DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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State Demonstrations Group

MAY 0 3 2018

Donna Frescatore
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Ms. Frescatore:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Behavioral Health Self-Directed Care Pilot Program ("SDC Pilot") evaluation design for New York's section 1115(a) demonstration (Project No. 11-W-00304/0), entitled "Medicaid Redesign Team" (MRT). We have determined that the submission dated April 20, 2018 meets the requirements set forth in the Special Terms and Conditions and, therefore, hereby approve the MRT's SDC Pilot evaluation design.

If you have any questions, please do not hesitate to contact your project officer, Mr. Adam Goldman. Mr. Goldman can be reached at (410) 786-2242, or at Adam.Goldman@cms.hhs.gov.

Sincerely,

[redacted]

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Michael Melendez, Associate Regional Administrator, CMS New York Region
Nicole McKnight, Program Branch Manager, CMS New York Region
Maria Tabakov, State Lead, CMS New York Region

Evaluation Framework for the NYS
Behavioral Health Self-Directed Care Pilot Program
Demonstration Period: January 1, 2018 – December 31, 2021

Overview

Background

Self-Directed Care

Self-directed care (SDC) gives the authority to the individual of using public dollars to purchase services and/or to employ service providers. By providing greater autonomy and choice, SDC can more flexibly match the needs of individuals for health care and related services. The ultimate goal of a better match between individual needs and services is to enhance progress toward recovery goals, and improve health and stability in the community. In the U.S. and internationally SDC programs have been implemented extensively for populations including older adults, persons with physical disabilities, and persons with intellectual or developmental disabilities[1]. More recently, SDC programs for persons with behavioral health needs have been tried in a number of states including Florida, Texas, Oregon, Pennsylvania, Michigan, and Utah.

Research findings for self-directed care programs overall have found increased satisfaction, better outcomes, and cost neutrality (if not cost savings) compared to comparison groups. In the demonstration phase of the national Cash and Counseling program, a randomized control trial in three states found that elderly and disabled Medicaid recipients who self-directed personal assistance services had more satisfaction, fewer unmet needs and comparable or better outcomes than a control group receiving traditional agency-directed personal assistance services[2,3]. For mental health SDC a randomized control trial in Texas found that SDC participants had reduced symptoms and higher levels of self-esteem and self-perceived recovery than the control group[4]. In both studies overall costs were similar for the SDC and control groups although the categories of cost were different: the SDC groups spent less on nursing care or inpatient services and more on personal assistance services and outpatient services than the comparison groups[5, 6].

New York State Context

In August 2015, the Centers for Medicare and Medicaid Services (CMS) approved New York State's request to implement Medicaid Managed Care (MMC) Health and Recovery Plans (HARPs) to integrate physical, behavioral health, and behavioral health home and community based services (BH HCBS) for Medicaid enrollees with diagnosed severe mental illness (SMI) and/or substance use disorders (SUD). Under this 1115 waiver demonstration, HARPs are a separate coverage product that is targeted to Medicaid enrollees who meet need-based criteria for SMI and/or SUD established by the state. HIV Special Needs Plans (HIV SNPs) under MMC will also offer behavioral health HCBS services to eligible individuals meeting targeting, risk, and functional needs criteria.

SDC Pilot Program

Included under the 1115 waiver demonstration is a pilot program of Self-Directed Care for individuals with behavioral health needs. The pilot program will offer opportunities for self-direction in terms of service choice and payment for individuals in NYS who are

eligible for the HARP benefit package and BH HCBS services. Two agencies, one in New York City and one outside New York City, have been chosen as sites for the SDC pilot. Additional sites may be added. The agencies will be responsible for recruiting and enrolling participants. The expected number of participants is 200 HARP enrolled and HCBS eligible individuals for the two sites, but may increase to 600 as additional sites are added. Each SDC participant will select a support broker who will work with the individual to identify recovery goals and assist in the creation and implementation of a budget to purchase those goods and services required to meet the recovery goals. Support brokers will be hired, trained and supervised at the participating agency sites. Support brokers will work with a fiscal intermediary who will provide training, support and monitoring for the authorization and purchasing of goods and services.

Pilot Evaluation

New York State will conduct an evaluation of the SDC pilot program using an external evaluator. The overall purpose of the SDC pilot evaluation is to provide policy makers and other stake-holders information related to the viability and effectiveness of the SDC program in NYS for the HARP behavioral health population, and to that end the evaluation will address the following pilot program goals: (1) Implementation of a viable and effective Self-Directed Care program for HARP enrolled/BH HCBS eligible individuals throughout New York State; (2) Improvement in recovery, health, behavioral health, and social functioning for SDC participants; and (3) Maintenance of Medicaid cost neutrality overall and reduction of behavioral health inpatient and crisis service utilization and cost for SDC participants. The evaluation plan will be finalized in an agreement with the independent evaluator. The evaluation will address the following questions to assess attainment of SDC pilot goals.

Goal 1: Implementation of a viable and effective Self-Directed Care program for HARP enrolled/HCBS eligible individuals throughout New York State

1. What are the characteristics of SDC participants and how do they compare to the larger HARP and HCBS eligible population?
2. What was the experience of HARP enrolled/HCBS eligible individuals participating in the SDC pilot program in relation to satisfaction with the SDC program and its impact on their recovery, quality of life, and benefit from health and behavioral health services?
3. What was the experience of non-participant stake-holders in the SDC pilot program (e.g., Support Brokers, pilot site agency staff, State program development/oversight staff, fiscal intermediary) in relation to SDC implementation including State oversight and contracting, fiscal policies and procedures, hiring of SDC staff, recruitment and work with participants, and coordination with the fiscal intermediary?
4. What were the facilitators and challenges to SDC pilot implementation and how would they impact state-wide roll-out?

Goal 2: Improvement in recovery, health, behavioral health, social functioning and satisfaction with care for SDC participants

1. Do HARP members have improved quality of life after participating in SDC?
2. Do HARP members show improved indicators of health, behavioral health and wellness after participating in SDC?
3. Do HARP members show improvement in education and employment after participating in SDC?
4. Do HARP members show improvement in community tenure (i.e. maintaining stable long-term independence in the community) after participating in SDC?
5. Do HARP members show improvement in social connectedness after participating in SDC?
6. Do HARP members report increased satisfaction with health and behavioral health services after participating in SDC?

Goal 3: Maintenance of Medicaid cost neutrality overall and reduction of behavioral health inpatient and crisis service utilization and cost for SDC participants

1. Does participation in SDC result in increased use and cost of outpatient behavioral health services and primary care?
2. Does participation in SDC result in decreased use and cost of behavioral health inpatient, emergency department and crisis services?
3. How does participation in SDC impact overall Medicaid spending?

Evaluation Framework

New York State will propose to the external evaluator that the evaluation of the SDC pilot program consist of two components: (1) a process evaluation of the implementation of the SDC pilot with the purpose of determining the viability of behavioral health SDC in New York State and assessing factors that will facilitate or challenge state-wide roll-out for HARP enrollees; and (2) an outcome evaluation to examine the impact of SDC on participant health, behavioral health, and quality of life as well as any impact on Medicaid spending.

Process Evaluation

It is expected that the Process Evaluation will be used to address the research questions relating to implementation of the program (specifically questions 1 through 4 listed under Goal 1 above). It will be suggested to the external evaluator that researchers will utilize qualitative methodologies to examine the perspectives of a variety of pilot participants including SDC participants, Support Brokers and pilot site agency leadership, Advisory Council members, and fiscal intermediary and Office of Mental Health program staff. The purpose of this evaluation is to assess the context and process of implementation of the pilot program and identify facilitators and barriers that could impact eventual implementation of a program for behavioral health Self-Directed Care throughout New York State.

