THROUGH THE NEXT DOOR

A DISCUSSION OF THE CHILD AND FAMILY BEHAVIORAL HEALTH SYSTEM UNDER HEALTH CARE REFORM IN NEW YORK STATE

New York State Coalition for Children's Mental Health Services

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RAYMOND SCHIMMER SERVED AS PRINCIPAL RESEARCHER AND WRITER FOR THE COALITION IN THE PRODUCTION OF “THROUGH THE NEXT DOOR.” PRIOR TO HIS RETIREMENT IN JULY, 2014 AS CEO OF NORTHERN RIVERS FAMILY SERVICES, MR. SCHIMMER WORKED FOR 40 YEARS IN THE FIELDS OF SPECIAL EDUCATION, CHILD WELFARE, AND CHILD AND FAMILY BEHAVIORAL HEALTH. HE MAY BE CONTACTED AT RAY.SCHIMMER@NORTHERNRIVERS.ORG.

PREFACE

In 1986, the nonprofit agencies operating New York State's new Residential Treatment Facilities (RTFs) came together to form the RTF Coalition. Many of the founding members were contracting with the NYS Office of Mental Health for the first time; in fact, some had never directly provided mental health services. All believed they were entering a world where there would be a steep learning curve and a great value in a collective approach to the challenges ahead.

RTF's turned out to be only the beginning. OMH was initiating a period of aggressive growth in the type and volume of mental health services that it sponsored, certified, and monitored. The RTF group became the NYS Coalition for Children's Mental Health Services. Membership grew as did the services offered to children and families, including Community Residences, Family-Based Treatment, Outpatient Clinics, Day Treatment, Family Support Services and Home and Community Based Waiver Services through 1915(c) authorization from the federal government. Along the way, inevitably, Coalition members began to regard themselves not only as providers, but as mental health advocates—as stakeholders in the growth and evolution of a growing field. The Coalition added a Policy Forum expressly for the public examination and discussion of issues by government, families, providers, and the community at large.

In 2003 and again in 2007, the Coalition perceived that the field had arrived pivotal points in its development and so commissioned whitepapers to stimulate review and discussion. In 2014, the Coalition finds our common work to be at an even more critical stage and offers a new statement—"Through the Next Door"—with the hope that it may contribute to the growth and happiness of children and their families, and to the policy discussion about a system redesign.

INTRODUCTION

> We hope to see a day when children and families will have access to a range and volume of mental health care equal to that available today in physical health care; that is, a day when a child afflicted with depression or any other mental health problem, will be treated as quickly and effectively as a child with a broken bone or a fever. On that day, parents' concerns for their children's mental health will be addressed by a wide array of preventive and intensive mental health services, just as their physical health concerns are addressed now by well-child care, by nurses in schools, by doctors in offices, and by specialists in hospitals. On that day, mothers and fathers won't need to worry about enough care being available. On that day, they won't be confused about where the help is, or how to get it[1].

WE HOPE TO SEE A DAY WHEN CHILDREN AND FAMILIES WILL HAVE ACCESS TO A RANGE AND VOLUME OF MENTAL HEALTH CARE EQUAL TO THAT AVAILABLE TODAY IN PHYSICAL HEALTH CARE; THAT IS, A DAY WHEN A CHILD AFFLICTED WITH DEPRESSION OR ANY OTHER MENTAL HEALTH PROBLEM, WILL BE TREATED AS QUICKLY AND EFFECTIVELY AS A CHILD WITH A BROKEN BONE OR A FEVER.

"A System of Care Blueprint for the Children's Mental Health System" • NYS Coalition for Children's Mental Health Services, 2003

The Coalition was dreaming of a better world when it published this first whitepaper in 2003 and its subsequent "blueprint" in 2007. It may not be outlandish to wonder if now, seven years later, we are not at least approaching the door to that world. The enormity of the risk and opportunity at hand is unprecedented for behavioral health in general and for the child and family system in particular. It feels appropriate to us at this time that we once again take stock of our contemporary context, evaluate the potential rewards and present dangers of change, and offer public commentary based on our particular experience and point of view.

We will catalogue some of the great events that have impacted our field since 2003, describe what we see as the categorical restructuring of finance and administration, consider some of the relevant, essential characteristics of children and families, and offer our perspective on the special circumstances that must be considered when designing, organizing, and providing a system of behavioral health care for children and families. We will discuss what we perceive to be the threats and opportunities that health care reform and managed care present to pediatric behavioral health services, and will conclude with a variety of recommendations that we believe may mitigate the risks and enhance those opportunities.

The purposes of our paper are to influence the continuing development of public policy, to energize our provider and family communities to rally together in support of policies that protect against threats, and to elicit the same promise of government protection for children that characterizes compulsory education laws, child labor law and child protective laws. We welcome response from all who share our concern for the future of child and family behavioral health.

FOREWARD

THE ADVENT OF CHANGE

If the Great Recession of 2008 was the proximate cause for reform, the seeds for the transformation of New York State's health care system were already germinating in 2000. The state was ***the*** extreme national outlier with respect to Medicaid. New York's outlay for Medicaid that year was $40 B, by far the most in the country.[2] In fact, it was $11 B more than that of the closest next state, California—and California's population exceeded New York's by almost 11 million people. New York's per capita Medicaid cost was $11,749, which was also by far the highest in the country and almost double the national average. New York's Medicaid expenses in 2000 constituted 26% of the state's "own source revenue"—10% higher than the national average and 6% higher than the next closest state.[3]

Not coincidentally, New York's Medicaid-eligible population was growing rapidly during the early 2000's by virtue of a variety of initiatives. Following the recession of 2002-2003, many Medicaid programs saw their roles expand. In 2002, the state created Disaster Relief access and instituted Family Health Plus coverage. It took advantage of the temporary Federal Medicaid Assisting Percentage (FMAP) increase in 2003, and established a limited Medicaid buy-in option in 2004. In 2005 the income threshold for children was reduced, and in 2008, the county Medicaid cap was instituted, encouraging counties to enroll more eligible citizens without additional impact to county budgets. Consequently, between 2000 and 2009, the state's Medicaid eligible population grew from 3.42 M to 4.985 M, an increase of about 31%[4].

Whether New York might have sustained this pre-eminence forever became a moot point due to the national recession in 2008. The Great Recession did what all recessions do, withering state resources while simultaneously increasing the number of citizens in need of state support. Nationally, state tax revenue was 17% lower in 2009 than it had been in 2008, and income tax revenue was down by 27%[5]. Between 2009 and 2012, 43 states experienced budget shortfalls. In August, 2008, Governor Paterson of New York convened an emergency session of the state legislature to cut $600 million out of the budget, despite the fact that the state budget passed only four months previously already contained a 7% spending reduction over the previous year, including a state government hiring freeze. New York State's total revenue dropped by almost $4 billion between 2008 and 2009, and did not climb back to the 2008 level until 2011[6]. State General Fund spending was reduced over and over again in an across-the-board fashion, without tremendous regard for the quality or impact of specific programs or services.

Reduced revenue diminished the government's ability to operate at its highest level. In 2012, Tracy Gordon and the Brookings Institution reported:

> State and local government spending cuts often translated into trimmed payrolls. Overall, state and local public sector employment fell by 624,000 from August 2008 to September 2012[7].

IT IS OF COMPELLING PUBLIC IMPORTANCE THAT THE STATE CONDUCT A FUNDAMENTAL RESTRUCTURING OF ITS MEDICAID PROGRAM TO ACHIEVE MEASURABLE IMPROVEMENT IN HEALTH OUTCOMES, SUSTAINABLE COST CONTROL AND A MORE EFFICIENT ADMINISTRATIVE STRUCTURE.

Governor Andrew Cuomo, January 5, 2011

After announcing that New York State lost nearly 100,000 manufacturing jobs from 2007-2012 (a rate of 16.9% compared to the national state average of 14.1%), the state's Comptroller also reported that New York State government employment diminished 2.4% during the same period--nearly twice the rate of the national government employment reduction.[8]

Having sustained grievous financial damage to their financial conditions, state governments were forced at the same time to respond to the many individual citizens who had lost or were losing their own financial integrity; in the years from 2009-2012, the country saw a 70% increase in unemployment assistance expenditures. This prompted the Federal government to provide assistance to the struggling states. The Accountable Recovery and Reinvestment Act (ARRA), passed in 2009, provided $787 B in federal funding for various state projects and significant FMAP increases were then extended to the states from Washington as a result of the passage and implementation of the Affordable Care Act; however, it was clear that the states—including, if not especially, New York—would need to reevaluate their practices with respect to Medicaid and health care.

USING A GOOD CRISIS

> *Determining how to optimally balance our collective demand for the best possible health care with our ability to fund such care through public and private efforts represents one of the most challenging political dilemmas facing the nation.*
>
> —Statement from Acting Chief Actuary, CMS[9]

Despite both significant Federal assistance and the subsequent financial recovery, New York State's health care and Medicaid spending policies had to be reformed. Change would come. The chief instruments were to be the New York State Medicaid Restructuring Team (MRT), established by Governor Andrew Cuomo via Executive Order 5 on January 5, 2011, and the Patient Protection and Affordable Care Act (ACA), signed by President Obama on March 23, 2014.

Although Governor Cuomo made a point of keeping New York's financial goals in the foreground--

> *It is of compelling public importance that the state conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure.*
>
> —Governor Andrew Cuomo, January 5, 2011[10]

--both the ACA and the MRT were dedicated to the "Triple Aims." Those Triple Aims--improve patient experience and quality of care, improve population health, and reduce per capita cost-- were promoted by Donald Berwick in his work with the Institute for Healthcare Improvement and in his role as Administrator of the Centers for Medicare and Medicaid.[11] Berwick asserted that no one of the Three Aims could be independent of any other, a philosophical point that posed a major challenge for managers, political figures, and the health care industry: how was care to be improved and expanded while at the same time controlling or even reducing costs?

Clearly a new set of assumptions would be required if the incoming tide of health care cost was to be rolled back during the greatest public resource crisis that our country had experienced in 85 years. Berwick proposed that there were three necessary "preconditions" for successful health care reform:

1. A recognition that "population" was the main "unit of concern";
2. Externally applied policy constraints; and
3. The existence of an "integrator" that would focus and coordinate services.[12]

"Population" here refers to the target as a defined group, and implies that the goal for the target is general improvement of whole-health status as measured across the entire target group. This concept may seem strange at first to providers who have focused for years on specific interventions for victims of particular afflictions, but the understanding of "population" as the "unit of concern" goes a long way in explaining the sheer scale of changes in health care related industries.

