
IOCC

December 2013

Inter-Office Coordinating Council



NYS Office of Alcoholism and Substance Abuse Services
Arlene González-Sánchez, Commissioner
IOCC Chair



NYS Office of Mental Health
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NYS Office for People With Developmental Disabilities
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2013 Report of Activities

Background

The Inter-Office Coordinating Council (IOCC) was created under Section 5.05(b) of New York State Mental Hygiene Law. This Report is submitted in accordance with Chapter 294 of the Laws of 2007, requiring the IOCC to issue an annual report on its activities to the Governor and the Legislature. A major aim of the IOCC is the elimination of barriers to accessing care and to improving coordination of services for people with disabilities, particularly those served across multiple agencies. This Report highlights the collaborative efforts by the three State mental hygiene agencies in 2013 to address the needs of New Yorkers with co-occurring disorders and multiple disabilities. The Report's primary focus includes the ongoing efforts to further the integration and alignment of agency structures and functions to improve outcomes for individuals and their families served by the State mental hygiene agencies.

Integrated Local Mental Hygiene Planning

Section 41.16(a) of New York State Mental Hygiene Law requires the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH) and the Office for People With Developmental Disabilities (OPWDD) to guide and facilitate the process of local planning. For the past six years, the three state agencies have collaborated on an integrated local planning process that enables Local Governmental Units (LGUs) to conduct planning in a way that better addresses the needs of people with co-occurring disorders and who require services from multiple systems.

LGUs annually submit a single integrated mental hygiene service plan that includes priorities that address local needs in a more coordinated and integrated way. The plans are submitted electronically via the online County Planning System (CPS), a web-based tool that integrates all local planning requirements of the three state agencies.

The Mental Hygiene Planning Committee guides the local planning process. The committee is a partnership of planning staff from the three state agencies, the Conference of Local Mental Hygiene Directors (CLMHD), and several counties. It meets regularly to ensure that state and local needs are met and that the local planning process remains relevant and supportive of efforts to make system-wide improvements in the quality of services and supports available to individuals, families, and communities.

In 2013, 69% of all priorities identified in the local plans addressed needs that crossed multiple disabilities, including 48% that incorporated all three mental hygiene disabilities. Among the top cross-disability priorities were:

- The need for safe and affordable supported housing;
- Expanding the capacity of local service systems to provide integrated and coordinated care;
- Supporting reforms such as the Affordable Care Act and Medicaid Redesign while maintaining and strengthening LGU oversight and system management responsibilities;

- Collaborating with local health departments (LHDs) to support the mental health and substance use disorder related priorities of the Department of Health's (DOH's) Prevention Agenda 2013-17.

A more detailed summary report of local priorities is included in each agency's Statewide Comprehensive Plan.

OASAS-OMH Joint Public Hearing

On August 27, 2013, OASAS and OMH held the second annual joint public hearing on their statewide comprehensive plans. The hearing was conducted by videoconference among eight locations: Albany, Buffalo, Long Island, Manhattan, Ogdensburg, Staten Island, Syracuse, and Rochester. OASAS Commissioner Arlene González-Sánchez and OMH Acting Commissioner John Tauriello gathered input for consideration in the development of their respective plans and ongoing initiatives to deliver more integrated care that meets the unique needs of those with co-occurring substance use and mental health disorders. Among the topics discussed at the hearing were: Health Homes, regional planning, implementation of Behavioral Health Organization (BHO) Phase 2, recovery supports, opioid treatment expansion, peer recovery support, and supportive housing.

Approval of Directors of Community Services

The Director of Community Services (DCS) is the chief executive officer of an LGU, which is the unit of local government that is given authority under New York State Mental Hygiene Law (MHL) to provide local mental hygiene services. Section 41.09 of the law establishes the job qualifications of a DCS.

Section 102.5 of Title 14 of the New York State Codes, Rules and Regulations requires the IOCC to establish procedures regarding the appointment of a DCS. These procedures can be found at: <http://www.oasas.ny.gov/pio/collaborate/IOCC/proposedprocedures.cfm>. Prior to approving the appointment of a DCS, the LGU must submit specific information to the IOCC for review and approval by each member agency.