Outcome Evaluation

It is expected that the Outcome Evaluation will be used to address the research questions relating to improvement in SDC participant recovery, quality of life, health and

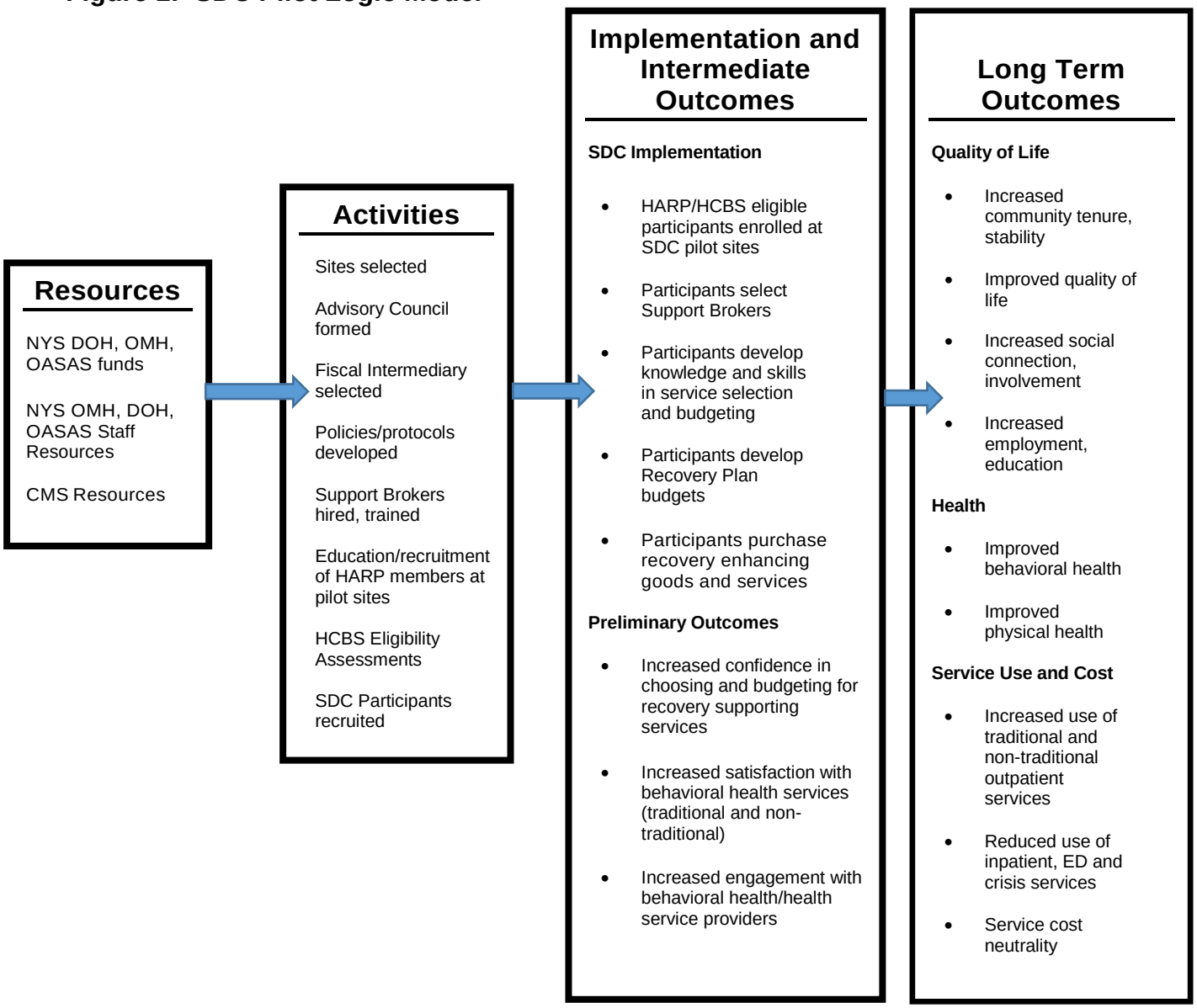
behavioral health, and satisfaction with care (specifically questions 1 through 6 under Goal 2 above). In addition, the Outcome Evaluation is expected to address the research questions on Medicaid service utilization and cost (questions 1 through 3 under Goal 3 above). The final design of the outcome evaluation will be agreed upon with the external evaluator. It is expected, however, that the design of the outcome evaluation will be quasi-experimental. Eligibility criteria for SDC participants includes Medicaid enrollment, HARP enrollment and eligibility for HCBS services. A comparison group would likely consist of Medicaid and HARP enrolled and HCBS eligible individuals served in locations where Self-Directed Care pilot programs are not available. Propensity score matching would be used to identify a comparison group comprised of Medicaid/HARP/HCBS eligible individuals who live in areas similar to the locations of the SDC sites and who are similar to the SDC participant group on important covariates. The comparison group would also allow the external evaluator to assess SDC program effects separately from the effects of other Medicaid Redesign initiatives implemented concurrently in New York State.

Evaluation Timeframe

It should be noted that this evaluation plan is conceived as approximately concurrent with the pilot demonstration program (see Evaluation Timeline in Table E below). If the evaluation were conducted at the end of the pilot demonstration program, there should be no impact on the Outcome Evaluation. However, the process evaluation of SDC pilot implementation may be impacted by the constraint of retroactively collecting qualitative data on implementation and participant perception of SDC.

Figure 1 shows a logic model of the SDC Pilot Demonstration showing expected resources, preliminary activities, implementation and intermediate outcomes, and long-term outcomes. The logic model provides a framework for both components of the evaluation. Data for the process evaluation of the implementation will come primarily from documents, site visits, interviews and focus groups. Data to inform the outcome evaluation will come from several sources. The Community Mental Health (CMH) Screen is conducted annually for all HARP enrolled/HCBS eligible individuals including SDC participants. This instrument is based on the InterRAI Community Mental Health Assessment, and gathers information about demographics, treatment history, housing, judicial system involvement, employment, education, risk behaviors, functional status, adverse life events, and social relationships. The HARP Perception of Care Survey will also be gathered annually from SDC participants and contains questions about quality of life and perception of care. The data from these two sources will be used to measure outcomes under Goal 2. Medicaid claims and encounter data will be used to measure changes in patterns of health and behavioral health service utilization and cost that address the questions under Goal 3. More detail on proposed evaluation methods and data sources are presented in the sections below.

Figure 1: SDC Pilot Logic Model



Evaluation Methods

It will be suggested to the external evaluator that for the process evaluation of SDC program implementation the primary method would be qualitative analyses of data from interviews, focus groups and documentation. For the outcome evaluation, it will be suggested that at least three analytic approaches be used. To gain a preliminary understanding of the characteristics of SDC participants, comparison group members and the larger HARP and HCBS eligible population, and to assess any differences in sub-groups (e.g., women, urban residents) descriptive statistics with corresponding graphical illustrations would be used. Assessment of outcomes over time for SDC

participants (and in some domains for the comparison group) would be conducted using Generalized Linear Modeling with mixed effects (GLMM). GLMM enables multivariate modeling on different types of outcome variables including rates (e.g., outpatient service use), non-normal distributions (e.g., cost), and categorical or indicator variables (e.g., arrested in past year) as well as normally distributed continuous outcomes. Random effects could be incorporated in the models on two levels: for persons within areas/site and for change over time within persons. Incorporating random effects allows for the accurate modeling of heterogeneity and correlation within both the SDC population and comparison group. Difference-in-Difference (DD) analyses could also be conducted to compare change over time between the two groups. A DD analysis assesses whether the relationship between trends over time for two groups prior to a cut-off point changes after the cut-off point; the assumption is that without the intervention the relationship between the trends for the two groups would remain the same. In this case, the intervention is the Self-Directed Care pilot program, cut-off point is enrollment in the SDC pilot program, and patterns over time will be assessed for variables such as rates of behavioral health inpatient use or overall Medicaid spending. Table A below relates each Research Question to these methods. The specific methods are discussed in more detail below.

Comparison Group (PSM Group)

It will be suggested to the external evaluator that using Propensity Score Matching (see below), the comparison group be derived using the following approach. Comparison group members are required to be HARP enrolled and HCBS eligible, which by definition means that they have been administered the CMH screen and should be re-assessed using the CMH screen annually. The pool of individuals who have been assessed using the CMH screen state-wide is currently over 20,000. It will be suggested to the external evaluator that areas with similar features to the areas of the SDC site populations first be selected; for example, 10 other areas within New York City or other large urban areas like Buffalo or Rochester would be selected for matching to the NYC SDC location, and 10 areas of small cities would be selected for matching to the Newburgh SDC location. The number of areas selected could be increased if necessary to get a sufficient pool for the next step. In the next step, Propensity Score Matching would be used to identify a comparison group matched to SDC participants using the CMH screen data and Medicaid claims data. As described below, the strategy would result in a larger (1:n) but analytically matched comparison group with covariate distributions balanced between the SDC group and the PSM comparison group.