The "policy constraints" are of paramount importance as the government seeks to provide for commercial parties incentives that do not exist naturally in a government-sponsored services environment, and to impose obligations on those parties that do not exist naturally in marketplace environment. It is perhaps not too much to say that the success of health care reform will depend upon the ultimate efficacy of the policy constraints that are laid down.

Efforts to establish Berwick's preconditions have been supported by the emergence of a few central ideas that have been increasingly incorporated into both national and state approaches to the Triple Aims. These central ideas may seem self-evident now, but they were not in 2003 and have only recently achieved recognizable definition. Without exception, each carries significant importance for children, families, and the field of behavioral health.

PART I:

LARGE ORDER CHANGES

BEHAVIORAL HEALTH IS NOW PART OF HEALTH CARE. SORT OF...

In 2003 we described mental health care as a second cousin to the health care system, supported by a disconnected mélange of often superficial commercial health benefits, government services marked by strict and limited eligibility restrictions, and separately-purchased private care. But in 2014 we increasingly refer to services as "behavioral health" rather than "mental health," and we find their substantive presence mandated by the Affordable Care Act, the Medicaid Restructuring Team, and the Delivery System Reform Incentive Program. The genesis of this transformation is to be found in citizen advocacy, research, and policy development.

The death of 11-year old Timothy O'Clair in March 2001 followed the premature expiration of limited insurance benefits and the brief provision of inappropriately categorical social services care. The boy's family and a circle of supporting advocates petitioned New York State for mental health parity legislation. That legislation was signed into law by Governor Pataki in December 2006; however, it carried a two-year "sunset" provision driven by the great fear that mandated behavioral health care would bankrupt the insurance industry and create unmanageable shared payments for customers. Superintendent of Insurance Eric Dinallo was to carry out an actuarial study that would determine the fate of renewal in 2009. Dinallo's report confirmed the previously scattered and superficial nature of commercial behavioral health care coverage, documented its enormous extension as a result of the parity law, and confirmed that cost was incidental:

> Prior to Timothy's Law, approximately 99% of all small [employer] groups and large groups offered some type of mental health benefits, but only 42% offered full 30/20 [i.e., 30 inpatient days/20 outpatient sessions]. After Timothy's Law, 100% of all small and large groups offered full 30/20 benefits.[13]

Coverage for biologically-based mental illness and serious emotional disturbance went up from 11% to 100% at large company employers, and up from 9.6% to 43.7% for small employers. As to the fear of runaway costs, Dinallo found that: "Consumers and brokers generally did not view the mandates as a significant issue

relative to cost or to their overall purchasing decision."[14] The passage of Timothy's Law reflected a growing belief on the part of the larger community that behavioral health care was both increasingly effective and commonly required. The O'Clairs and their allies had humanized the need for service and normalized its utilization by those in need. It is hardly coincidental that Senators Paul Wellstone and Pete Domenici, sponsors of the federal parity legislation (The Mental Health Parity and Addiction Equity Act of 2008) were motivated in part by their own family experiences. These advocates showed that the presence or absence of behavioral health services could be essential to the integrity of real people and real families; perhaps as importantly, they showed that policies and systems that effectively created financial resource and access were a necessity with respect to the therapeutic process.

THE SOCIAL DETERMINANTS OF HEALTH ARE THE CONDITIONS IN WHICH PEOPLE ARE BORN, GROW, LIVE, WORK, AND AGE. THE CIRCUMSTANCES ARE SHAPED BY THE DISTRIBUTION OF MONEY, POWER, AND RESOURCES AT GLOBAL, NATIONAL, AND LOCAL LEVELS.

World Health Organization (WHO)

At the same time that advocates were realizing success in extending insurance coverage for behavioral health, research was coming to maturation that supported the advocacy community's belief in both the importance of behavioral health, and the enlargement of the common definition of "health care." Richard Wilkinson and Michael Marmot published the second edition of The Solid Facts[15] in 2003, expanding on the concept "Social Determinants of Health," which has been embraced first by the World Health Organization (WHO) and the Centers for Disease Control (CDC), and eventually by the New York State Medicaid Redesign Team. Social determinants theory extends the definition of health care beyond the limits of direct medical provision to include macro-factors that affect the health status of an entire population. WHO's definition is deceptively simple:

The social determinants of health are the conditions in which people are born, grow, live, work, and age. The circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.[16]

The importance of emotional support in early childhood is one of the ten "solid facts:"

> The judgments, based on evidence, that health would be improved by a nurturing environment for children, better education, a socially supportive environment for adults, better psycho-social working conditions…relies on observation more than experiment….Slow growth and poor emotional support raise the lifetime risk of poor physical health and reduce physical, cognitive, and emotional functioning in adulthood. Poor early experience and slow growth become embedded in biology during the processes of development and form the basis of the individual's biological and human capital, which affects health throughout life.[17]

Although the definition may be simple, its implications for ancien regime health care and Medicaid systems are far-reaching. Its imperatives—"a nurturing environment for children," "better education," "a socially supportive environment for adults"—would have an integrated system of service that would require criss-crossing all over long-observed bureaucratic, community, and corporate boundaries. Its emphasis on early development would seem to call for turning our current age-based expenditure differentials upside down.

Volume I, Issue 1 of "ACE Reporter"[18] was also released in 2003. The ACE Reporter described follow-up research to Kaiser Permanente's 1995-1997 study of adults whose compromised health status apparently correlated with specific physical and

emotional insults suffered during childhood. Co-Principal Investigators Vincent Felitti, MD, of Kaiser Permanente and Robert Anda, MD, MS, of the Centers for Disease Control worked to substantiate the connection between childhood experiences and adult health status, and to quantify the financial consequence of the health care outcomes over time.[19] Although ACE theory was little known at first, in recent years, the theory's adherents have achieved national attention.[20]

...THE CONNECTION BETWEEN CHILDHOOD EXPERIENCES AND ADULT HEALTH STATUS, AND TO QUANTIFY THE FINANCIAL CONSEQUENCE OF THE HEALTH CARE OUTCOMES OVER TIME.[19] ALTHOUGH ACE THEORY WAS LITTLE KNOWN AT FIRST, IN RECENT YEARS, THE THEORY'S ADHERENTS HAVE ACHIEVED NATIONAL ATTENTION.

Kaiser Permanente's 1995-1997

ACE's research showed the real-people, real-time effects of the "poor early experience" that that Wilkerson and Marmot warned about. It identified specifically how biology itself could be warped, and it quantified the impact on an "individual's biological and human capital." SDOH and ACEs form a confluence in which the impact of critical social circumstances and early developmental insults can be seen on both individual and population. Together they imply that treating individual and discrete disease states without reference to early quality of life and general social circumstance is like building sandcastles at the edge of a stormy sea.

Sandcastles aside, policy-makers still had to accommodate real-world political considerations as they designed the revolutionary policy initiatives to pursue Triple Aims; however, the Department of Health and Human Services has been consistent in its intent to expand the definition of health care to include behavioral health:

> The Affordable Care Act will provide one of the largest expansions of mental health and substance abuse disorder in a generation. Beginning in 2014 under the law all new small group and individual market plans will be required to cover the Essential Health Benefit categories, including mental health and substance disorder services, and will be required to cover them at parity with medical and surgical benefits. The Affordable Care Act builds on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008….[21]

Among the New York State Medicaid Reform Team's ten work groups are the Behavioral Health Reform Work Group, and the Social Determinants of Health Work Group. In August, 2014, the state's Delivery System Reform Incentive Program (DSRIP) initiative laid out its strategy in a draft "toolkit":

> To transform the system, DSRIP will focus on the provision of high quality, integrated primary, specialty, and behavioral health care in the community setting….[22]

If in 2003 and 2007 we wanted mental health care to be treated as part of health care, then we appear to be advancing in the right direction. But although the system has been re-conceptualized and redesigned, it has not yet coalesced into a working model. That coalescence may take years, as a Kaiser Family Foundation description of our current situation implies:

> The behavioral health system…in the United States is financed through multiple sources. These include states and counties, the federal Medicaid program, private insurance coverage, patients' out-of-pocket expenditures,

THE BEHAVIORAL HEALTH SYSTEM…IN THE UNITED STATES IS FINANCED THROUGH MULTIPLE SOURCES. THESE INCLUDE STATES AND COUNTIES, THE FEDERAL MEDICAID PROGRAM, PRIVATE INSURANCE COVERAGE, PATIENTS' OUT-OF-POCKET EXPENDITURES, AND A HOST OF SMALLER PUBLIC AND PRIVATE PROGRAMS. THE VARIOUS FUNDING SOURCES FORM A COMPLEX PATCHWORK OF PROGRAMS, EACH WITH PARTICULAR ELIGIBILITY RULES AND BENEFIT PACKAGES. THE COMPLEXITY OF THESE PROGRAMS CHALLENGES POLICYMAKERS' ABILITY TO UNDERTAKE REFORM IN MENTAL HEALTH POLICY.

Kaiser Family Foundation

> and a host of smaller public and private programs. The various funding sources form a complex patchwork of programs, each with particular eligibility rules and benefit packages. The complexity of these programs challenges policymakers' ability to undertake reform in mental health policy.[23]

The important words about behavioral health in ACA, MRT, and DSRIP documents constitute an almost unimaginable leap forward in a relative nanosecond on the clock of public policy. The very speed of the advance may constitute a problem. Establishing fundamental conceptual understanding in the hearts and minds of the many stakeholders will take generations. Demanding or even legislating change doesn't make a new reality. One is reminded of Glendower's boast in the Shakespearian history, and Hotspur's deflating response:

> Glendower: I can call spirits from the vasty deep!
> Hotspur: Why, so can I, or so can any man. But will they come when you do call for them?[24]

Calling for true parity and integrated care is a start, but there is a "vastly deep" cultural chasm and a hoary legacy of practice separating the parallel universes of primary medical care from behavioral health, hospitals from community organizations, insurers from providers, preventive services from Medicaid services, government from non-government, government departments from one another, and schools from everything. Should the desired reality ever be attained, great work will have been done to dispel the profound ignorance that exists in every system and attitudes will have been conceived toward collaboration that are without historical precedent.

This great leap forward will call for adjustments by all parties. In exchange for relief from isolation, the child and family behavioral health community will find itself one small entity in a community of many. It has gained admission, but admission as a cadet member; it will struggle to solidify and legitimize its presence. The historic primacy of adult orientation in both medical and behavioral health fields threatens to overwhelm the child and family sector.

THE INSURANCE AND HOSPITAL INDUSTRIES ARE "INTEGRATORS" OF CARE

The third of Berwick et. al.'s "inescapable design constraints" is the "existence of an 'integrator.'"