In 2013, the IOCC approved permanent or interim DCS appointments for the following counties: Erie, Genesee, Lewis, Madison, Onondaga, Ontario, Orleans, Rensselaer, Ulster, Westchester, and Wyoming.

Behavioral Health Services Advisory Council

A significant development in the integration of care for individuals with co-occurring substance use and mental health disorders was the formation of the Behavioral Health Services Advisory Council (BHSAC). Changes to Mental Hygiene Law in 2012 established the Council, which replaced the former OASAS Advisory Council on Alcoholism and Substance Abuse and the OMH Mental Health Services Council.

The BHSAC will advise the two state agencies on matters relating to the provision of behavioral health services, the integration of health and behavioral health services, and prevention and systems planning. The OASAS and OMH commissioners are non-voting members of the BHSAC. The Chair of the Conference of Local Mental Hygiene Directors (CLMHD) serves on the Council. The 28 members of the BHSAC were nominated by the Governor and approved by the Senate in 2013. OASAS and OMH staff conducted an orientation for BHSAC members on October 1, 2013 and the Council held its first meeting on October 2, 2013.

Behavioral Health Organizations

Governor Cuomo established the Medicaid Redesign Team (MRT) and charged it with finding ways to reduce costs, and increase quality and efficiency in the Medicaid program. One of the MRT's recommendations was to move all Medicaid beneficiaries, including people with substance use disorders and mental illness who were previously exempted from managed care requirements, into a managed care behavioral health model. This move would bring fee-for-service payment to an end and reduce Medicaid costs and improve outcomes for patients in both systems of care. Because Medicaid managed care organizations have limited experience working with these populations, the MRT recommended a transition period for bringing them into managed care.

Phase I began in January 2012 when OASAS and OMH contracted with five Behavioral Health Organizations (BHOs) to monitor inpatient behavioral health services for Medicaid-enrolled individuals whose inpatient behavioral health services were not covered by a Medicaid Managed Care plan and were not enrolled in Medicare. The Phase 1 BHOs were responsible for working with providers to learn how to improve care in anticipation of a managed care environment. This involved: collecting and submitting data to help OASAS and OMH learn how to improve care; identifying improvements in inpatient discharge planning and ambulatory engagement/continuity of care utilizing Medicaid data to inform treatment and care planning; and developing and testing metrics for monitoring behavioral health system performance.

The state refined the role of the BHOs in 2012 to focus on identifying new approaches and evidence-based practices that would: facilitate the transition from inpatient care to the community; sustain engagement in community-based care; and address co-morbid medical problems and co-occurring substance use and mental health disorders. In addition, the state narrowed the focus of the BHOs to fee-for-service populations with "complex needs" that met a certain incident threshold criteria. BHOs would also more actively work with inpatient providers on care coordination, peer and system supports, outreach, and follow-up.

One of the main goals of Phase II is for the state to establish contracts with specialty managed care plans to comprehensively address both physical and behavioral health needs.

After extensive research and analysis, OASAS and OMH, in conjunction with DOH, presented the design for managed behavioral health to the MRT in May 2013. The MRT endorsed the design, which includes the following provisions and key requirements:

- Behavioral health will be managed by special needs Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs;
- Mainstream managed care plans may operate services directly only if they meet rigorous standards or partner with a BHO that meets those standards;
- Design will enhance the array and quality of services available in all plans;
- All plans must meet rigorous standards for managing behavioral health benefits;
- All plans must qualify to manage currently carved out behavioral health services and populations;
- Plans may apply to be a HARP with expanded benefits;
- Individual plans of care and care coordination must be person-centered and be accountable for both in-plan benefits and non-plan services;
- Plans must interface with social service systems to address homelessness, criminal justice, and employment related issues for members;
- Plans must interface with Local Governmental Units (LGUs);
- Plans must interface with State psychiatric centers to coordinate care for members.

On December 5, 2013, OMH, OASAS, and DOH released a Request for Information (RFI) regarding “New York’s Request for Qualifications (RFQ) for Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plan.” The RFI solicited input concerning New York State’s draft proposal to manage Medicaid substance use and mental health benefits. Stakeholder feedback will help inform any revisions to the final RFQ as well as guide New York State in the provision of Plan and Provider readiness assistance. The RFQ will establish the qualification parameters for HARPs for individuals with higher levels of SUD and MH treatment and support needs.