An important aspect of the use of a comparison group is to control for the effects of other Medicaid Redesign initiatives implemented concurrently with SDC. It will be proposed to the external evaluator that the areas of the SDC sites and the other areas chosen for the comparison group be assessed for the presence of other initiatives and that these be factored into the balancing of the SDC and comparison groups on an area level. The comparison group would be used to partially address most of the research questions under Goals 2 and 3 using either GLMM or Difference-in-Difference described below. The exceptions are Research Questions 1 and 6 under Goal 2 as these rely

solely on indicators contained in the HARP PCS. As the HARP PCS for non-SDC participants is based on annual random sampling it would not be used as a basis for the PSM comparison group but would be used to descriptively compare the larger HARP enrolled population to SDC participants. Table A presents the Research Questions, the proposed methods for addressing them, and whether they will involve group comparisons. This is followed by detailed descriptions of both the quantitative and qualitative methods.

Table A. Methods to Address Research Questions

Goal. RQ #	Research Question	Quant./ Qual.	Method(s) (Data Sources)	Group Comparisons
1.1	What are the characteristics of SDC participants and how do they compare to the larger HARP and HCBS eligible population?	Quant.	-Descriptive statistics (CMH; HARP PCS; Medicaid)	-Larger HARP -PSM Group
1.2	What was the experience of HARP enrolled/HCBS eligible individuals participating in the SDC pilot program in relation to satisfaction with the SDC program and its impact on their recovery, quality of life, and benefit from health and behavioral health services?	Qual.	-Qualitative analyses (Participant Focus Groups)	NA
1.3	What was the experience of non-participant stake-holders in the SDC pilot program in relation to SDC implementation including State oversight and contracting, fiscal policies and procedures, hiring of SDC staff, recruitment and work with participants, and coordination with the fiscal intermediary?	Qual.	-Qualitative analyses (Documentation; Key Informant Interviews)	NA
1.4	What were the facilitators and challenges to SDC pilot implementation and how would they impact state-wide roll-out?	Qual.	-Qualitative analyses (Documentation; Key Informant Interviews)	NA
2.1	Do HARP members have improved quality of life after participating in SDC?	Quant.	-Descriptive statistics -GLMM (HARP PCS)	None
2.2	Do HARP members show improved indicators of health, behavioral health and wellness after participating in SDC?	Quant.	-Descriptive statistics -GLMM (CMH, HARP PCS)	-PSM Group (CMH Only)
2.3	Do HARP members show improvement in education and employment after participating in SDC?	Quant.	-Descriptive statistics -GLMM (CMH, HARP PCS)	-PSM Group (CMH Only)
2.4	Do HARP members show improvement in community tenure after participating in SDC?	Quant.	-Descriptive statistics -GLMM (CMH, HARP PCS)	-PSM Group (CMH Only)
2.5	Do HARP members show improvement in social	Quant.	-Descriptive statistics -GLMM	-PSM Group

	connectedness after participating in SDC?		**(CMH)**	
2.6	**Do HARP members report increased satisfaction with health and behavioral health services after participating in SDC?**	**Quant.**	**-Descriptive statistics -GLMM (HARP PCS)**	**None**
3.1	**Does participation in SDC result in increased use and cost of outpatient behavioral health services and primary care?**	**Quant.**	**-Descriptive statistics -DD (Medicaid Claims)**	**-PSM Group**
3.2	**Does participation in SDC result in decreased use and cost of behavioral health inpatient, emergency department and crisis services?**	**Quant.**	**-Descriptive statistics -DD (Medicaid Claims)**	**-PSM Group**
3.3	**How does participation in SDC impact overall Medicaid spending?**	**Quant.**	**-Descriptive statistics -DD (Medicaid Claims)**	**-PSM Group**

Quantitative Methods

Quantitative Method I. Descriptive Statistics

The external evaluator will be asked to use descriptive statistics including frequencies, measures of central tendency (means, medians), and distributions (histograms, boxplots) to describe the characteristics of SDC participants, comparison group members, and HARP and HCBS eligible individuals more generally. To describe univariate differences or similarities between the SDC and comparison groups or between sub-populations of interest (e.g., based on site, gender, diagnosis), chi-square tests, t-tests or ANOVAs could be conducted depending on variable type. To describe simple differences between time periods (pre to post SDC) paired sample t-tests could be used. Bonferroni adjustments for multiple tests can be applied to the threshold p-value as necessary. Non-parametric tests might be used for measures that do not follow distributional assumptions.

Quantitative Method II: Longitudinal Mixed Effect Regression Method

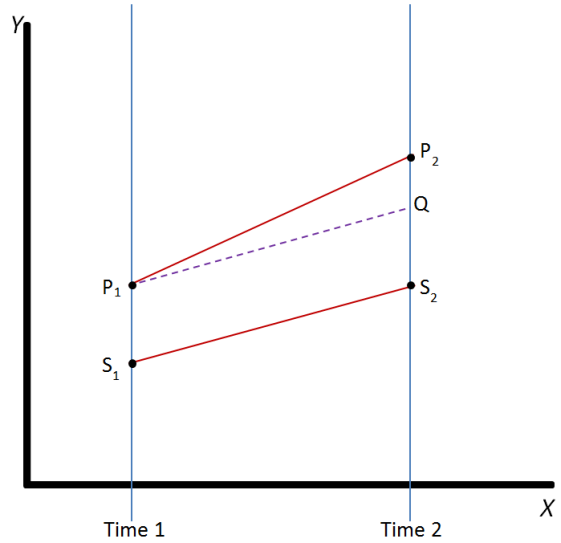
The primary analytic approach suggested to assess change in the SDC participant group would be Generalized Linear Mixed Modeling (GLMM). GLMM can address the potential heterogeneity in the SDC pilot implementation effect and estimate an average program effect while controlling for important covariates[7, 8]. This framework has the advantage of separating the effects of time from that of the SDC implementation, accommodating the heterogeneity in the SDC implementation effect, and accounting for serial correlations within individuals (resulting from repeated measurements). Random effects could be included on one or two levels depending on the model and use of the comparison group. For all the models, change over time would be allowed to vary across individuals. This has the advantage that different numbers and times of measurements across individuals can be used; it also accurately accounts for correlation between measurements within individuals. These models could be used for HARP PCS data as well as CMH screen data for the SDC participant group. Random effects could also be used on the area/site level described in the section on the

Comparison Group above. Individuals would be allowed to vary within areas to more accurately assess area level effects and to be able to identify SDC program effects apart from effects that may result from differences in areas (e.g., large urban versus small city; additional service initiatives). These models would be used with the PSM Comparison Group but limited to CMH screen or Medicaid claims data. As with implementation longitudinal data, the outcome metrics such as employment, enrollment in formal education, social relationships, social strengths, and behavioral health service utilization may vary considerably over time due to a strong temporal trend before and/or after program implementation. Explanatory risk factors including homelessness, criminal justice involvement (arrest history, incarceration history), alcohol use, drug use, chronic physical health conditions, and traumatic life events would likely vary considerably over time. The GLMM framework helps determine the amount of variability that may be due to temporal trend and the amount due to the new program implementation. The GLMM was chosen because it accounts for the intrinsic differences among individuals, the variability in program impact on individuals, and the correlation potentially induced by collecting data on the same individuals over time. GLMM could also usefully incorporate the PSM comparison group to look at differences over time in outcomes between SDC and the comparison group with the ability to more accurately model differences in persons by area. This would enable detection of program effects by separately comparing the two program site areas with similar areas in NYS.

