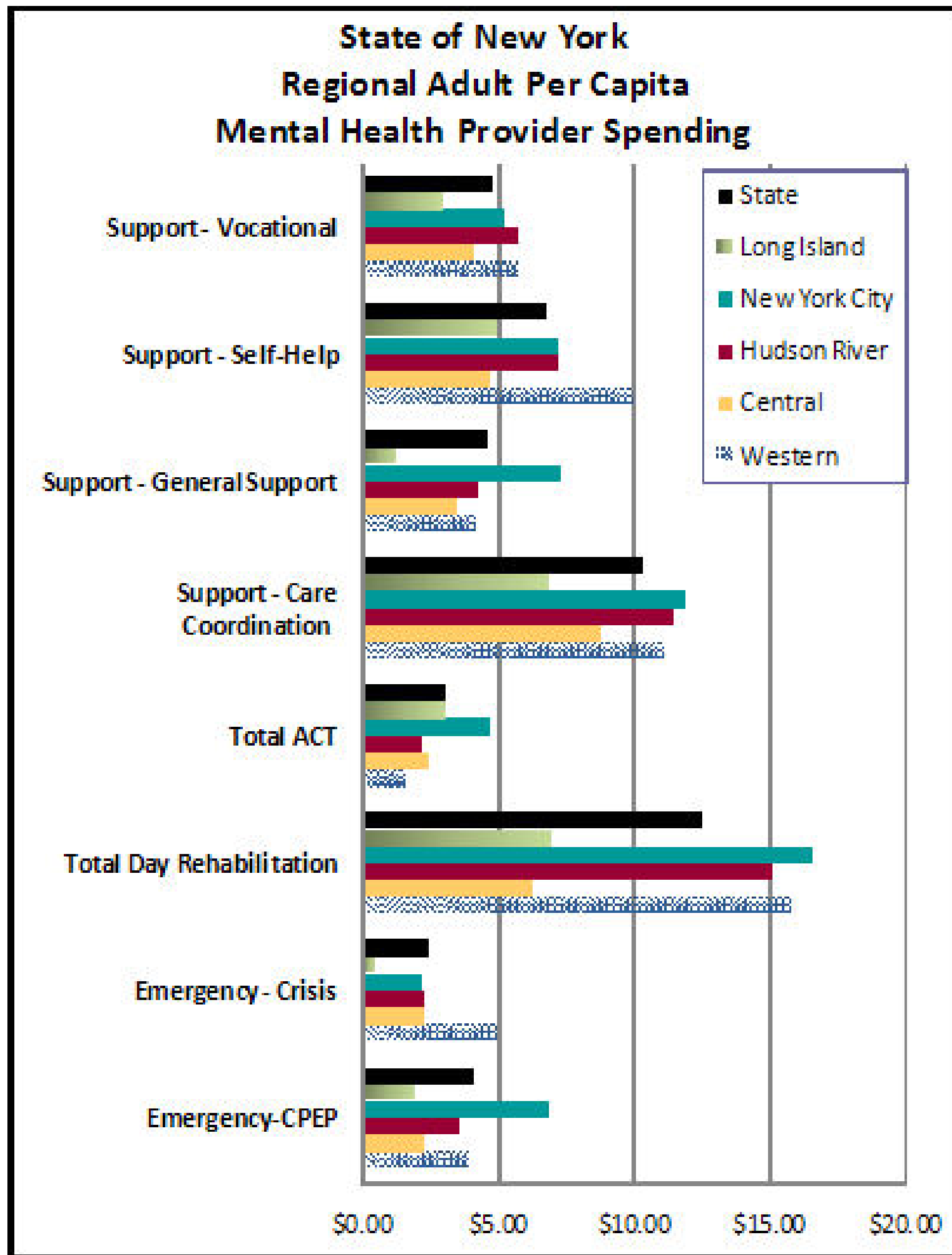
[59] As noted earlier, some CFR services include costs for providing services to both adults and children.

[60] Identification of the region is based upon the addresses of providers' administrative offices and as a result does not align perfectly with service locations or with the county of residence for

Central New York and Long Island stand out as having low per capita spending levels for services. Per capita rates for Care Coordination range from $6.94 in Long Island to $11.47 in Hudson River. Day Rehabilitation rates were $16.59 in New York City but $6.24 in Central New York. Care coordination, vocational support services and ACT show the least regional variation.