> An "integrator" is an entity that accepts responsibility for all three components of the Triple Aim for a specified population. Importantly, by definition, an integrator cannot exclude members or subgroups of the population for which it is responsible….That role might be within the reach of a powerful, visionary insurer; a large primary care group in partnership with payers; or even a hospital, with some affiliated physician group that seeks to be especially attractive to payers.[25]

To be effective, Berwick's integrators also require capital, great political influence and enormous pre-existing industrial capability—properties possessed by both the hospital and insurance industries. As designed, neither ACA or DSRIP can work without them, however ambivalent the regulatory language may be. In the very first paragraph of its first Title the ACA makes clear, somewhat famously, that the central position of the insurance agency and the insurance model in modern American healthcare is assumed. In the second paragraph it assures the public that the government will hedge over-aggression in the marketplace:

> For Americans with insurance coverage who like what they have, they can keep it. Nothing in the Act or anywhere in the bill forces anyone to change the insurance they have, period….
>
> The insurance exchange will pool buying power and give Americans new affordable choices of private insurance plans….*It [the ACA] keeps insurance companies honest by setting clear rules*….[26] [Italics added].
>
> —Affordable Care Act, Title I: Quality Affordable Care for All Americans

New York State's 1115 Waiver Partnership Plan, submitted to HHS in order to establish DSRIP, targeted reduction of inappropriate hospital admissions directly. This target indirectly identified hospitals as the organizers of the community providers. The state incentivized hospital involvement in reducing hospital admissions by offering approximately $6 B of the $8 B federal waiver transfer to do the job. The application contained some audacious requests of an industry not historically distinguished by its emphasis on services integration across the community:

> **B. Element 2: Integration Across Settings** The DSRIP will further the transformation of patient care systems to create strong links between different settings in which care is provided, including inpatient and outpatient settings, institutional and community based settings, *and importantly behavioral and physical health providers.* [Italics added]
>
> **C. Element 3: Assuming Responsibility for a Defined Population** The DSRIP projects will be designed in ways that promote integrated systems assuming responsibility for the overall needs of a population…*not simply responding to the patients that arrive at the door of a hospital.*[27] {Italics added}

Once the chimerical notion of a single government payer system had been set aside, the federal and state governments needed industries—i.e., insurance and hospital—with capital, experience, and tactical capability to step into the integrator role. If government expected its new partners to behave now in historically unprecedented ways to attain all three of the Triple Aims, it needed to offer historically unprecedented incentives, and it did. One finds somewhat unsettling, however, that both the federal and state government appear to distrust the power of the incentives alone, and that each felt compelled to add "Dutch uncle" language to its documents (italics above).

Children and families, advocates, and behavioral health providers must acknowledge the new organizational framework while keeping their eyes wide open to the currently under-developed leverage they have within it. The community may then ask what are the specific threats posed to the child and family community, and what are the general directions it might consider?

Children and families will face complex choices regarding their care. They may find themselves involved with concentric provider networks and they will rely increasingly on care managers who may be invaluable guides; however, they may also find themselves involved with more systems and continuing technical glitches before the ACA matures and the DSRIPs consolidate. It is possible that educational, developmental disabilities, and social service sectors will not be effectively attached to the larger health care system following eventual DSRIP cohesion; if so, securing and sustaining essential care for children may still be confusing and disorienting.

Providers will need to adapt quickly to the commercial industry methods that convinced the government that they were the way to achieve at least one of the Triple Aims. Value-based contracting; continual justification of medical necessity; collection, analysis, and application of data; orientation to performance measures; efficient contracting and billing; rapid response to service requests; tight management of administrative costs—every new macro-organizational unit from Health Homes to DSRIPs to Managed Care Organizations will demand these skills from their providers and will shape their provider systems accordingly.

Advocates will need to sustain and expand contacts with actual children and families through peer-provider contact and outreach to individuals. Much of the new design flows from Berwick's vastly helpful concept of "population benefit," but in the end, the lens of population will not suffice by itself. We will always need to know what happens to individuals, and we will always need to inform the ultimate payer—i.e., the taxpayer—exactly what is happening with his/her money.

Advocates must also be preparing for the second wave of healthcare reform, which will begin when the newly-designed systems have been in place long enough for us to see what must be fixed. Of special importance will be the premiums based upon the actuarial work performed by the state's contractor, Mercer. Mercer has been engaged by the state to evaluate spending and utilization history to inform the movement of all children's Medicaid services to managed care. This analysis will be essential for both MCOs and providers, and yes, for children and families in determining whether access to quality care is sufficient, transparent and practical.

ALL CARE IS MANAGED

THE BALANCED PURSUIT OF THE TRIPLE AIM IS NOT CONGRUENT WITH THE CURRENT BUSINESS MODELS OF ANY BUT A TINY NUMBER OF U. S. HEALTH CARE ORGANIZATIONS.

Berwick

Federal and New York state governments have chosen to use commercial organizations as central agents in health care reform and the pursuit of the Triple Aims. The only alternative was to build a government single-payer system from the ground up. The practicality of that dubious proposition was never to be tested, however, given the utter impossibility of the political situation. Thus, the first and most profound decision was made to access the capital, technology, and capability of the commercial sector and its powerful methodology, managed care. The first and most profound challenge for the government would be creating incentives to induce the commercial sector to participate in an expansion of service that would, in the case of Medicaid, eventually involve customers who could not afford the product. Berwick memorably describes the situation:

> The balanced pursuit of the Triple Aim is not congruent with the current business models of any but a tiny number of U. S. health care organizations…. Thus, we face a paradox with respect to pursuit of the Triple Aim. From the viewpoint of the United States as a whole, it is essential; yet from the viewpoint of individual actors, pursuing the three aims at once is not in their immediate self-interest.[28]

Why would it be worth making the Triple Aim congruent with commercial business plans? The reasons are several and powerful. Pre-recession, as we have seen, the government's Medicaid system finances were unhealthy and deteriorating. Post-recession they were self-evidently unsustainable. Simply put, the government had failed as a manager of Medicaid while commercial sector plans were operating successfully. The commercial sector was financially equipped to carry risk; its competitive environment was driving was driving quality up and cost down; and it was possessed of a tried and effective basic methodology—managed care.

To some, New York's choice of managed care as its fundamental methodology appears to be working. The Commonwealth Fund compliments New York specifically in its 2014 scorecard report on state health systems, a document that is anything but complimentary in general:

> In most states, performance worsened on almost as many indicators as it improved. A few states stand out for achieving the greatest net improvement across indicators: Colorado, Maryland, New Hampshire, and New York.[29]

The Department of Health, in its September 2012 Update, asked itself: "Are we lowering costs and improving outcomes?"[30] The answer was "yes," and with respect to cost the Team said of itself: "The MRT is beginning to really bend the cost curve." The MRT believed that it saved $4.6 B over projected estimates of cost without MRT intervention, and reported that it came in $4 B under the previous year's expenditure during Year One while finishing and $200 M below the Global Spending Cap in Year Two—and this, despite an increase in state Medicaid recipients from 4.266 M in 2003 to 5.578 M in 2012. How? Per capita expenditure declined three years in a row, leaving it at its lowest total since 2006.[31] With respect to quality, the National Council on Quality Assurance offers the state faint praise overall, but singles out the Medicaid Managed Care program as excellent:

> New York is exemplary in many ways, but does not have the highest quality in the country, or even the Northeast….Medicaid HMOs were the best in the state, outperforming commercial HMOs and PPOs, as well as Medicare HMOs and PPOs.[32]

The watery quality of NCQA's endorsement notwithstanding, there can be little doubt that New York has managed its transition to managed care with good effect—so far—particularly with regard to children. Virtually the entire child population now has health care coverage of one sort or another, the integration of children into managed care is being phased in carefully, and the state has made extraordinary efforts to prepare for Health Homes that may offer specialization for children. Unlike the NCQA, which in its annual report[33] does not have a section for behavioral health--much less one for children's behavioral health-- the MRT specifically declares its intent to "address the unique needs of children and families,[34] and assures that "the children's design is still under development."[35] This is as it should be: the number of arrangements under which children's services currently receive Medicaid funding is enormous; the details of those arrangements are often bewildering; and the systems within which the services occur are numerous and disconnected. To the extent that DOH has taken a "first do no harm" stance in the matter of migrating children's health services into managed care, we are grateful.

Traditional providers of children's behavioral health services will be embracing profound change by January 2016, the date at which DOH currently intends to have all children's Medicaid services under managed care. Simply stated: The providers will have new paymasters. The state's role will diminish, and except in instances where nonprofit "middle men" develop to stand between providers and the MCOs, providers will find themselves with partners whose business world has little in common with the nonprofit sector. Providers and Medicaid care recipients will need to recognize and adapt to fundamental changes:

- MCO heart's-blood connections are to specific contracts rather than to general missions. They are at existential risk to produce particular service in volume at a specific price with a particular level of quality in a highly competitive environment. Nonprofits that will work successfully with the Medicaid MCOs will understand the MCOs imperatives and incentives; those that do not may be of little use to the MCO in time.
- Care management is at the core. Nonprofits used to working in terms of "programs" will need to become skilled at care management; they will be responsible for the measured outcome of a comprehensive health care plan rather than for demonstrating they have faithfully executed the defined tasks of a particular service.
- Nonprofits will generate data for three reasons: to prove they are in accord with Medicaid requirements; to allow MCOs to prove to the government that the MCOs have executed their contracts capably; and to improve continuously their own performance as subcontractors so that they can show MCOs they are valuable partners in an increasingly competitive environment.
- Nonprofits—and the families they serve—will need to become adept at negotiating with MCOs at the micro-level of medical necessity and appeals, and at the macro-level with respect to rates and contract demands.

- Nonprofits will need to learn not to expect Medicaid MCOs—or commercial MCOs, for that matter—to fund the difference between a contact and the nonprofit's mission. Nonprofits will need to find other resources to cover long-term capital needs and those services, that are supported by all the research, that they believe are important to child health and wellness, but that are, at least temporarily, not currently measurable in managed care terms.