Quantitative Method III. Difference in Difference Analysis

The primary method suggested to the external evaluator to assess differences in service use, cost and outcomes between the SDC participant group and the quasi-experimental comparison group would be a Difference in Difference (DD) analysis. This approach or strategy accounts for any secular trend/changes in the outcome metrics (it eliminates fixed differences not related to program implementation), with remaining significant differences attributable to the impact of program implementation[9]. The study groups would be prepared by match-pairing individuals using propensity scores derived from logistic regression based on selected demographic, clinical and social indicators, and health care utilization characteristics (see Quantitative Method IV). The outcome metrics, health care costs per member per month (PMPM) and service use rates, such as hospital admission rates, will be measured over two consecutive periods. Periods of two years prior and two years following program enrollment could be assessed as a preliminary examination of changes in trends. Additionally, periods of four years before and four years after program enrollment could be calculated for a total duration of eight years. Changes in outcome metrics from prior measurement periods to post measurement periods would be compared. Although the approximate measurement periods for two years are pre-period (January 1, 2016 – December 31, 2017) and post-period (January 1, 2018 – December 31, 2019), the actual trends will be based on SDC participant enrollment. For example, for a participant whose enrollment was on June 1, 2018 their last pre-period month would be May 2018 and their first post-period month would be June 2018. Their n matches in the PSM comparison group would be assigned the same pre and post periods. Averages over years would be calculated from the PMPM rates.

Figure 3: Idealized representation of DD Method



Quantitative Method IV: Propensity Score Matching

Propensity score matching is a technique developed to mimic randomization in observational studies like the SDC pilot evaluation[10]. A propensity score is the probability that an individual would be assigned to the treatment (SDC) versus comparison group conditioned on a set of observed covariates, such as demographics, diagnosis, service utilization history, and other factors. An advantage to propensity score matching is that a large set of potentially confounding covariates can be included without a loss of observations. This method would be applied in the design phase with application for a variety of causal models which may be selected. The propensity scores will be estimated using logistic regression, with the outcome being SDC participation, and predictors being derived from an array of demographic, clinical and social indicator constructs. The potential confounders will be selected a priori based on subject matter knowledge and in consultation with subject matter experts. Matching will also be done on timing of assessments. A greedy matching algorithm with an appropriate matching ratio of SDC participants to not SDC participants (1:n) will be used to create a matched analytic cohort based on the estimated propensity score[10, 11]. Balance in covariate distribution between SDC participants and not SDC participants in the matched analytic cohort will be assessed with weighted standardized difference[12]. The matched cohorts will be used for the quantitative methods indicated above as suggested in Table A.

Consumer Survey

The broader evaluation of the HARP Managed Care enrollment program has developed a member survey, the HARP Perception of Care Survey (HARP PCS), designed to measure experience with care, perception of care and perception of quality of life. Although members enrolled in HARPs and BH HCBS eligible members enrolled

in HIV SNPs are being surveyed annually through a random sampling, all SDC participants in the pilot program will be asked to complete the survey annually.

During the development of the HARP PCS, several validated instruments intended to assess consumer perception of the performance of health plans and behavioral health services were reviewed. The HARP PCS was derived from those instruments. Specifically, questions were drawn from the Experience of Care and Health Outcomes (ECHO) Survey, the Mental Health Statistics Improvement Program (MHSIP) Survey, the Personal Wellbeing Index adult version (PWI-A), and the Maryland Outcomes Measurement System. NYS OMH also formulated questions for pertinent topic areas where none could be found in existing instruments. The majority of questions address domains of member experience such as accessibility of services, quality of services, and appropriateness of care, wellness, quality of life, and social connectedness. Additionally, a set of socio-demographic questions are included which will allow examination of disparities.

The HARP PCS was piloted by NYS OMH in the fall of 2016 with 8 NYS OMH (4) and OASAS (4) funded behavioral health programs. Peers and staff at the programs received training on survey administration from OMH. Feedback was gathered from pilot participants about the length of the survey, clarity of the questions, and relevance of the questions. Results from the pilot were analyzed and the final version of the survey developed. Initial administration to random samples of HARP enrollees was conducted in 2017 and will be continued annually. The survey is being implemented using two random samplings of HARP enrollees. One random sample selects service providers who serve at least 15 HARP members in mental health or substance use disorder specialty services; all HARP members receiving the service are surveyed. A second random sample uses direct mailing to HARP members. Over 3000 HARP members were asked to complete the survey in 2017.The survey consists of 61 questions found in Appendix C.

Qualitative Methods

The final plan for the process evaluation will be determined together with the external evaluator. It will be suggested to the external researchers that the process evaluation address Goal 1 through collection of documentation, administrative data, and qualitative data from key informant interviews and focus groups. Documentation would comprise program specification, policy and related documents developed by the Office of Mental Health, SDC Advisory Council, fiscal and administrative entities, and pilot site agencies. Topics might include descriptions of administrative and fiscal intermediaries and pilot site agencies, how they were selected, and their operations; structure, membership and meeting minutes of the SDC Advisory Council; eligibility criteria and recruitment strategies; credentialing, hiring, training and supervision of support brokers; budget allocations and financial rules including authorized and prohibited goods and services; and other areas. Administrative data routinely collected from the fiscal and administrative intermediaries and the pilot agencies could also be used to describe ongoing processes between participants, support brokers, and administrative bodies.

For example, the process of participants working with support brokers to develop budgets based on recovery goals, requesting and receiving approval and funds from the administrative and fiscal intermediaries, and documenting final purchases is being recorded in an application with data that can be made available to the external evaluator.

It will be suggested that interviews be held with key personnel from OMH Bureau of Program and Policy Development; SDC Advisory Council; and the fiscal intermediary. It will be suggested that site visits to each pilot site be scheduled within the first nine months from start-up and annually thereafter. It will be proposed that focus groups, which often lead to expanded discussion on mutual topics, be scheduled with at least a subset of SDC participants depending on the numbers enrolled[13]. At a minimum, 1 to 3 focus groups would be scheduled annually at each site involving 25 to 30 participants. Site agencies would be asked to help recruit participants to focus groups and the external evaluator would be asked to provide a gift card for participants attending the groups. Focus group topics would be expected to include participant perceptions about the process of developing recovery plans and budgets; relationships between participants and support brokers; satisfaction with health and behavioral health services; and SDC impact on participant recovery and quality of life. It will be suggested that interviews also be scheduled with all support brokers, and leadership and supervisory staff at the pilot site agencies. Topics would include relationships with administrative and fiscal intermediaries; credentialing, hiring, training and supervision of support brokers; budget allocations and financial rules including authorized and prohibited goods and services; process of recovery plan and budget development and purchasing of goods and services; relationships between SDC participants, Support Brokers and other staff; and facilitators and challenges of pilot program implementation. Interviews and focus groups would be conducted using semi-structured protocols to allow for data collection on pre-established topic areas and openness to other topic areas of potential interest to the evaluation.

Qualitative Analysis Method

The qualitative data analysis method will be finalized by the external evaluator. One suggested approach would be for the external researchers to follow a framework described by Bradley, Curry, & Devers[14] that has been effectively used in health services research. This involves preliminary review of the data using a grounded theory approach (i.e. without predetermined categories) performed to identify emergent themes. A coding structure is then established through an iterative process that labels concepts, relationships between concepts, and, if applicable, evaluative participant perspectives (i.e., statements that are positive, negative, or indifferent to their experiences or observations). Where appropriate (e.g., for interview data) the coding structure also captures respondent characteristics (e.g., age, sex, support broker or position or role in organization) and setting (e.g., pilot site, region). Responses are then re-reviewed independently by at least two researchers, applying the finalized coding structure. Coding discrepancies between reviewers are subsequently resolved through

discussion to achieve consensus for the final coding of the data. Coded data is analyzed and interpreted to identify major concept domains and themes.

Integration of Quantitative and Qualitative Methods

It will be suggested to the external evaluator that findings from quantitative and qualitative analyses be integrated in order to refine and deepen the results from the different methods. For example, qualitative information from participant focus groups could be combined with quantitative findings on change indicators (Goal 2) to gain a more nuanced understanding of participant outcomes. In addition, barriers and facilitators of SDC implementation identified through the qualitative data and methods of the process evaluation could be combined with quantitative findings derived from the two pilot sites to gain an understanding of whether there are elements critical to effective implementation. This approach will be particularly important if additional sites are added.