Figure F-2 – Regional Adult CFR Per Capita Spending



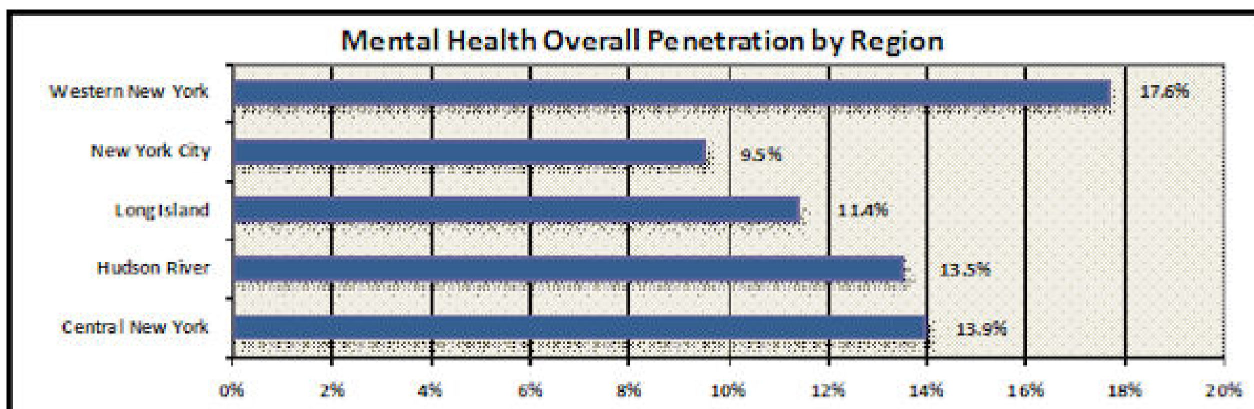
consumers. This is unlikely to be a significant problem for most services, especially at the regional level.

A comprehensive analysis of regional ambulatory capacity should also include utilization clinic and ambulatory State operated services, particularly since State hospitals are not distributed evenly across the State. This was beyond the scope of our study.

Medicaid Penetration Rates

Overall adult Medicaid penetration rates[61] vary significantly by county, ranging from 6.4 percent to almost 23 percent. Analyzed on a regional basis to reduce intercounty variation, rates ranged from 9.5 percent to 17.6 percent (see Figure F-3 below). Medicaid recipients in Western New York have the highest penetration rate, almost double the rate of NYC and almost four percentage points higher than the next closest region, Central NY.

Figure F-3 – Medicaid Penetration



The differences among penetration rates may be due to supply of services, the result of different practice patterns, system structure or perhaps the availability of resources. Interviews and focus groups confirmed that practice patterns are perceived to vary dramatically across counties or regions, based on the availability of specific service types and the training and experience of staff.

There are significant and surprising differences among the regions in penetration and per capita[62] and per recipient[63] expenditure levels for each service type (see Tables F-4-6).

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[61] The Medicaid penetration rate is the unduplicated number of Medicaid recipients who received at least one mental health service in a year divided by the total unduplicated number of individuals who are Medicaid eligible in the population during the same year.

[62] Total Medicaid claims for each service category and region divided by the unduplicated number of individuals enrolled in Medicaid for the region.

[63] Total Medicaid claims for each service category and region divided by the number of individuals receiving those services in that region (note in these data that there may be some duplication of recipients with service categories if individuals received more than on e service code within the category)

Table F-4 – Regional Mental Health Penetration by Service

Regional Medicaid Penetration by Service Category					
	Central NY	Hudson River	Long Island	New York City	Western NY
Ambulatory	3.8%	4.3%	5.5%	2.4%	5.4%
Residential	0.7%	1.0%	1.0%	0.2%	0.7%
Hospital Inpatient	2.0%	2.6%	2.3%	1.7%	2.1%
Partial Hospitalization	0.0%	0.4%	0.5%	0.1%	0.4%
State Hospital	0.01%	0.01%	0.00%	0.00%	0.00%
PMHP	1.1%	0.8%	0.6%	0.3%	0.2%
Clinic Service Individual	11.1%	10.2%	7.4%	7.3%	15.2%