If the great bargain between the government and the insurance industry holds, nonprofits and families will certainly accommodate themselves to the new reality over time. But the question now is: will the bargain hold? That is, will corporations whose operational revenue and profit derive from selling expensive and sophisticated products to consumers who can afford them, continue to participate in a model in which they sell those same products to people who cannot? Is the state's Medicaid "checkbook" big enough to keep insurers on board? Will the plans sit still while the state says that it "captures shared savings by lowering managed care payments as costs decline?"[36] Can the state force "managed care organizations to develop plans for shared savings with their provider networks?" and at the same time "ensure these agreements are enforced?"[37]

It is too soon offer definitive answers, but there are some troubling signs apart from the MRT's reports of early cost savings and improving quality. The Healthcare Payer News reported the departure of BlueCross BlueShield of Western New York from the state's managed care program in July 2014:

> "The premium dollars we receive from the state continue to be insufficient to cover the medical and pharmacy claims we pay for our members' health care" wrote Steven Swift, executive vice president and chief financial officer of BlueCross BlueShield of Western New York.
>
> HealthNow New York's other insurer, Blue Shield of Northeastern New York, stopped participating in Medicaid managed care back in 2007. Last fall Excellus BlueCross BlueShield decided to end the Medicaid program in 25 counties, continuing in just four counties…after posting a $100 million loss on the program in the 2013 fiscal year alone.
>
> As BCBSWNY's Swift put it, the company was "faced with an unsustainable model that left us no choice but to proceed with a responsible exit."[38]

Swift's use of the phrase "unsustainable model" calls to mind Berwick's observation about the paucity of companies with business models that might be congruent with the Triple Aim.

In worst case scenarios, particularly upstate, MCOs face an insurance nightmare: a concentration of high-need, high-cost members with few low-cost members to reduce per capita average expenditure; relatively few members per square mile, and a small n of providers to populate a robust network. Economies of scale cannot be developed for small populations, and losses mount.

Should these MCO defections prove to be a trend rather than just a natural early-phase shakeout, there will be will be several consequences, none of which are good. For poor families, the departure of an MCO leaves them again alienated from the health care system, as many had been prior to the advent of Medicaid managed care. Presumably any "responsible" exit plan will have provisions for re-connection, but the experience would be daunting and it is hard to see how anything positive could emerge for a family dealing with a seriously handicapped child. Perhaps more disturbing might be the tactics that could be employed by a company struggling to stay in business while in deep financial stress. Excessive claims denials and downward pressure on rates could do harm to many individuals and to providers of services in that twilight time just before a company chooses to exit responsibly.

In an alternative scenario, the difficult circumstances could whittle down the number of participating MCOs, leaving those that remain holding a very strong hand across the table from government, which may have no choice but to throw money at the survivors in order to keep the services running, its role as selective manager compromised by an absence of choice. Similarly, competition driven by member choice, so potent a force in driving commercial quality and cost reduction, may be fatally diluted in the Medicaid Managed Care system as the patients are less able to "vote with their feet" and demand an alternate plan.

Providers are on the other side of the financial equation. Will there be enough money to sustain the interest of the MCOs and at the same time enough to allow providers to cover overhead while maintaining an adequately, evidence-based-practice-trained and decently-paid workforce? When the old government rate system and its various cost-centers and its cost-based rate setting methodologies are withdrawn, will MCO subcontracting suffice to cover daily operational costs and capital development and upkeep? There are concerns that that DOH cost analysis, under development for children's services by Mercer, will be actuarially inaccurate because historic data will not reflect the impact of new services on the utilization of traditional services, e.g. 1915(i)-like services. Initial miscalculations could prove serious and even lethal to a nonprofit provider community that has far smaller financial reserves than its MCO partners. Assuming appropriate rates are eventually established for transitional purposes, it will be incumbent on government to see that the relationship between volume of service per unit of payment is realistic and that it will be honored by MCOs.

PART II:

THE NATURE OF CHILDREN AND FAMILIES: HOW REFORM SERVES AND DOES NOT SERVE THEM

THE PRECARIOUS SITUATION OF CHILDREN AND FAMILIES

The first section of this paper describes a few of the more profound changes to health care since 2003:

- National and state governments recognized the unsustainable nature of pre-recession healthcare expenditure trajectories.
- The definition of healthcare itself has been expanded, and may be now said to include the concept of social determinants of health and the field of behavioral health. This expanded definition has not yet been operationalized and will demand unprecedented care integration.
- Population health is now understood to be a core concept and its attainment the equivalent of a national asset.
- There has been a re-ordering of the concept of healthcare system administration and the initiation of several large-order programs that may fill the role of "integrator."
- Care management is an accepted tool of choice in our pursuit of the Triple Aims.

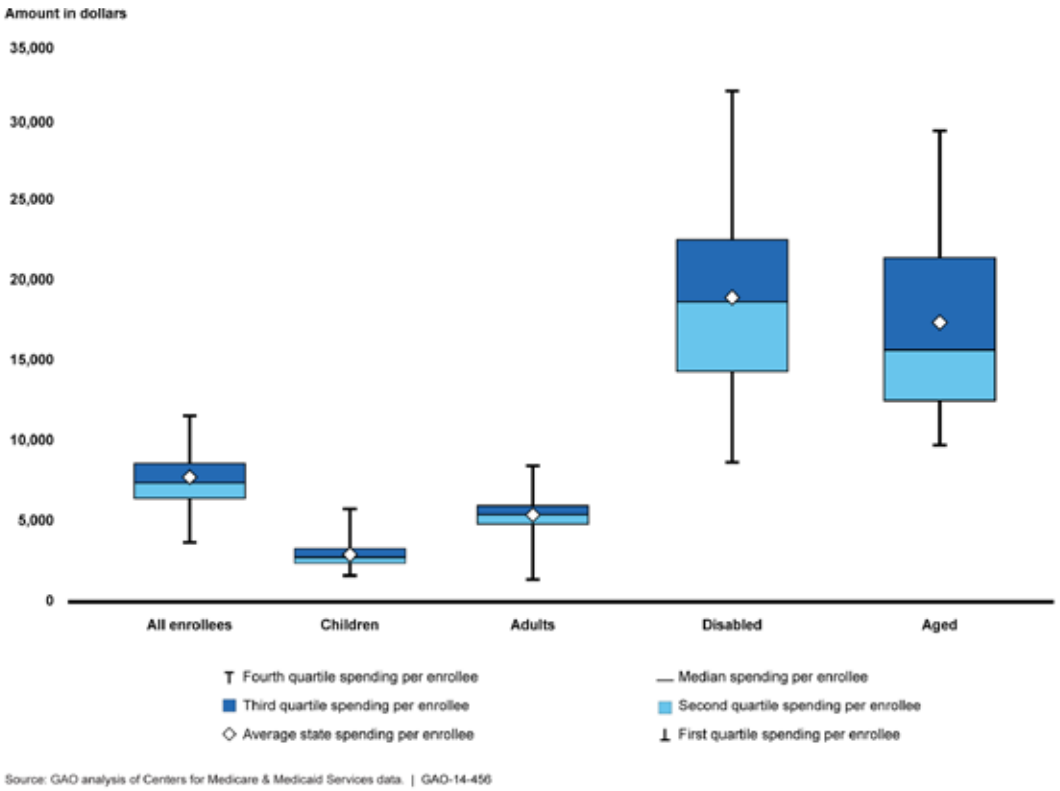
How do these changes affect children and families? What direction exists for children's behavioral health under the various proposed new schemes of organization? Why is this subset of the population so different from the others?

The position of children and families among all these changing parts is precarious.

Child and family health care does not appear to be a "hotspot" of expenditure. Resource does not pool here and there is not much to be saved immediately. In 2011, the national per capita average for an aged Medicaid recipient was $15,931; the average for all Medicaid recipients was $6,982. Children got $2,851 apiece.[39] During the first quarter of 2013, only 11% of New York State's Medicaid expenditures

Chart 1: MEDICAID ASSESSMENT OF VARIATION AMONG STATES IN PER ENROLLEE SPENDING

Estimated State Medicaid Spending per Enrollee, by Eligibility Group, Fiscal Year, 2008



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-14-456

Notes: Spending per enrollee includes federal and state spending on regular Medicaid payments to providers and managed care plans for covered services provided to enrollees as well as Disproportionate Share Hospital (DSH) and non-DSH supplemental payments, but does not include administrative costs. Estimates also do not reflect states' subsequent changes, including adjustments or collections, to the spending originally reported for this year. Enrollment is measured in terms of full-year-equivalent enrollees. Both enrollment and expenditure data include all enrollees, regardless of the scope of benefits offered. We excluded Massachusetts from all calculations and Maine from calculations at the eligibility group level because of errors or omissions in fiscal year 2008 data for these states. Average state spending per enrollee represents the sum of each state's spending per enrollee divided by the number of states. For purposes of this analysis, we include the District of Columbia as a state. Each box in the figure denotes the dollar range for states in the second and third quartiles in spending per enrollee. The horizontal line between the boxes denotes the median, the diamond denotes the average, and the vertical lines extending above and below each box denote the highest and lowest quartile state spending per enrollee.

went to children[40], who at the time constituted 21.6% of the state's population[41]. Chart 1 from the Government Accounting Office graphically represents this disparity at the national level.

Children's behavioral health, in particular, has a similarly modest profile when one is looking at the cost component of the Triple Aim. The Center for Health Care Strategies reported in 2013 that only 10% of the total child Medicaid population was receiving behavioral health care.[42] Similarly, DSRIP instructions did not mention pediatric care prominently, understandable given that pediatric discharges in 2008—with the exception of new-borns—constituted only 6% of the state's total[43]. These are not compelling numbers for a program which has as its principal goal the reduction of hospitalizations.

> Adult Medicaid beneficiaries with chronic conditions…garner considerable attention for state and federal policy makers. Some state reforms geared toward those adults—health home proposals for example—will include children with serious behavioral

health challenges, but often without necessary recognition of the differences between the adult and child populations and appropriately unique care delivery approach:[44]

—Center for Health Care Strategies, 2013

WHAT ONE MEASURES AT ANY GIVEN POINT IN TIME MISLEADS WITH RESPECT TO LONG-TERM OUTCOME. BASING POLICY ON ASSESSMENTS THAT DESCRIBE CHILDREN AS LITERALLY SMALL AND UNIMPORTANT CONDEMNS THE COMMUNITY TO FACING A PROBLEM SET THAT WILL EVENTUALLY BE LARGE, IMPORTANT, AND OFTEN INTRACTABLE.