Evaluation Tools

Goal 1: Implementation of a viable and effective Self-Directed Care program for HARP enrolled/HCBS eligible individuals throughout New York State

Evaluation Questions

1. What are the characteristics of SDC participants and how do they compare to the larger HARP and HCBS eligible population?
2. What was the experience of HARP enrolled/HCBS eligible individuals participating in the SDC pilot program in relation to satisfaction with the SDC program and its impact on their recovery, quality of life, and benefit from health and behavioral health services?
3. What was the experience of non-participant stake-holders in the SDC pilot program (e.g., Support Brokers, pilot site agency staff, State program development/oversight staff, fiscal intermediary) in relation to SDC implementation including State oversight and contracting, fiscal policies and procedures, hiring of SDC staff, recruitment and work with participants, and coordination with the fiscal intermediary?
4. What were the facilitators and challenges to SDC pilot implementation and how would they impact state-wide roll-out?

To address Goal 1, we would suggest that the external evaluator use Quantitative method I (Descriptive Statistics) to address question 1 by describing the characteristics and service utilization patterns of SDC participants and how they compare to the larger HARP enrolled/HCBS eligible population. The remaining questions under Goal 1 would be addressed at the discretion of the external evaluator using qualitative methods such as those described above. Suggested measures, data sources, and methods are listed below in the Evaluation Tool for Goal 1 (Table B).

Table B: Evaluation Tool for Goal 1

Q #	Implementation Indicator	Measure	Data Source	Related Expectation	Possible Methodologies
Q1	SDC participant enrollment	Count SDC participants stratified by demographic, clinical, health and functional characteristics	-Pilot site enrollment data -CMH Screen data -HARP PCS data -Medicaid claims data	Members of HARP/HCBS population will be enrolled for participation in SDC at the two pilot sites	-Descriptive analysis of pilot site enrollment data -Descriptive analysis of CMH Screen, HARP PCS and Medicaid claims data comparing SDC enrollees to larger HARP/HCBS population
Q2	SDC participant recovery, quality of life, health and behavioral health services	Describe participant perspectives on SDC program, staff and process; impacts on their recovery, quality of life, health and behavioral health; satisfaction; with services	Transcripts of SDC participant focus groups	Participants will gain experience with budgeting and using funds to meet recovery goals with resulting improvement in satisfaction with services, recovery, quality of life, and health/ behavioral health	-Qualitative analysis of themes and concepts derived from transcripts of focus groups
Q3	State oversight and contracting	Describe program polices regarding the selection, agreements made and ongoing monitoring of SDC sites and fiscal intermediary	-OMH administrative documentation -OMH administrative staff interviews	OMH administrative staff will develop selection criteria, contract deliverables and procedures for ongoing monitoring for both pilot site agencies and the fiscal intermediary	-Description of the OMH policies regarding SDC program implementation - Qualitative analysis of themes and concepts from interviews

Q3	Fiscal policies and procedures	Describe program policies regarding participant eligibility criteria, budgeting/use of funds, conflict of interest, and complaint/ incident handling	-OMH administrative documentation -OMH administrative staff interviews -Pilot site staff interviews	OMH administrative staff will develop fiscal policy and oversee fiscal intermediary and pilot site implementation	-Description of the OMH policies regarding SDC program implementation and fiscal policy - Qualitative analysis of themes and concepts from interviews
Q3	SDC support broker and supervisory staff hiring and training	Describe support broker and supervisory staff demographics, credentials, training, supervision and their perspectives on the pilot program and their relationship with participants and fiscal and state oversight	-Pilot site documentation on hiring, training and supervising of support brokers - Transcripts from interviews with support brokers, pilot site agency leadership/supervisory, fiscal intermediary and state oversight staff	Support brokers will be hired, trained and supervised by pilot sites and will interact with SDC participants and supervisory, fiscal intermediary and state oversight to facilitate SDC among participants	-Description of documentation regarding the hiring, training and supervision of support brokers for each site -Qualitative analysis of themes and concepts derived from interviews
Q3	SDC participant recruitment, enrollment and program participation	Describe pilot site agencies process for recruiting participants, educating participants about what SDC is and how they can participate, enrolling	-Pilot site administrative documents - Pilot site staff interviews -SDC participant focus groups	Pilot sites will work within OMH administrative policy to recruit, enroll, and facilitate ongoing participation in SDC	-Description of the pilot site policies regarding SDC program implementation - Qualitative analysis of themes and concepts from interviews and focus groups

		participants and facilitating ongoing participation			
Q3	Fiscal intermediary practices and coordination	Describe fiscal intermediary's policy and infrastructure for providing payments, monitoring payments and supporting customers	-Fiscal intermediary administrative and technical documents -Interviews with fiscal intermediary staff, pilot site staff, state oversight staff	Fiscal intermediary will develop a web based system for entering, approving and monitoring participant spending and will provide customer service to support brokers and SDC participants	- Description of the fiscal intermediary's process for payments, monitoring and assisting support brokers and participants - Qualitative analysis of themes and concepts from interviews
Q4	Facilitators and challenges to SDC pilot implementation	Identify and describe facilitators and challenges to the implementation of the SDC pilot program	-Interviews with state oversight, fiscal intermediary, pilot site agency staff -Focus groups with participants	-State oversight, pilot site agencies, and SDC participants will encounter both opportunities and barriers in the SDC process	-Qualitative analysis of themes and concepts from interviews and focus groups

Goal 2: Improvement in recovery, health, behavioral health, social functioning and satisfaction with care for SDC participants

Evaluation Questions

1. Do HARP members have improved quality of life after participating in SDC?
2. Do HARP members show improved indicators of health, behavioral health and wellness after participating in SDC?
3. Do HARP members show improvement in education and employment after participating in SDC?
4. Do HARP members show improvement in community tenure (i.e. maintaining stable long-term independence in the community) after participating in SDC?
5. Do HARP members show improvement in social connectedness after participating in SDC?

6. Do HARP members report increased satisfaction with health and behavioral health services after participating in SDC?

To address Goal 2, we would propose that the external evaluator assess changes in outcomes for SDC participants between baseline and multiple follow up points over the four years of the pilot program (January 1, 2018-December 31, 2021) using data from the Community Mental Health (CMH) Screen and HARP PCS. We would suggest using GLMM models (Quantitative Method II) that allow time points to vary both in number and spacing, and also adjust for correlation between measures taken at different time points for an individual. This approach will assess average trends on outcome measures derived from the CMH Screen and HARP PCS for SDC participants while controlling for possible confounding factors. Data from the PSM comparison group could be included to examine differences for HARP members participating in SDC versus those who are not, on Research Questions 2-5 using data from CMH. HARP PCS data, which Research Questions 1 and 6 rely upon, is not available for comparison group analyses. The Evaluation Tool for Goal 2 (Table C) presents outcome indicators, measures, data sources, hypotheses and methods for each question.

Table C: Evaluation Tool for Goal 2

Q #	Outcome Indicator	Measure	Data Source	Related Hypotheses	Possible Methodologies
Q1	Participant quality of life	-Life satisfaction scale -Quality of life scale	HARP PCS	Quality of life will improve between baseline and three year and subse-quent follow-up for SDC participants	-GLMM
Q2	Participant behavioral health	-Tobacco use -Alcohol use -Illegal drug use -Misuse of prescription medications -Difficulty due to substance use -Reduced ideation/acts of harm to self/others	-CMH Screen -HARP PCS	Indicators of behavioral health will improve between baseline and three year and subse-quent follow-up for SDC participants	- GLMM
Q2	Participant physical	-Health status -Difficulty due to	-CMH Screen	Health indicators will	- GLMM

	health	physical health	-HARP PCS	improve between baseline and three year and subse-quent follow-up for SDC participants	
Q3	Participant employment and participation in education	-Employment status -Hours worked in competitive employment -Educational status -Enrollment in educational program	-CMH Screen -HARP PCS	Participation in employ-ment and/or educational activities will increase between baseline and three year and subse-quent follow-up for SDC participants	- GLMM
Q4	Participant community tenure and stability	-Residential status/housing stability -Arrest, incarceration, other legal involvement -AOT order -Functional independence	-CMH Screen -HARP PCS	Stability in the community will improve between baseline and three year and subse-quent follow-up for SDC participants	- GLMM
Q5	Participant social connection	-Social relationship strengths -Level of social activity	-CMH Screen	Social connected-ness will increase between baseline and three year and subse-quent follow-up for SDC participants	- GLMM
Q6	Participant satisfaction	-Quality of Care -Helpfulness of	-HARP PCS	Satisfaction with care for	-GLMM

	with care	Services		behavioral health services will improve between baseline and three year and subse-quent follow-up for SDC participants	

Goal 3: Maintenance of Medicaid cost neutrality overall and reduction of behavioral health inpatient and crisis service utilization and cost for SDC participants

Evaluation Questions

1. Does participation in SDC result in increased use and cost of outpatient behavioral health services and primary care?
2. Does participation in SDC result in decreased use and cost of behavioral health inpatient, emergency department and crisis services?
3. How does participation in SDC impact overall Medicaid spending?