Table F-5 – Spending Per Capita by Service

Regional Medicaid Spending per Capita					
	Central NY	Hudson River	Long Island	New York City	Western NY
Ambulatory	$153.27	$268.49	$308.25	$142.38	$216.88
Residential	$99.65	$170.96	$263.85	$40.06	$110.08
Hospital Inpatient	$141.45	$338.13	$345.61	$397.00	$171.46
Partial Hospitalization	$0.26	$6.19	$7.28	$2.81	$3.31
State Hospital	$2.09	$2.10	$0.02	$1.01	$0.47
PMHP	$169.84	$120.94	$99.52	$36.81	$37.78
Clinic Service Individual	$164.94	$251.78	$237.16	$157.49	$202.01
Total	$731.49	$1,158.60	$1,261.69	$777.55	$741.99

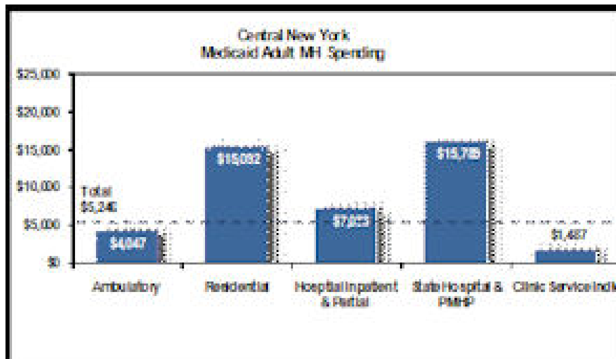
Table F-6 – Spending Per Recipient by Service

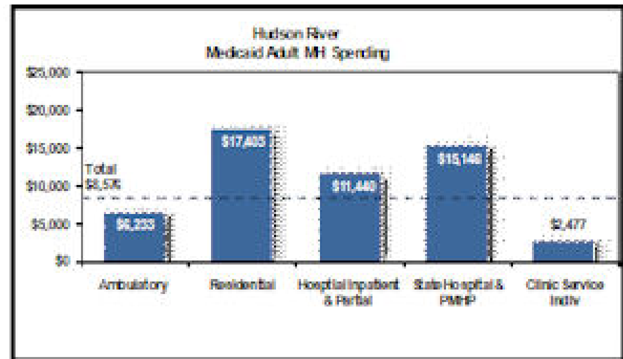
Regional Medicaid Spending per Recipient					
	Central NY	Hudson River	Long Island	New York City	Western NY
Ambulatory	$4,047	$6,233	$5,611	$5,900	$4,030
Residential	$15,092	$17,403	$25,719	$18,029	$15,038
Hospital Inpatient	$7,059	$13,095	$15,354	$23,752	$7,991
Partial Hospitalization	$2,299	$1,448	$1,476	$2,848	$935
State Hospital	$18,835	$33,669	$1,020	$103,579	$9,735
PMHP	$15,757	$15,002	$16,565	$14,636	$15,437
Clinic Service Individual	$1,487	$2,477	$3,220	$2,144	$1,325

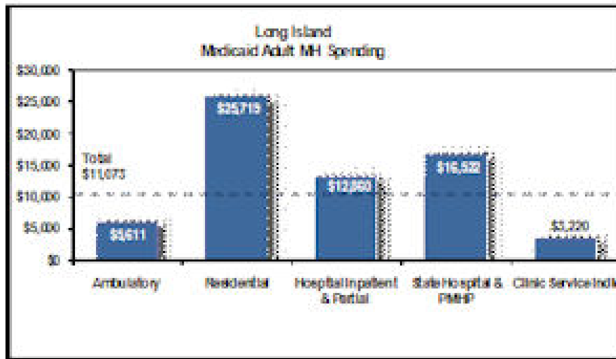
The data reveal interesting relationships between the regional penetration rates, capitation rates and rates per recipient (total claims divided by unduplicated total of consumers). Western New York has a dramatically higher overall penetration rate (primarily due to clinic access rates), and relatively low per capita and per recipient costs (in comparison with other regions). New York City has low penetration, low overall per capita costs, the lowest ambulatory costs and highest inpatient hospital costs.