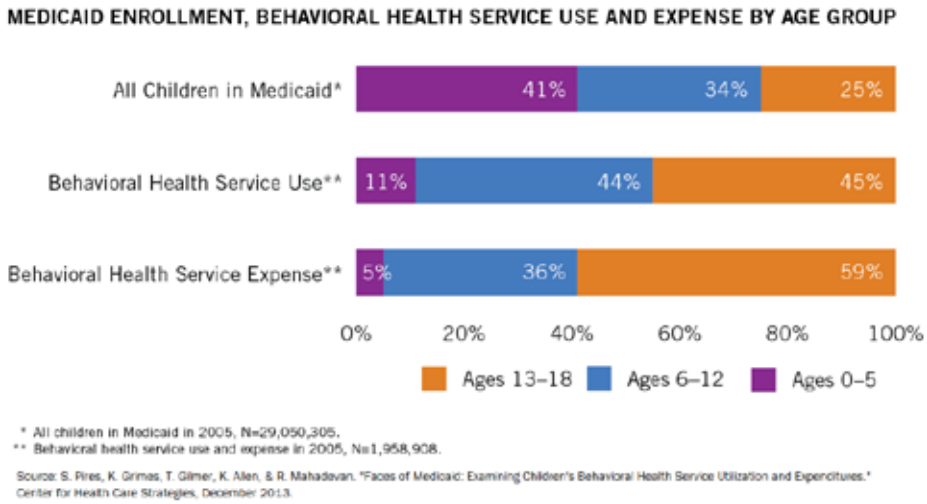
New York State Coalition for Children's Mental Health Services

These superficial assessments of immediate child and family health and behavioral health expenditures are terribly inaccurate for two reasons: they grossly over-value the importance of present-timeframe analysis and fail to calculate impact over longer cycles of return; and they fail to account for vast expenditures hidden in "other systems" (e.g., education, social services, juvenile justice, developmental disabilities, and substance abuse) that are driven by behavioral health needs. We will discuss the "other systems" distortion at more length below and will introduce a concept called "total child spend" that we believe will help us attain a more complete picture of the financial importance of child behavioral health. When we use only "short-cycle" medical expenditure as the ruling measure, we put child and family behavioral health at serious risk of not receiving the attention it merits. But when we look more deeply, we see the long-term and actual significance of childhood health and behavioral health issues.

The chart below gives some indication of how behavioral health issues grow with respect to intensity and cost over time. We can see that although 41% of all children in Medicaid are three-years old or younger, they receive only 11% of all Medicaid-funded children's behavioral health services and only 5% of the MA behavioral health expenditures. Children 13-18 years old comprise only 25% of the MA children's population, but they use 45% of all behavioral health service and account for 59% of the money spent in this area. In all ways, child development is dynamic. Pediatric behavioral health issues metastasize. What one measures at any given point in time

Chart 2: CENTER FOR HEALTH CARE STRATEGIES' CHILDREN'S BEHAVIORAL SERVICE UTILIZATION AND EXPENDITURES

Adolescents, ages 13–18, represent 25% of the overall Medicaid child population, but 45% of children in Medicaid using behavioral health services, and nearly 60% of total behavioral health expenditures.



* All children in Medicaid in 2005, N=29,050,305.
** Behavioral health service use and expense in 2005, N=1,958,908.

Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

Chart 3: ACE SCORE AND INDICATORS OF IMPAIRED WORKER PERFORMANCE

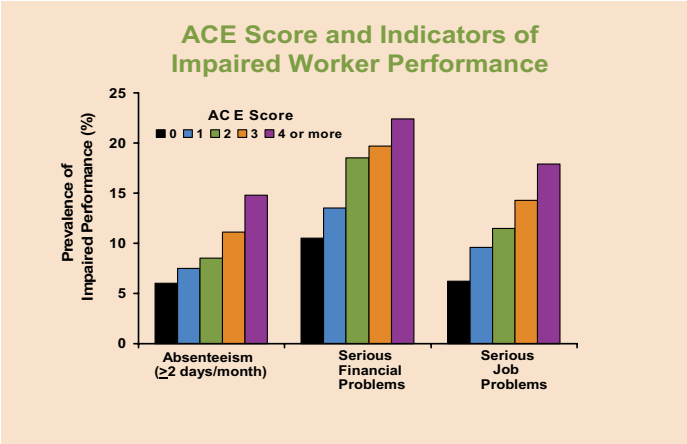
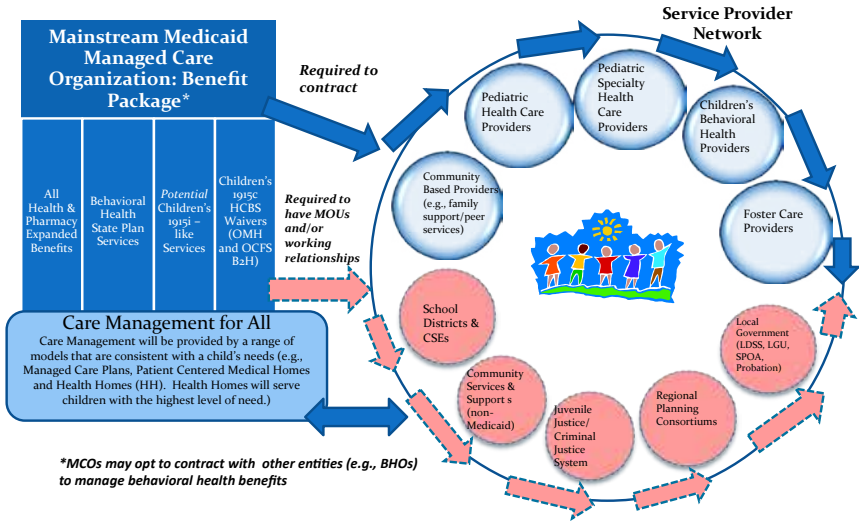


Chart 4: PROPOSED 2016 CHILDREN'S MEDICAID MANAGED CARE MODEL FOR ALL CHILDREN 0-20 YEARS OLD.



misleads with respect to long-term outcome. Basing policy on assessments that describe children as literally small and unimportant condemns the community to facing a problem set that will eventually be large, important, and often intractable.

ACEs research gives us an inkling of "down the road" impact. Chart 3 quantifies the eventual consequences of childhood behavioral health insults as they manifest themselves in adulthood.

To its great credit, New York State has expressed its intention to avoid underestimating the importance and complexity of childhood behavioral health. The New York State Medicaid Redesign Team, in composition and in action, has protected so far the exceptionality of pediatric behavioral health during the Medicaid redesign process. MRT includes, as noted earlier, a Behavioral Health Work Group. That Work Group created a Children's Behavioral Health Subcommittee that has burrowed vigorously into the almost impenetrable thicket of nuance that attends children's behavioral care.

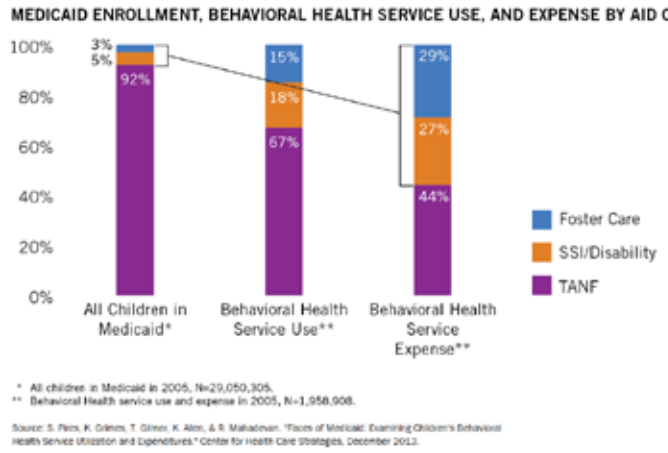
The Subcommittee has contributed heavily to the proposed revision to the State's Medicaid Plan, bringing forward a variety of previously non-Medicaidable services directly aimed at SDOH issues, including the absolutely indispensable family and youth-peer services that have blossomed since 2000. The group's concept and graphic for service design have given structure to additional efforts to create children's health homes while maintaining the highly successful case management and waiver programs (At least initially--the highly successful waivers are to be subsumed into Health Homes after one year, and there is concern that non-Medicaid eligible children will lose access to SCM and ICM waiver services, and that current B2H and HCBW clients will see increased case loads). The MRT has also advanced the difficult job of describing large-scale integrated care to the public.

The Subcommittee's efforts are important and well-directed: the circumstances in which children and families live are unlike those of the rest of the population. Although we will cite additional areas of activity for the Subcommittee's attention later, its very existence and record of accomplishment to date represent exactly that "recognition of the differences" that the Center for Health Care Strategies calls for.

In spite of the MRT's efforts, children and families remain at some serious disadvantages in the larger reformed health care structure.

Chart 5: CHCS FOSTER CARE BEHAVIORAL HEALTH UTILIZATION

Children in foster care and those with SSI/disability eligibility together represent only 8% of the Medicaid child population, but their care accounts for 56% of total behavioral health spending.



Our chief concern as a child and family behavioral health community is that for all their value and promise, the Medicaid reform effort and its insurance paradigm are simply too narrowly focused. From a Medicaid managed care point of view, Berwick's "population" is not New York State's children, but only those eligible for Medicaid. The range of acceptable activity may not address Wilkinson and Marmot's "biological and human capital" that will determine lifetime health care status, but is instead a list of acceptable services as determined by a limited list of contractually-approved services.

Deliberations with respect to the foster care population might stand as a material example of our concern. Few who know anything at all about child welfare would dispute that a child and family's involvement in that system constitutes proof of the need for behavioral health assistance. The long-standing conditions (i.e., social determinants of health) and the specific insults supported by those conditions (i.e., ACEs) that drive children and families into child welfare are manifestly health issues, not legal issues. Differentially high utilization of behavioral health services by children in foster care confirms this assessment.

The involvement of adults and children in the child welfare system is an irrefutable signal that the current health of those individuals is in jeopardy, and the quality of the lifetimes before them is at stake. But that signal alone does not constitute eligibility for Medicaid. Our struggles to include the foster care population in managed care evidence the dilemma.

This difficulty is hardly the fault of state officials who, across bureaucratic borders, have been perceptive, creative, and energetic in their attempts to expand Medicaid eligibility and to alter the state Medicaid Plan to fund a broader range of supportive and clinical activities. It is to say, rather, that Medicaid reform and the insurance managed care paradigms themselves will not allow us to do all of what we know must be done.

WHERE MANAGED CARE MIGHT PINCH

There are at least five specific "classes" of problem that may grow up for children in a completely managed care system.