To address Goal 3, we would propose a more rigorous approach to identify change in Medicaid service utilization and spending patterns using a Difference-in-Difference analysis (Quantitative Method III). The DD analysis would employ the quasi-experimental comparison group derived using Propensity Score Matching (Quantitative Method IV). The DD analysis can assess how change in service use and cost for SDC participants from the pre-period before SDC participation to the post-period compares to patterns in the same timeframes for the comparison group. The Evaluation Tool for Goal 3 (Table D) presents outcomes, measures, data sources, hypotheses and methods for each question.

Table D: Evaluation Tool for Goal 3

Q #	Outcome Indicator	Measure	Data Source	Related Hypotheses	Possible Methodologies
Q1	Participant use of outpatient behavioral health services	-Claims for behavioral health outpatient services	-Medicaid Claims and Encounters	Outpatient behavioral health service use will increase between baseline and	- Difference in Difference

				three year and subsequent follow-up for SDC participants	
Q1	Participant use of primary care	-Claims for primary care visits	-Medicaid Claims and Encounters	Use of primary care will increase between baseline and three year and subsequent follow-up for SDC participants	- Difference in Difference
Q2	Behavioral health inpatient stays	-Rates of admissions and days for behavioral health inpatient stays	-Medicaid Claims and Encounters -NYS OMH State Psychiatric Center records (MHARS)	Inpatient stays for behavioral health will decrease between baseline and three year and subsequent follow-up for SDC participants	- Difference in Difference
Q2	Use of emergency department and behavioral health crisis services	-Rates of behavioral health emergency department use -Rates of non-behavioral health ED use -Rates of behavioral health crisis service use	-Medicaid Claims and Encounters	Emergency department and behavioral health crisis service use will decrease between baseline and three year and subsequent follow-up for SDC participants	- Difference in Difference
Q3	Spending on behavioral health outpatient services	-Cost per member per month of behavioral	-Medicaid Claims and Encounters	Spending on behavioral health outpatient	- Difference in Difference

		health outpatient services		services (including non-traditional services) will increase between baseline and three year and subsequent follow-up for SDC participants	
Q3	Spending on primary care	-Cost per member per month of primary care	-Medicaid Claims and Encounters	Spending on primary care will increase between baseline and three year and subsequent follow-up for SDC participants	- Difference in Difference
Q3	Spending on ED, behavioral health inpatient and crisis service use	-Cost per member per month of ED use, and behavioral health inpatient and crisis services	-Medicaid Claims and Encounters	Spending on ED and behavioral health inpatient and crisis service use will decrease between baseline and three year and subsequent follow-up for SDC participants	- Difference in Difference
Q3	Overall Medicaid spending	-Overall Medicaid cost per member per month	-Medicaid Claims and Encounters	Overall Medicaid spending will stay the same between baseline and three year and subsequent	- Difference in Difference

				follow-up for SDC participants	

Evaluation Timeline

Table E presents a suggested timeline of Evaluation activities and deliverables for the external evaluator.

Table E. Suggested Evaluation Timeline

Evaluation Activity	2019		2020		2021		2022	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Qualitative Data								
Collect Documentation	x	x	x					
Conduct Participant Focus Groups	x		x		x			
Conduct Key Informant Interviews		x		x		x		
Quantitative Data								
Administer HARP Survey (to SDC)	x		x		x			
Prepare Comparison Group (PSM)			x	x				
Prepare CMH Data			x					
Prepare Medicaid Claims Data			x					
Prepare HARP PCS Data			x					
Data Analyses								
Qualitative Analyses				x	x	x	x	
Descriptive Analyses				x	x			
GLMM					x	x	x	
Difference-in-Difference					x	x	x	
Integrate Qualitative & Quantitative						x	x	
Reporting and Dissemination								
Preliminary Descriptive Report						x		
Final Report								x
Presentations						x	x	x

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Appendix A
Data Sources

Pilot Site Enrollment Data
OMH has designed a secure web application for use by SDC Participants and Support Brokers to develop and manage SDC budgets based on personal recovery plans and goals. Data from this application includes SDC enrollment information by site and recovery goal-related expenditures. The application data can be linked to Medicaid claims data.

Medicaid Claims
This database contains billing records for health care services, including pharmacy, for approximately 5.7 million individuals enrolled in Medicaid in a given year. Also included are data on Medicaid enrollment status, diagnoses and provider associated with the billed services. The Medicaid claims database is updated on a monthly basis to include additional claims and modifications to existing claims. Medicaid claims database will receive data from all managed care plans providing services to the demonstration population. Given the claims processing, there is a 6-month lag in the availability of complete and finalized Medicaid claims data, where data for a given year are considered final by June 30th of the following year.

Community Mental Health (CMH) Screen
The Uniform Assessment System contains CMH Screen data on HARP eligible individuals enrolled in HARPs or HIV SNPS. Data include patient functional status, living situation, employment, education, health status, cognitive functioning, substance use, harm to self and others, stress and trauma. and social relations. Data are a mix of self-reported information and information that is available to assessors through the care management process. HCBS eligibility requires an annual re-assessment using the CMH screen. This applies to both SDC enrollees and the PSM comparison group.

HARP Perception of Care Survey
The HARP Perception of Care Survey (HARP PCS) will be administered to all SDC participants annually. For non-SDC HARP members enrolled in HARP or HIV-SNP plans, a random sample of members is surveyed annually to measure perception of care and quality of life outcomes. The survey instrument was piloted in late 2016. The final instrument consists of 61 questions (see Appendix C). The survey is being implemented using two random samplings of HARP enrollees by product line for HARPs and HIV SNPs. One random sample selects service providers who serve at least 15 HARP members in mental health or substance use disorder specialty services; all HARP members receiving the service are surveyed. A second random sample uses direct mailing to HARP members. Over 3000 HARP members were given the survey in 2017. Specific survey domains include Perception of Outcomes, Daily Functioning, Access to Services, Appropriateness of Services, Social Connectedness, and Quality of Life. Findings will be examined for change in BH services satisfaction levels over time. Data will be self-reported and from a sample of HARP members. The experiences of the

survey respondent population may be different than those of non-respondents with respect to their health care services. Therefore, data users should consider the potential for non-response bias when interpreting HARP PCS results.

NYS OMH Psychiatric Center Records

OMH maintains the Mental Health Automated Records System (MHARS) for episodes of inpatient, residential, and outpatient care in New York State Psychiatric Centers. This data will be used to identify psychiatric inpatient stays not included in Medicaid claims data.