The new implementation dates for the final steps in the behavioral health transformation are:

- January 1, 2015: Implementation BH Adults in NYC (HARP and Non HARP)
- July 1, 2015: Implementation BH Adults in Rest of State (HARP and Non HARP)
- January 1, 2016: Implementation BH Children Statewide

The additional time allotted with the revised implementation dates will allow the state to:

1. Provide Medicaid managed care plans and behavioral health providers more time to prepare;
2. Continue to obtain feedback from stakeholders and better leverage community based services in the design;
3. Develop key performance measures for the new behavioral health services environment;
4. Obtain needed federal approval for new services and design; and,
5. Allow DOH, OASAS, and OMH to continue working on reasonable and efficient plan and service payment rates with the state’s actuary.

During 2013, OMH, OASAS, and DOH continued to monitor the data from the Phase 1 BHOs. The second BHO phase will involve the enrollment of all Medicaid recipients in a managed care

plan for their behavioral health needs. Currently the Offices, along with DOH, Office of Children and Family Services (OCFS), and New York City Department of Health and Mental Hygiene (NYCDOHMH) are completing the program design. The Offices have contracted with Mercer consulting group for assistance in designing the system and developing plan premiums.

Health Homes

New York State is authorized under the federal Patient Protection and Affordable Care Act (ACA) to develop and provide Health Home services for Medicaid recipients with chronic illness. Health Home services support the provision of coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through care coordination and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology (HIT), and avoids unnecessary care. Health Home services include:

- Comprehensive care management;
- Health promotion;
- Transitional care, including appropriate follow-up from inpatient to other settings;
- Patient and family support;
- Referral to community and social support services;
- Use of health information technology to link services.

An individual is eligible for Health Home enrollment if he or she is currently on Medicaid and has multiple conditions and/or serious persistent mental illness.

OASAS and OMH continue to work with DOH on the management and oversight of Health Homes and provider networks across the state. Additional monitoring and evaluation tools are being developed within a larger evaluation plan that includes an external entity, the National Center on Addiction and Substance Abuse (CASA) at Columbia University, conducting in-depth analyses of outcomes for individuals with a substance use disorder engaged in Health Homes.

The Justice Center

The Justice Center became functional on July 1, 2013. This new state agency is in charge of investigating, prosecuting, and monitoring all human service agencies that provide care to “vulnerable persons.” State law defines vulnerable persons, mandated reporting, incidents, cases, investigations, oversight and monitoring. A number of changes were made to existing statutes to enable the Justice Center to operate and effectively oversee any potential abuse, neglect, significant incidents, financial crimes or crimes that might occur in a program that serves vulnerable populations. The Justice Center is also the central point of contact for all state agencies to uniformly and consistently run criminal background checks on employees who have a role in direct patient care. This is to ensure that vulnerable people do not get abused or neglected in the various systems of care throughout the state.

The Justice Center instituted a statewide mandatory computer based system to classify, triage, assign, investigate and monitor all incidents of abuse and neglect by providers under all state

human service agencies. OASAS, OMH, and OPWDD and their providers are mandated to report.

The Justice Center instituted a new system of investigating and prosecuting cases of abuse and neglect, as well as assigning investigations to the state oversight agency and monitoring corrective action plans to deal with systemic or programmatic changes necessary as the result of an incident.

This initiative requires the collaboration of OMH, OASAS, OPWDD, DOH, OCFS, Office of Temporary and Disability Assistance (OTDA), State Education Department (SED), and the former Commission on Quality Care, as well law enforcement and prosecutorial agencies. Each agency is using the same system to communicate and coordinate efforts between and within systems to better manage the care of each agency's population. Collaboration and coordination of reporting, investigating, problem solving, and, in some cases, prosecuting wrongdoers are the functions of the Justice Center.

Integration of the Federal Block Grant Plan

With the implementation of health care reform and affordable insurance exchanges, the Substance Abuse and Mental Health Services Administration (SAMHSA) encouraged OASAS and OMH to submit an integrated Block Grant application. While the federal application is not yet integrated, OMH and OASAS submitted a joint application during 2013.