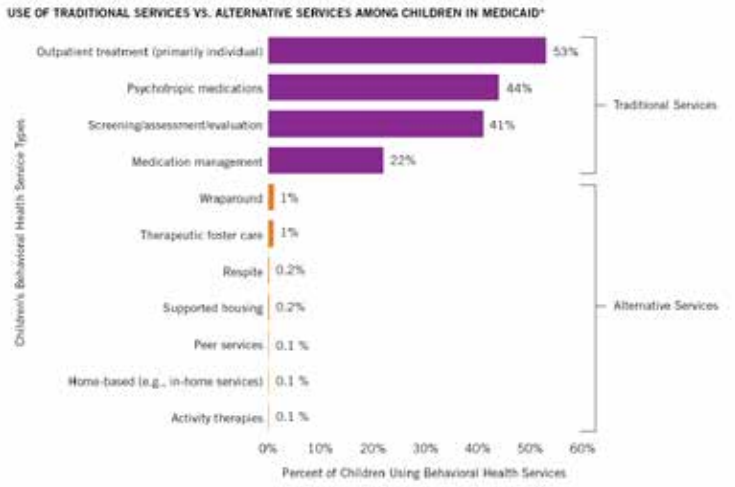
1. The decision to apply an insurance paradigm to public funding of health care is logical when political, financial, and technical factors are all weighed, and that

paradigm may prove to be well-suited to grappling with massive questions of financial sustainability. But it may also be at variance with the central agenda of childhood—i.e., growth and development—with the "cycle of investment" that childhood requires, and with the importance of early response to childhood disorders that have the potential to become expensive adult disease states.

Very simply described, a health insurance "experience" involves a temporary deterioration of an individual's health status, the application of specific remedies, and restoration of the original status. This is for the most part a transaction conducted in the present tense.

Chart 6: CHCS USE OF TRADITIONAL SERVICES VS. ALTERNATIVE SERVICES

Children in Medicaid are more likely to receive traditional behavioral health services, like outpatient treatment and psychotropic medication, vs. alternative approaches with an emerging or established evidence base.



Children's health status is certainly a present tense affair, but the growth and development agenda—and its furious pace in the earliest years—will be stunningly consequential for lifetime of the individual and for the community throughout that lifetime. Positive contributions must be made as early as possible to growth and development, and they must be continued for some time to overlap successive phases of development. Increasing "positive contributions" will be difficult because there is little precedent for them in the child Medicaid funding history. Spending has traditionally supported outpatient therapy and psychotropic medication rather than alternative, strength-focused services.

Contributions of this sort are additionally difficult to provide in a Medicaid-insurance model, in which something demonstrably bad must happen in order to justify expenditures for remediation. Even obviously harmful events, e.g., those ten kinds of "adverse experiences", may be difficult to identify as extant disease states. Witnessing an episode of domestic abuse, living in a household with an adult substance abusers or incarcerated parent—these things have powerful long-term health consequences but are not "coverable" per se.

Robert Anda addresses these phenomena in describing the effects of Adverse Childhood Experiences:

> The effects of ACEs are long-term, powerful, cumulative, and likely to be invisible to health care providers, educators, social services organizations, and policy makers because the linkage between cause and effect is concealed by time, the inability to 'see' the process of neurodevelopment, and because the effects of the original traumatic insults may not become manifest until much later in life.[45]

Anda specifies the adult disease states that have been associated with ACEs—ischemic heart disease, cancer, chronic pulmonary disease, the poor mental health, and the damaged sexual and reproductive health—and ascribes to them a measurable reduction of national worker productivity.[46] If a broadly defined integrated health care system cannot effectively assist family caretakers to protect and nurture young children, the financial penalty down the line will be heavy.

2. The "cycle of return" for investments in children can be very long, as any parent knows. Decades can pass before all that is provided to a child in the form of protection, nurturance, material support and education returns dividends to the many investors who are necessary to raise a child to productive maturity. It is unfair to expect commercial corporations with boards of directors, shareholders, and much shorter cycles of return based on quarterly reports and annual budgets to enthusiastically invest cash in early education, home visiting, recreational programming and cross-sector administration, and yet that is exactly what must be done, and in volume. Money "saved" in the future by these developmental contributions is real and significant, but it is not reflected on balance sheets and cannot be used to offset actual debts. Companies cannot invest resource in expectation of returns that will not be realized for 20 years and which, when they do come, will almost certainly benefit the community at large but not the specific financial entity that made them. But if we intend to integrate care while improving population health, we will have to account for those developmental contributions. Some stakeholder will need to fill needs that an insurance-oriented model cannot.

IF A BROADLY DEFINED INTEGRATED HEALTH CARE SYSTEM CANNOT EFFECTIVELY ASSIST FAMILY CARETAKERS TO PROTECT AND NURTURE YOUNG CHILDREN, THE FINANCIAL PENALTY DOWN THE LINE WILL BE HEAVY.

New York State Coalition for Children's Mental Health Services

3. We also know that children grow best in families. Children are legally and literally dependent. They are anything but independent consumers.

   Medicaid managed care model may not be sufficiently supportive of the child's unique and indispensable and unique context.

   When families function well, there is no better instrument of protection and nurturance for their children. When families are overwhelmed by poverty, substance abuse, mental illness, social isolation, or the burden of caring for children with outstanding medical or developmental disorders (e.g., rare genetic disorders, developmental disabilities), there is great risk that impaired physical and behavioral health profiles will diminish the lifetime of the child, deprive the community of a future productive citizen, while at the same reducing the immediate productive capacity and mental health of other family members. When children are without obvious family resources, providers must make every effort to locate available supports, using Family Team Conferencing or Family Find-type methodologies.

   Families themselves must be directly supported in the interests of their children's health care status. The Annie E. Casey Foundation reports that New York State has made excellent progress with respect to child medical insurance, with only 4% of the state's population uncovered—but the same report only ranks New York 37th in the nation with respect to family and community strength.[47] Providing the resource to pay for care is not the same thing as providing care.

Having health insurance does not guarantee professional attention. A child does not track his medical encounter schedule, make his own appointments, drive to examining offices, ask follow up questions, and execute a treatment regime. Adult caretakers do these things—that is, if they are not so overwhelmed by social determinants, their own socio-medical conditions, or intensity of child need so much that they are unable to function properly.

THE ANNIE E. CASEY FOUNDATION REPORTS THAT NEW YORK STATE HAS MADE EXCELLENT PROGRESS WITH RESPECT TO CHILD MEDICAL INSURANCE, WITH ONLY 4% OF THE STATE'S POPULATION UNCOVERED—BUT THE SAME REPORT ONLY RANKS NEW YORK 37TH IN THE NATION WITH RESPECT TO FAMILY AND COMMUNITY STRENGTH.47 PROVIDING THE RESOURCE TO PAY FOR CARE IS NOT THE SAME THING AS PROVIDING CARE.

Anne E. Casey Foundation

We urge that even more consideration be given to families as we finalize the transitional phases of managed care. We have as yet heard nothing on the children's side comparable to the extraordinary investment into expanded housing for adult Medicaid recipients. Children cannot be served alone. When we look at a child, we must never fail to see as well the two or five or ten caretakers around him, his community, the capability of his school to accommodate his needs and his access to social supports. A child and families' health care status and general well-being is as important to a child's health as is the presiding managed care company that administers and pays for services that administers and pays for services.

We in New York can be proud of the progress we have made with waivers and with case management programs, both of which have developed in the past decade. We have high hopes for the growth of children's health homes as vehicles for the provision of support to families facing the most difficult situations. As noted above, we are enthusiastic about the inclusion of family and youth peer services in the State's forthcoming Medicaid Plan submission to the Federal government and heartened by the existence of an MRT Subcommittee for Children's Behavioral Health—although we might have wished for status as a full Workgroup. We urge policy makers to continue the development of these forms of support to children's families, to recognize them as necessary adjuncts to an insurance-oriented system that cannot be expected to invent and sustain such tools itself.

Families are simply the first and best behavioral health asset that a child can have.

4. The insurance model—both Medicaid managed care and commercial—is unlikely to address the problems of youth that do not rise to the level of medical necessity. Children who are not Medicaid eligible might be overlooked entirely. One might plausibly make the case that the legions of youth in education programs for the emotionally disturbed are in fact behavioral health care patients, despite the fact that many are receiving no behavioral health care per se. Youth in social services' prevention programs, others in family foster care, still others in probation—all with justifiable claims to behavioral health service, but all at risk for being missed in a straight insurance care model.

5. The fifth potential problem for children is a powerful threat to the concept of integrated care. It is rooted in the large number of legacy public systems in which children find themselves, and in the relatively disconnected nature of those systems. Children may be and often are at the same time receiving services from schools, social services agencies, behavioral health providers, developmental disabilities systems, juvenile justice departments, and substance

abuse care givers. The various services may be sponsored by federal, state, county, or even municipal governments. It is possible that before a child reaches age 5, he or she may have been in preschool services offered through the Federal government (Head Start), in county social services (subsidized daycare and family preventive services), and in a local school district (UPK).

Pity the well intentioned MCO managed care coordinator or a health home care manager who must try to knit all this together so that the application of a child's behavioral health care benefit operates within an integrated care plan. Pity the poor Committee on Special Education Chair who must craft behavioral supports as part of a school IEP while managed care behavioral supports are being provided to the same child outside of the school and without reference to it. Pity the poor family that is pin-balled from one treatment planning session to the next, rarely seeing the same coordinator twice.

Robert Anda directs us toward the elephant in the room with his commentary on categorical care:

> Categorical approaches to the individual ACEs as well as the health and social problems strongly related to them tend to be 'siloed'…the professions, research priorities, organizations, and resources that are necessary to healing frequently exist in 'siloes'—separate, often competitive rather than collaborative entities, each preserving and advancing the resources and work that is historically 'theirs."[48]

We wonder if the tangled jurisdiction and responsibility in children's services might frustrate the achievement of an integrated and enlarged model of healthcare. Might not the bureaucratic demarcations that were sensibly set down in the 19th century be handicapping good people with outstanding talent from achieving an important vision in the 21st?

Consider education, a principal social determinant of child health. The New York State Education Department is separated from the other New York State offices; staff report to the Commissioner and the Board of Regents, not to the Governor. There are currently 698 school districts in the state and 37 BOCES districts.[49] The number of boundaries within the educational system is bewildering, and the problem grows when the task is connecting the work of outside services with those offered inside of schools.

The Medicaid School Supportive Health Services Program (SSHSP), for example, uses Medicaid funds to "provide[s] an array of services beyond traditional education services, the aim of which is to ensure that students are fully able to participate in the school environment."[50] Note that the statement of purpose refers directly to the educational environment and not to the student's health care status or health care plan. This is understandable: the direct mission of schools is not to address health care but to transmit information and community values while supporting individual growth and cognitive development. But in fact, schools cannot succeed if students' health status is impaired. Schools know this and address health care in a variety of ways, some funded by Medicaid, many not, few if any by commercial health care, and none easily included as part of an integrated plan of service.