Appendix B
Community Mental Health Screen

NEW YORK STATE

Office of Mental Health
Office of Alcoholism and
Substance Abuse Services

Eligibility Assessment

PARTICIPANT INFORMATION

Name (First, Middle Initial, Last)

Medicaid ID (CIN) ☐☐☐☐☐☐☐☐☐☐

Date of Birth
☐☐ / ☐☐ / ☐☐☐☐
Month Day Year

Is person on HARP-eligible list?
- O On HARP list
- O Not on HARP list

IDENTIFICATION INFORMATION

Date of Assessment ☐☐ / ☐☐ / ☐☐☐☐

Reason for Assessment
- O First assessment
- O Routine reassessment
- O Return assessment
- O Significant change in status reassessment
- O Exit assessment
- O Eligibility denial/appeal
- O Other (e.g., research)

What was individual's sex at birth? (on original birth certificate)
- O Male
- O Female
- O Other

Gender Identity
- O Male
- O Female
- O Other
- O Could not (would not) answer

Sexual Orientation
- O Heterosexual or straight
- O Homosexual, gay, or lesbian
- O Bisexual
- O Other
- O Not sure
- O Could not (would not) answer

Marital Status
- O Never married
- O Married
- O Partner/Significant Other
- O Widowed
- O Separated
- O Divorced
- O Unknown

Health Home where person is enrolled

Health Home Local Case ☐☐☐☐☐☐☐☐☐☐

Plan name if Health Home not known

What is person's religion?
- O Roman Catholic
- O Mainline Protestant
- O Evangelical Protestant
- O Non-denominational Protestant
- O Historically Black Protestant
- O Eastern Orthodox
- O Latter-Day Saints (Mormon)
- O Unknown
- O Unspecified Christian
- O Jewish
- O Muslim
- O Buddhist
- O Hindu
- O Other
- O No religion

Residential/Living status at time of assessment
- O Private home/apartment/rented room
- O DOH adult home
- O Homeless - shelter
- O Homeless - street
- O Mental Health supported/supportive housing (all types)
- O OASAS/SUD community residence
- O OCFS/ACS/DSS community residential program (Family foster care group home, Therapeutic foster care)
- O OPWDD community residence
- O Long-term care facility (nursing home)
- O Rehabilitation hospital/unit
- O Hospice facility/palliative care unit
- O Acute care hospital
- O Correctional facility
- O Other

Living Arrangement
- O Alone
- O With spouse/partner only
- O With spouse/partner and other(s)
- O With child (not spouse/partner)
- O With parent(s) or guardian(s)
- O With sibling(s)
- O With other relatives
- O With non-relative(s)

Individual receives housing supports
O No O Yes

Residential Instability
Residential instability over LAST 2 YEARS (e.g., evicted from home, 3 or more moves, no permanent address, homeless, living in shelter)
O No O Yes

NEW YORK STATE

Office of Mental Health
Office of Alcoholism and
Substance Abuse Services

Eligibility Assessment

Cultural/Ethnic Information

Hispanic	O No	O Yes
If Hispanic is "Yes":		
Cuban	O No	O Yes
Mexican	O No	O Yes
Puerto Rican	O No	O Yes
Dominican	O No	O Yes
Ecuadorian	O No	O Yes
Other Hispanic	O No	O Yes
Unknown	O No	O Yes

Preferred Language

- O English
- O Spanish
- O American Sign language
- O Arabic
- O Cantonese
- O Fujianese
- O Mandarin
- O Other Chinese
- O French
- O German
- O Greek
- O Haitian/ French Creole
- O Other language not listed:
- O Hebrew
- O Hindi
- O Italian
- O Japanese
- O Korean
- O Polish
- O Russian
- O Tagalog
- O Urdu
- O Vietnamese
- O Yiddish
- O Unknown

Self-Identified Race/Ethnicity
(Check two most important racial/ethnic group identities)

- O White
- O Eastern European
- O Other European
- O Middle Eastern
- O Other white
- O Black
- O African-American
- O Afro-Caribbean
- O African Continent
- O Other black
- O Unknown black
- O American Indian or Alaska Native
- O Unknown American Indian or Alaska Native tribe
- O Asian
- O Chinese
- O Japanese
- O Asian Indian
- O Pakastani
- O Filipino
- O Vietnamese
- O Korean
- O Other Asian
- O Native Hawiian
- O Other Pacific islander
- O Unknown Native Hawaiian or Other Pacific Islander
- O Other
- O Unknown

ASSESSMENT INFORMATION

Mental Health Services

Time since last contact with community mental health agency or professional in PAST YEAR
(e.g., psychiatrist, social worker)
EXCLUDE THIS CONTACT

- O No contact in past year
- O 31 days or more
- O 30 days or less

Time since last psychiatric hospital discharge
Code for most recent instance in LAST 90 DAYS

- O No hospitalization within last 90 days
- O More than 30 days ago
- O 15 to 30 days ago
- O 8 to 14 days ago
- O Within in last 7 days
- O Now in hospital

Number Psychiatric Admissions in LAST 2 YEARS

- O None
- O 1 to 2
- O 3 or more

Number Lifetime Psychiatric Admissions

- O None
- O 1 to 3
- O 4 to 5
- O 6 or more

Addiction Treatment History
Code for time since last discharge from addiction treatment program or service

- O 30 days or less (from this program)
- O 30 days or less (from another program)
- O 31 - 90 days
- O 91 days to 1 year
- O More than 1 year
- O Not applicable (no prior admission or service)

Inpatient stay for substance use disorder

Number of inpatient rehabilitation admissions for substance use disorder in the past 6 months

- O None
- O 1 - 2
- O 3 or more

Number of inpatient detoxification admissions for substance use disorder in the past 6 months

- O None
- O 1 - 2
- O 3 or more

NEW YORK STATE

Office of Mental Health
Office of Alcoholism and
Substance Abuse Services

Eligibility Assessment

Alcohol
Highest number of drinks in any "single sitting" in LAST 14 DAYS

O None O 1 O 2 - 4 O 5 or more

Number of days in last 30 days consumed alcohol to point of intoxication
- O None
- O 1 day
- O 2 to 8 days
- O 9 or more days, but not daily
- O Daily

Time since use of the following substances

0 = Never
1 = More than 1 year ago
2 = 31 days to 1 year ago
3 = 8 to 30 days ago
4 = 4 to 7 days ago
5 = In last 3 days

	0	1	2	3	4	5
Inhalants (e.g., glue, gasoline, paint thinners, solvents)	O	O	O	O	O	O
Hallucinogens (e.g., phencyclidine or "angel dust", LSD or "acid", "magic mushrooms", "ecstasy")	O	O	O	O	O	O
Cocaine or crack	O	O	O	O	O	O
Stimulants (e.g., amphetamines, "uppers", "speed", methamphetamine, prescription stimulant not prescribed)	O	O	O	O	O	O
Heroin	O	O	O	O	O	O
Other opiates (including synthetics) (e.g., oxycodone, hydrocodone, or methadone not prescribed)	O	O	O	O	O	O
Marijuana not prescribed	O	O	O	O	O	O
Sedatives or anti-anxiety not prescribed	O	O	O	O	O	O

Intentional misuse of prescription or over-the-counter medication in LAST 90 DAYS
(e.g., used medication such as benzodiazepines or analgesics for purpose other than intended)

O No O Yes

Injection drug use
(Exclude prescription medications)
- O Never used injection drugs
- O Used injection drugs more than 30 days ago
- O Used injection drugs in last 30 days; did not share needles
- O Used injection drugs in last 30 days; did share needles

Overdose (ingestion of drugs or alcohol in an amount exceeding what the body can metabolize or excrete before toxicity)

Code for most recent time of event

- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Self-injurious ideation or attempt
Code for most recent instance

Considered performing self-injurious act
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Most recent self-injurious attempt
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Intent of any self-injurious attempt was to kill him/herself

O No O Yes O No attempt

Other indicators of self-injurious behavior

Family, caregiver, friend, or staff expresses concern that the person is at risk for self-injury

O No O Yes

Suicide plan - in LAST 30 DAYS, formulated a scheme to end own life

O No O Yes

Violence: Code for most recent instance

Violent ideation - (e.g., reports of pre-meditated thoughts, statements, plans to commit violence)
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Intimidation of others or threatened violence - (e.g., threatening gestures or stance with no physical contact, shouting angrily, throwing furniture, explicit threats of violence)
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Violence to others - Acts with **purposeful, malicious, or vicious** intent, resulting in physical harm to another (e.g., stabbing, choking, beating)
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

NEW YORK STATE

Office of Mental Health
Office of Alcoholism and
Substance Abuse Services

Eligibility Assessment

Police Intervention
Code for MOST RECENT instance (exclude contact as victim)

Arrested with charges
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Incarcerated (i.e., jail or prison with overnight stay)
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Currently on probation or parole O No O Yes

Currently on court diversion/support program O No O Yes

Restraining order(s)
- O Never present
- O Previous order(s), but none present now
- O Order(s) present

Community treatment order(s) (AOT)
- O Not present
- O Present

Cognitive Skills for Daily Decision Making
Making decisions regarding tasks of daily life (e.g., when to get up or have meals, which clothes to wear or activities to do)
- O Independent - decisions consistent, reasonable and safe
- O Modified independence - some difficulty in new situations only
- O Minimally impaired - in specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times
- O Moderately impaired - decisions consistently poor or unsafe; cues/supervision required at all times
- O Severely impaired - never or rarely makes decisions
- O No discernible consciousness, coma