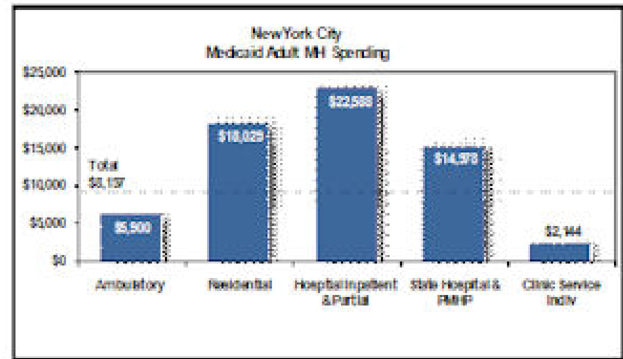
The regional variations in service access, cost and utilization are the result of historical State funding practices or they reflect the role of individual counties in budgeting, staffing and contracting for mental health services in New York. Until recently, county funds and State Aid to counties provided a significant portion of both the non Medicaid services and the required State match for Medicaid funding. However the county Medicaid contribution has been capped in recent years, reducing county incentives to control growth of Medicaid spending. The significantly different economies, policies and priorities in New York City, other urban areas and the remaining counties further compound the disparities in spending and programming that are seen today. State operated services, also play a part in these regional funding disparities. Ultimately the factors that drive these differences need to be studied further and local planning should incorporate these data, developing strategies to reduce unwanted variation.

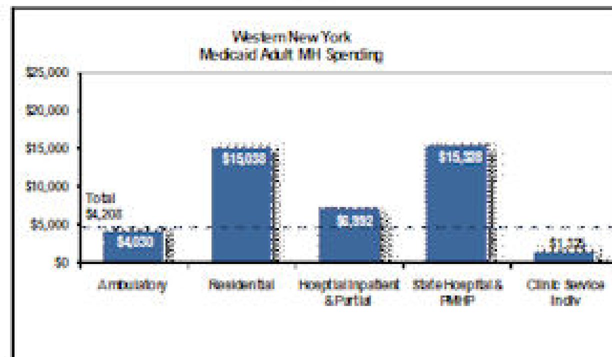
Attachment G - Medicaid Adult MH Regional Adult Spending Per Recipient











Attachment H – Selected Stakeholder Recommendations from Focus Groups

Improving Care and Care Management

- One person – One Plan: Develop rules and a process whereby one treatment plan is developed for all services a person receives.
- Compare the costs and benefits of keeping case management as an independent service with the costs and benefits of integrating it with other services. Evaluate training and qualifications of current case managers to determine whether they should be upgraded.
- Develop care coordination at the front door to improve engagement and build on the DOH Chronic Care Demonstrations.
- Expand the use of peer or recovery support staff to increase care coordination.
- Increase the emphasis on coordinating consumers' transitions between levels of care, especially following hospital discharge. Use bridgers and peers to help facilitate these transitions.
- Increase training in and support of person centered planning as a vehicle for transforming the system.
- Develop technologies to help counties identify high risk and high need cases for chronic illness management approaches.

Improving Administrative Functions

- Develop billing codes other than case management for the services such as navigation and support that case managers currently perform in their efforts to maintain consumers in the community.
- Develop contract and program performance indicators and increase provider reporting and transparency of data in the system.
- Implement more routine provider and county reporting for utilization and cost data.
- Find ways to reward rapid response, engagement and retention in care, such as:
  - Develop performance contracting guidelines for key service types based upon indicators;
  - Assist counties with their implementation; and
  - Consider withholds or bonuses in contracts.
- Reduce bureaucratic requirements for annual cost reconciliation and/or change the methods of contracting and rate setting.
- Encourage, facilitate and incentivize county and regional approaches to restructuring.
- Consider requiring county 5.07 Plans to more systematically address the need for restructuring and regional approaches if needed.

Reducing Regional Variation

- Analyze reasons for regional variation in service penetration and utilization. Require this as a part of county annual planning.
- Use quality improvement practices to reduce regional variation in practice and utilization.
- Develop utilization management capabilities in the system through the SPOAs or some similar entity.
- Consider ways to encourage county collaborations and multi county initiatives similar to the Pennsylvania and Western New York models.

Supporting Implementation of Person Centered Care

- Increase support for consumer education to improve consumers' ability to navigate the healthcare system and to enhance choice.
- Facilitate the development of pilots in self direction and "money follows the client" approaches.