The differences between the educational and medical systems are profound. The Affordable Care Act strives to make health care available to all, irrespective of health care status, for the first time in the country's history; the Individuals with Disabilities Education Act has attempted to do the same thing with respect to education since 1975. The two acts define culture and practice within their respective worlds, but there is no direct connection between the two. It is almost impossible to imagine meaningful accommodation between the systems, even in the interests of integrated care and cost control.

More specifically, we wonder how a single school will relate to the policies and procedures of multiple MCOs, or to commercial plans in the interests of its students' behavioral health; similarly, it is hard to see how an MCO or commercial plan coordinator will collaborate effectively with all the many different schools its members attend. What avenue will develop to allow for services to be delivered in schools and coordinated with a health care plan?

In practice, the number of individual arrangements between schools and health care partners—physical and behavioral—has been inspiring. Federally Qualified Health Care Centers, non-profit agencies, hospitals, and numerous school districts have recognized the importance of the educational venue as a site for the provision of health care, based on the intensive involvement of children and families in that enormously important social institution. Partnerships involving the establishment of school-based clinics and jointly–operated grant funded programs are blossoming, although too often in spite of the state of coordination among child-serving systems, rather than because of it.

The education/health care system link is just one example of detachment among child-serving systems. These disconnections are the source of profound problems: they completely hide the total cost of governmentally-sponsored health care for children by sequestering expenditures in a variety of separate budgets; they constitute in their current state an almost insuperable challenge to the integration of children's health care; and they maintain a long list of inappropriate categorical descriptors for what are actually health care issues.

> From our point of view, the children's "population" being addressed in health care reform and in the pursuit of the Triple Aim can only be the population of all children in the state, not simply those who qualify for an expanded definition of Medicaid eligibility. And if that is the case, then when we consider relevant expenditures and cost controls, we must look at more than Medicaid and hospital activity. We must instead consider the "total government child spend;" that is, all health-related expenditures, including those supported by Medicaid funding but also by those that sustain Early Intervention, special education, out-of-state placements by various state agencies, juvenile justice, county social services' preventive activity, and substance abuse services. Only then will we have a clear understanding of the enormity of our current expenditure for children's health care, and only then will we begin to consider seriously health care integration for the population.

FROM OUR POINT OF VIEW, THE CHILDREN'S "POPULATION" BEING ADDRESSED IN HEALTH CARE REFORM AND IN THE PURSUIT OF THE TRIPLE AIM CAN ONLY BE THE POPULATION OF ALL CHILDREN IN THE STATE, NOT SIMPLY THOSE WHO QUALIFY FOR AN EXPANDED DEFINITION OF MEDICAID ELIGIBILITY. AND IF THAT IS THE CASE, THEN WHEN WE CONSIDER RELEVANT EXPENDITURES AND COST CONTROLS, WE MUST LOOK AT MORE THAN MEDICAID AND HOSPITAL ACTIVITY. WE MUST INSTEAD CONSIDER THE "TOTAL GOVERNMENT CHILD SPEND;" THAT IS, ALL HEALTH-RELATED EXPENDITURES, INCLUDING THOSE SUPPORTED BY MEDICAID FUNDING BUT ALSO BY THOSE THAT SUSTAIN EARLY INTERVENTION, SPECIAL EDUCATION, OUT-OF-STATE PLACEMENTS BY VARIOUS STATE AGENCIES, JUVENILE JUSTICE, COUNTY SOCIAL SERVICES' PREVENTIVE ACTIVITY, AND SUBSTANCE ABUSE SERVICES. ONLY THEN WILL WE HAVE A CLEAR UNDERSTANDING OF THE ENORMITY OF OUR CURRENT EXPENDITURE FOR CHILDREN'S HEALTH CARE, AND ONLY THEN WILL WE BEGIN TO CONSIDER SERIOUSLY HEALTH CARE INTEGRATION FOR THE POPULATION.

New York State Coalition for Children's Mental Health Services

PART III:

THE NYS COALITION FOR CHILDREN'S MENTAL HEALTH SERVICES RECOMMENDATIONS

CONCERNING IMPLEMENTATION OF MANAGED CARE

a. NYSDOH prepare for an extended and active oversight role during and after the implementation of Medicaid managed care. Government is the absolutely essential "clutch" between the engine of managed care and the families and children in Medicaid. In the absence of a "normative" economic relationship between producer and consumer, government must provide the incentive and the business environment that makes corporate success feasible. It must also, in the words of the Affordable Care Act, keep the MCOs "honest;" i.e., assure that despite pressures on corporations, those corporations will give providers rates and working agreements that make their success possible, while assuring continuing improvement in the health care status of children and families;

b. An extended transitional phase—up to five years-- be set for the establishment of Medicaid managed care rates for children. This extended period will allow actuaries to develop accurate data regarding the costs of newer services (e.g., mobile crisis teams, peer supports, respite services, high fidelity wraparound care, etc.) before setting rates;

c. DOH consider alternative funding practices for children's Medicaid managed care, similar to the "episode of care" approaches being explored in Massachusetts, Idaho, and Rhode Island [Suzanne Fields, MSW, University of Maryland School of Social Work]. Episodes of care payment, as opposed to payment for delivery of approved services in the context of a treatment plan, may prove more suitable to extended growth and development phases so important to the development of child health status;

d. State government intensify its support to county and regional entities that have traditionally supplied preventive and enrichment services to children and families. These services should be recognized increasingly as indispensable components of children's health care even though they lay beyond the purview of managed care. Coordination between—and mutual planning by—state and counties will be an important pathway;

e. Government re-calculate its own needs relative to oversight of the managed care system as opposed to those it had when it was regulator, direct care provider, and sole payer in pre-recession Medicaid system. Letting go of old regulations and changing old expenditure patterns will be essential if there is to be enough resource to go around. Government cannot charge MCOs with controlling costs or demand service efficiencies from providers, while at the same time maintaining or even increasing what appears to be expensive micro-management. Only government can re-design itself in this respect. It alone has the power;

f. The Department of Health introduce the concept of "total child health care spend" and convene an empowered, cross-governmental group that can quantify this "spend" and integrate its application. Looking only at Medicaid expenditure and hospital-based expenditures to determine the relative importance of children's primary and behavioral health is misleading in the extreme; in fact, schools, school-funded residential placements, juvenile justice, county social services, substance abuse programs, and a plethora of Early Intervention program models are all part of the children's health care effort and are all essential. The combined expenditure is enormous, and the consequences of inefficiency and effectiveness over time are staggering. We understand the extraordinary implications of such a sweeping recommendation, but we really cannot understand the task of reform in children's health care without pointing directly to this situation. The bureaucratic structure is to serve the mission, not the other way around;

g. A multi-state office, multi-sector, multi-stakeholder work group be convened to consider options for revising licensing, certification and mandates in order to advance the Triple Aims. Licensing, program and professional staff certification, and services mandates will be powerful considerations for government. They have the potential to insure quality health c or to drive up costs unnecessarily. Decisions made concerning social work and medical licensure along with corresponding scope of practices will be critical. Program mandates and oversight regimes prevalent prior to the recession may be unsupportable and counter-productive now. Services developed according to government specifications (e.g., children's RTFs) could be retrofitted for use by both commercial insurance and Medicaid managed care, assuming that operating regulations and the process of continuing recertification can be managed for effect and economy;

h. The state consider expansion of the Social Investment Bond project on a scale that may be more accessible to providers, and also consider other financing mechanisms that are used to finance infrastructure (e.g., highways, water systems, medical research, etc.) over longer periods. Managed care is a proven method for the management of operational expenditures but offers no means

of providing for the long-term investments necessary to account for the 15-20 years worth of investment in a child that is necessary to build a solid health care platform for an adult individual. MCOs cannot be expected to contribute to capital projects for providers, housing for families, or employment preparation programs, yet all these services and more are essential in opposing negative social determinants of health care. Government must be prepared to incentivize and support long-term development of science, research, technology, training, and direct service when the natural marketplace does not;

i. Individual providers who depend on Medicaid for any part of their revenue—with the assistance of their trade groups and partners—develop tool kits and expertise for competent participation in managed care. Providers must familiarize themselves with the imperatives and incentives faced by MCOs so that the providers can make themselves valuable partners. Providers must understand that MCOs are compelled to behave as commercial companies, not as nonprofits themselves. The providers will hone new skills in referral management, establishment of medical necessity, appeals, billing, and documentation;

j. All parties consider, given resource limitations and the increase of Medicaid beneficiaries, the most likely source of savings that does not involve client service is management overhead. We recommend that providers consider advantages of scale relative to price for those functions—e.g., billing, accounting, payroll, etc.-- not directly involving client care or clinical process and batching those overhead functions wherever possible. This applies to MCOs and government as well;

k. The government consider the challenges of rural service as a separate topic, and consider the creation of specific subsidies to MCOs and rural providers in order to achieve the goal of equity of service for all citizens. The difficulties attending equitable distribution of service in rural areas may be more than the natural marketplace can surmount. There is often an inadequate presence of service providers and therefore no services to buy. The cost of travel per unit of service delivered is much higher than in urban areas. The absence of competition drives unit costs up. MCOs will struggle to break even financially on the one hand, and on the other will have difficulty providing an acceptable array and quality of service; and

l. The government take an active role in the identification and deployment of relevant technology. Potential areas of attention:
   - Centralize and standardize data collection and improve accessibility across state offices.
   - Insist that MCOs and Health Homes standardize data sets and be able to accept data from a wide set of provider IT systems. Without previous agreement on ECR models, the demands of multiple recording and transmissions formats are wasting untold amounts of resource.
   - Create the capability at the state level to review and identify "best practice" versions of new client-centered technology—e.g. new apps that connect "circles of caring" for individual clients
   - Return to the entire field results and conclusions deriving from the analysis of any particular component of health care activity. The amount of data available relative to children's health care through DSRIPs, MCOs and Health Homes will be unprecedented; analyzing the entirety this data and turning it into actionable best practice recommendations will be something best done by state government.