People First Waiver

As part of Medicaid Reform, OPWDD, in consultation with DOH, has continued seeking significant programmatic and fiscal improvements to the service system through the development of the "People First Waiver." The waiver will consist of a combination of two types of Medicaid waivers, a 1915(b) waiver to authorize service delivery through a managed care infrastructure, and a 1915(c) Home and Community Based Services waiver to authorize community-based supports and services.

The new system includes:

- A "no wrong door" approach that enables people to access supports and services through multiple points of entry;
- Coordinated care organizations that assist individuals with the coordination of all of their Medicaid and other service needs;
- A quality framework based on personal outcomes and proven health and safety measures;
- An infrastructure that ensures fiscal sustainability while providing more flexible supports and service options to individuals in the least restrictive setting; and
- Expanded capacity to provide appropriate clinical, behavioral, and medical supports to more people in community settings.

For individuals with developmental disabilities and their families, this means that access to services will be easier and that there will be greater opportunities for choice and control over

supports. The goal of this system redesign is to serve New Yorkers holistically by providing long-term supports traditionally funded by OPWDD, as well as physical health, mental health, substance use disorder services, and other supports across systems.

OPWDD Aging Collaboration

OPWDD maintains long-standing alliances with the State Office For the Aging (SOFA), OMH, and other State and voluntary agencies that encourage future collaboration and improve service delivery and planning for older adults with developmental disabilities and their families. OPWDD continues to work with all of its partners to ensure continuous system improvements; increased equity of access to needed supports and services; and advancements in identification, prevention, and treatment for individuals with developmental disabilities, as well as outreach and support to their families. OPWDD and SOFA are collaborating on No Wrong Door/Single Point of Entry communications through NY Connects and OPWDD regional offices to ensure people are more easily able to access information about services. OPWDD is partnering with SOFA on a Legal Services Initiative intended to understand existing limitations and gaps related to legal services and the legal field and to develop associated strategies and recommendations. OPWDD also participates in the Geriatric Mental Health Council, chaired by OMH and SOFA, in an interagency effort to advance geriatric mental health care.

Workforce Training and Development

OPWDD is committed to maintaining a culture based on its values of dignity, diversity, honesty, compassion, and excellence. Those values are the foundation of a quality system of supports for individuals with intellectual and developmental disabilities, and for the workforce.

OPWDD is engaged in a number of workforce initiatives to foster and shape that culture, including the creation of six Regional Centers for Workforce Transformation that will support implementation of the recently adopted Core Competencies for Direct Support Professionals and the National Alliance for Direct Support Professionals (NADSP) Code of Ethics.

OPWDD also participates in a state and nonprofit workgroup whose goal is to develop cross-system, statewide implementation plans for nationally validated direct support workforce core competencies. The competencies, published in August 2013 by CMS, will help states enhance the capacity of their workforce to support people who are aging, have behavioral health issues, substance abuse problems, physical disabilities, and/or developmental disabilities. OPWDD's Talent Development Consortium, a stakeholder group comprising family members, self-advocates, nonprofit providers, and agency staff, is also supporting workforce development.

Olmstead Report

In November 2012, Governor Cuomo signed Executive Order 84 establishing an Olmstead Plan Development and Implementation Cabinet. The Olmstead Cabinet issued its final Report and Recommendations in October 2013 (<http://www.governor.ny.gov/olmstead/home>).

The Report identified specific actions state agencies responsible for providing services to people with disabilities will take to serve those individuals in the most integrated setting, including:

- Assisting in transitioning people with disabilities out of segregated settings and into community settings;
- Changing the way New York assesses and measures Olmstead performance;
- Enhancing the integration of people in their communities; and,
- Assuring accountability for serving people in the most integrated setting.

Systematic, Therapeutic, Assessment, Respite and Treatment (START)

OPWDD is piloting a national program known as START (Systematic, Therapeutic, Assessment, Respite and Treatment) to provide emergency crisis services and limited therapeutic respite services to support individuals in family homes and least restrictive community settings. The program will promote a system of community services, natural supports, and mental health treatment to people with intellectual and developmental disability and mental health issues (IDD/MH). START's mission is to enhance local capacity and provide collaborative cost-effective support to individuals and their families through exemplary clinical services, education, and training, with close attention to service outcomes.