THE NYS COALITION FOR CHILDREN'S MENTAL HEALTH SERVICES RECOMMENDATIONS

CONCERNING THE SUPPORT OF CHILD GROWTH AND FAMILY INTEGRITY

a. The concept of family centrality infuse continuing policy and network development. Positive adult health status for children depends in the first instance on the integrity and capability of the family. The ideal child behavioral health care system would identify and support families as care managers wherever possible, utilizing the practicality and economies that a family-centric system offers. In those situations where family resources do not appear readily available, we urge that methodologies such as "Family Find" be employed to locate individual with care-taking potential for each individual child. We commend the multiple state offices that have recognized the desperate situation of children whose family support has been compromised for one reason or another—e.g., children in foster care, in school-funded residential placement, and in other forms of long term care—and urge government to continue to face the complexity here rather than give in to oversimplification;

b. The entire system—MCOs, providers, commercial insurers, family members and peers, overseeing government agencies—develop coordinated approaches to the reduction of adverse childhood experiences. We believe that the research into the impact of these events on current and future health care status is sound, as are the calculations of enormous added future health care cost. Programs with proven results—such as the OCFS Home Visiting program—can be considered valuable adjuncts to the health care system and should be supported. Teen Screen, an evidence-based alcohol and substance abuse screening and brief intervention service, should be widely available and applied before risk behaviors become life-changing habits;

c. Advances made in this year's state budget concerning early childhood development be redoubled going forward. This progress should include not only the increase of resource devoted to the general area (it should), but also a close study of the current disconnected nature of the service in the state. There are a lot of programs (Early Head Start, Head Start, private daycare, county subsidized daycare, approved home daycare, Universal Pre-Kindergarten, Home Visiting, Nurse Family Partnerships, Youth Development Program, Teen Screen, preventive services and school-based health and mental health services), but they are far from being integrated as such an important influence on social determinants of health might be;

d. The State Department of Education be engaged much more directly and intensively as a partner in the integration of children's health care, including,

of course, behavioral health. The psychological importance of school to child and family and the sheer amount of time children actually spend in schools make it obvious that one cannot address the health care of children without the educational institution. The importance of a child's educational experience as a social determinant of health compels us to link behavioral health and education systemically, rather than leave coordinated work as the occasional result of accident, opportunity, and individual creativity. compels us to link behavioral health and education systemically, rather than as the occasional result of accident, opportunity, and individual initiative . The large number of special education students placed for some form of emotional disturbance, along with the appallingly-low graduation rates in our urban schools, call loudly for the presence of behavioral health services in every district. The proliferation of partnerships between individual districts and behavioral health providers indicates that an intensification of interaction at a systems level would be welcome. Differences between the educational and medical worlds are profound, but we will not ever achieve the goal of integrated care for children without intensive work on the part of each to synchronize with and support the other;

e. Closest attention be given to waiver and care management service approaches as we move forward. We are deeply concerned that case ratios may be sacrificed unrealistically for budgetary convenience. We are highly disturbed by the possibility that members of the child population who are not eligible for Medicaid will lose access to services that have been demonstrably successful We are also highly disturbed by the possibility that members of the child population who are not eligible for Medicaid will lose access to services that have been demonstrably successful;

f. We applaud once again the state's plan to include family and youth peer services in the application to the federal government for a revised Medicaid plan. We recommend that should the federal government refuse peer services as Medicaid-billable items, the state determine a way to fund the services separately. Their practical effectiveness and support of family centrality is immense;

g. We are very aware of the numerous and powerful reasons to delay the inclusion of Developmental Disabilities services into the health care system in these early days of re-design, but recommend that this inclusion be developed as a specific future target. It is at best an awkward fit for an insurance/managed care model, but must be directly addressed before long to make DD services available in a system of relaxed eligibility while still providing for the long term care so man require; and

h. Finally, we recommend that all advocates for health care, behavioral health, and child and family behavioral health prepare themselves for a new day and a new orientation. Many advocacy groups were founded for special groups with limited missions and few connections; all will now be participating in a general system that demands extensive connections, communications, and sharing of resources. The changes underway are too radical and sweeping to be made without error—it will be up to a healthy advocacy community united behind the Triple Aims to tell our New York public what is working and what is not.

PART IV:

CONCLUSION

We had anticipated change eagerly in 2003 and in 2007, well before the international financial crisis that ultimately compelled it. In the event, that change was far greater than anything we might have imagined. It has also presented us with potential that was beyond dreaming 11 years ago.

But fear attends rapid, large order change, and the current revolutionary health care reform transformation is no exception. We are worried that under the enormous pressure to design successful business relationships and to assure universal coverage while controlling expenditure, the special circumstances and needs of children and their families will not be accommodated. We are concerned that those circumstances and needs will be assessed in such a way that they fit the new paradigm rather than that the paradigm will be adjusted to accommodate the need. We suspect that in a short cycle business environment, the disproportionate importance of childhood to the shape of lifetime health status will be overlooked.

We are concerned that the emphasis on Medicaid expenditure and the installation of managed care as a universally applied apparatus for cost control might lead to a diminution of our understanding of health care, rather than to an expansion of our sense of possibility. An overly-narrow focus on regulation and eligibility could marginalize the set of preventive activities and positive contributions to growth and development that we believe are at the heart of child and family behavioral health.

We wonder if there will be enough money. How can there be enough money to retain the participation of the insurance industry while allowing providers to meet operational needs, pay for necessary overhead, and maintain a strong, capable work force? Will rates be adequate, and will the government be there to assure that they are paid in full and on a timely basis? Will as yet un-invented administrative technologies create efficiencies that will unexpectedly pay for new services and new coverage, or will health care reform force both the cannibalization of essential but expensive high end services and the shifting of costs to already stressed non-Medicaid providers of children's services?

Change also drives hope. Parity for behavioral health services was a dream 11 years ago; now we have it, at least in concept, at both the state and national levels. It is reasonable to think that we will see a continuing positive trend in de-stigmatization of those using services, an increase in the number of individuals who consider utilization a normative aspect of health care, and continually accelerating improvement in the quality of clinical care and in access to it. The standardization, collection, and establishment of a centralized data pool suggest a potential for research and quality improvement that none of us have seen in our professional lifetimes. The financial imperatives that are determining unprecedented collaboration and partnership may bring us further away from parochial concerns and closer to a common mission than we have ever been before.

There can be no question of the conceptual and legal progress that we have made in a very short time with respect to child and family behavioral health care; now we must backfill with practice design, application, and quality improvement cycles. The devil is not in the detail—the devil is the detail. As we struggle not to lose perspective going forward, we might do well to keep in mind a different kind of Triple Aim for child and family behavioral health, conceived 75 years ago by Anna Freud under vastly different circumstances, but relevant nonetheless as we struggle with the mechanics and economics of a new health care day. Ms. Freud's Triple Aim reminds us of what our new system, at the end of the day, must be capable of producing.

> …three needs of the growing child which override all others: the need for intimate exchange of affection with maternal figure; the need for ample and constant external stimulation of innate potentialities; and the need for unbroken continuity of care.[51]

…THREE NEEDS OF THE GROWING CHILD WHICH OVERRIDE ALL OTHERS: THE NEED FOR INTIMATE EXCHANGE OF AFFECTION WITH MATERNAL FIGURE; THE NEED FOR AMPLE AND CONSTANT EXTERNAL STIMULATION OF INNATE POTENTIALITIES; AND THE NEED FOR UNBROKEN CONTINUITY OF CARE.

Freud and Burlingham,
Infants Without Families

We would argue that government's health goals for the state's children, and the goals of providers privileged to work with those children and their families--no matter how complicated the necessary operational detail or the nature of the essential financial arrangements-- must answer positively the questions implicit in Anna Freud's Triple Aim: has our work made it more likely that a family can love and protect its own children; have we created powerful and effective educational opportunities for every child; and have we assured that our support will continue, no matter the vicissitudes of the world?

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CHARTS

Chart 1: "Estimated State Medicaid Spending Per Enrollee, by Eligibility Group, Fiscal Year 2008." Report to Congressional Requesters. United States Government Accountability Office, GAO 14-456, p. 13. June 2014.

Chart 2: "Medicaid Enrollment, Behavioral Health, Service Use and Expense by Age Group." Faces of Medicaid Chartbook, Slide 6. Source: Pires, S., Grimes, K., Gilmer, T., Allen, K., and Mahadavan, R. Center for Health Care Strategies.

Chart 3: "ACE Score and Indicators of Impaired Worker Performance, Figure 10." Source: Anda, R. The Health and Social Impact of Growing Up with Adverse Childhood Experience: The Human and Economic Cost of Status Quo.

Chart 4: "Proposed 2016 Children's Medicaid Managed Care Model for All Children 0-20 Years Old." New York State Quarterly Update to MRT Children's Behavioral Health Subcommittee, p.9. October 2013

Chart 5: "Medicaid Enrollment, Behavioral Health Service Use, and Expense by Aid Category." Slide 7. Source: Pires, S. et. al.

Chart 6: "Use of Traditional vs. Alternative Services for Children in Medicaid." Slide 9. Source: Pires, S., et. al.

THE NEW YORK STATE COALITION FOR CHILDREN'S MENTAL HEALTH SERVICES

OUR MISSION

To promote quality mental health services for New York's children with serious emotional disturbance and their families by leading the service provider community in identifying effective practices and participating in planning and implementing a continuum of services that are family-focused, comprehensive, cost-effective, culturally responsive, coordinated and appropriately funded.

The New York State Coalition for Children's Mental Health Services (the Coalition) is a 501c (3) organization dedicated to the advancement of children's mental health services in New York State. The Coalition represents the interests of children and youth, family members and providers who seek to inform and educate policymakers about the need for a comprehensive children's mental health system of care.

The Coalition was founded in 1986 by non-profit children's behavioral health care providers to represent the collective needs of providers in an emerging field. New York State was initiating a period of aggressive expansion in the type and volume of children's mental health services in an effort to address long stays in state-operated children's psychiatric hospitals and general hospitals. During that expansion, the Coalition began to regard themselves not only as providers, but also as mental health advocates – as both clinical experts in the field and as policy experts.

In 1999, Andrea Smyth joined the Coalition as Executive Director. Under her leadership, the organization added Policy Papers and an Annual Policy Forum to their activities, expressly to expand the public examination and discussion of children's behavioral health issues by government, families, providers and the community at large. The New York State Office of Mental Health and the Coalition retained its relationship as regulator and regulated, but expanded a partnership based upon mutually identified research and policy analysis targets.

The Coalition has been a pioneer in stretching the boundaries and parameters that define the children's mental health system. The organization has been a leader in evolutionary change, including the creation of residential treatment facilities in the 1980's; embracing the state's application in the 1990's for a federal 1915 c Home and Community Based Waiver program and leading by example by incorporating the family voice into decision-making on our Board of Directors in the early 2000's. The NYS Coalition for Children's Mental Health Services continues to be the leading voice for children, youth and families in community behavioral health services throughout New York State.

New York State Coalition for Children's Mental Health Services
PO Box 7124, Albany, NY 12224
Phone (518) 436-8715
Fax: (518) 427-8676
email: info@cmhny.org
www.cmhny.org

Andrea Smyth, Executive Director
Jacqueline Negri, Associate Executive Director