Acute Change in Mental Status from Person's Usual Functioning (e.g., restlessness, lethargy, difficult to arouse, altered environmental perception) O No O Yes

Independent Living Skills (IADLs)

Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0 = Independent - no help, setup, or supervision
1 = Setup help only
2 = Supervision - oversight/cuing
3 = Limited assistance - help on some occasions
4 = Extensive assistance - help throughout task, but performs 50% or more of task on own
5 = Maximal assistance - help throughout task, but performs less than 50% of task on own
6 = Total dependence - full performance by others during entire period
8 = Activity did not occur - during entire period (DO **NOT** USE THIS CODE IN SCORING CAPACITY)

	PERFORMANCE								CAPACITY						
	0	1	2	3	4	5	6	8	0	1	2	3	4	5	6
Meal preparation - How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
Managing finances - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
Managing medications - How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
Phone use - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
Transportation - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, in and out of vehicles)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O

NEW YORK STATE

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Eligibility Assessment

Life Events
Code for most recent time of event

Codes:
0 = Never
1 = More than 1 year ago
2 = 31 days - 1 year ago
3 = 8 - 30 days ago
4 = 4 - 7 days ago
5 = In last 3 days

	0	1	2	3	4	5
Serious accident or physical impairment	O	O	O	O	O	O
Distressed about health of another person	O	O	O	O	O	O
Death of close family member or friend	O	O	O	O	O	O
Child custody issues; birth or adoption of child	O	O	O	O	O	O
Conflict-laden or severed relationship, including divorce	O	O	O	O	O	O
Failed or dropped out of education program	O	O	O	O	O	O
Major loss of income or serious economic hardship due to poverty	O	O	O	O	O	O
Review hearing (e.g., forensic, certification, capacity hearing)	O	O	O	O	O	O
Immigration, including refuge status	O	O	O	O	O	O
Lived in war zone or area of violent conflict (combatant or civilian)	O	O	O	O	O	O
Witnessed severe accident, disaster, terrorism, violence, or abuse	O	O	O	O	O	O
Victim of crime (e.g., robbery) - exclude assault	O	O	O	O	O	O
Victim of sexual assault or abuse	O	O	O	O	O	O
Victim of physical assault or abuse	O	O	O	O	O	O
Victim of emotional abuse	O	O	O	O	O	O
Parental abuse of alcohol and/or drugs	O	O	O	O	O	O

Person prefers change (when asked)
Peer supports (e.g., programs, staff)
O No O Yes
O Could/would not respond

Treatment Modalities
Code for treatment modalities used in LAST 30 DAYS (or since admission if less than 30 days ago)

0 = Not offered and not received
1 = Offered, but refused
2 = Not received, but scheduled to start within next 30 days
3 = Received 8 - 30 days ago
4 = Received in last 7 days

	0	1	2	3	4
Individual	O	O	O	O	O
Group	O	O	O	O	O
Family or couple	O	O	O	O	O
Self-help/consumer group (e.g., Double Trouble, Alcoholics Anonymous)	O	O	O	O	O
Complementary therapy or treatment	O	O	O	O	O
Day Hospital/Outpatient Program	O	O	O	O	O

Strengths

Reports having a confidant	O No	O Yes
Consistent positive outlook	O No	O Yes
Strong and supportive relationship with family	O No	O Yes
Reports strong sense of involvement in community	O No	O Yes

Social Relationships
[Note: Whenever possible, ask person]
Codes:
0 = Never
1 = More than 30 days ago
2 = 8 to 30 days ago
3 = 4 to 7 days ago
4 = In last 3 days
8 = Unable to determine

	0	1	2	3	4	8
Participation in social activities of long-standing interest	O	O	O	O	O	O
Visit with a long-standing social relation or family member	O	O	O	O	O	O
Other interaction with long-standing social relation or family member (e.g., telephone, email, text, social media)	O	O	O	O	O	O

Person prefers change (when asked)

Recreational activities (e.g., type, number, or level of participation)
O No O Yes
O Could/would not respond

Relationships (e.g., establishing friendships, improving existing relationships)
O No O Yes
O Could/would not respond

NEW YORK STATE

Office of Mental Health
Office of Alcoholism and
Substance Abuse Services

Eligibility Assessment

Employment Status

- O Employed
- O Unemployed, seeking employment
- O Unemployed, not seeking employment

Employment Arrangements - Exclude volunteering

- O Integrated (competitive) without supports
- O Integrated (competitive) with supports (e.g., Transitional employment, intensive supportive employment, ongoing supported employment)
- O Non-integrated (non-competitive)
- O Not employed

Compensation for work - Exclude volunteer work

- O At or above minimum wage
- O Below minimum wage
- O No pay
- O Not employed

Volunteers
Works as a volunteer (e.g., for community services) O No O Yes

Highest level of education completed

- O No schooling
- O 8th grade or less
- O 9-11 grades
- O High school or GED
- O Business or technical school
- O Some college, no degree
- O Associate's degree
- O Bachelor's degree
- O Graduate degree

Enrolled in formal education program

- O No
- O Part-time
- O Full-time

Average hours worked per week in the past month - Exclude volunteer work

- O At least 35 hours
- O 10 - 34 hours
- O 1 - 9 hours
- O None
- O Not employed

Risk of unemployment or disrupted education

Increase in lateness or absenteeism over LAST 6 MONTHS	O No O Yes O Not applicable
Poor productivity or disruptiveness at work or school	O No O Yes O Not applicable
Expresses intent to quit work or school	O No O Yes O Not applicable
Persistent unemployment or fluctuating work history over LAST 2 YEARS	O No O Yes O Not applicable

Person prefers change (when asked)

Paid employment (e.g., type, hours, pay)	O No O Yes O Could/would not respond
Employment support services (e.g., pre-vocational services, transitional employment, Intensive supported employment, ongoing supported employment)	O No O Yes O Could/would not respond
Education/training	O No O Yes O Could/would not respond
Educational support services	O No O Yes O Could/would not respond

Finances
Because of limited funds, during the LAST 30 DAYS made trade offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care O No O Yes

Psychiatric Diagnoses
(Mental Health and Substance Use Disorder)
Enter Axis I and Axis II DSM-IV diagnoses, if known. Must be completed on program discharge, but also complete with earlier assessments if specific psychiatric diagnosis already determined.

Axis I - DSM-IV code

_____

_____

Axis II - DSM-IV code

_____

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Eligibility Assessment

Intellectual Disability
(e.g., Down Syndrome) O No O Yes

Medical Diagnoses

Disease code
0 = Not present
2 = Diagnosis present, receiving active treatment
3 = Diagnosis present, monitored but no active treatment

	0	2	3
Asthma	O	O	O
Diabetes mellitus	O	O	O
Hypothyroidism	O	O	O
Migraine	O	O	O
Traumatic brain injury	O	O	O
Heart disease	O	O	O
HIV/AIDS	O	O	O
Chronic Obstructive Pulmonary Disease (COPD)	O	O	O
Hypertension	O	O	O
High cholesterol or triglycerides	O	O	O
Tuberculosis (either active or newly confirmed inactive infection)	O	O	O
Hepatitis C	O	O	O

Assessment Notes Comment on additional information that is pertinent to this individual or contributors to the assessment process:

Appendix C

Perception of Care Survey for Medicaid Managed Care Members

Please tell us about your experience with your Medicaid Managed Care plan, the care you receive(d) from providers, and your perception of your own health and well-being.

We're asking about the behavioral health services covered in your plan. Behavioral health means mental health and/or substance use disorder.

- We want to know about your experience with behavioral health services like counseling, rehabilitation, inpatient treatment, emergency/crisis services, or medicine for mental health or substance use conditions.

PART I: YOUR BEHAVIORAL HEALTH SERVICES

1. Did you receive behavioral health services in the last 12 months? ☐ Yes ☐ No
2. In the last 12 months, did you receive any treatment, counseling, or medicine for:
   a. Emotional or mental illness? ☐ Yes ☐ No
   b. Alcohol use? ☐ Yes ☐ No
   c. Drug use? ☐ Yes ☐ No
   d. Tobacco use? ☐ Yes ☐ No

3. Are you currently receiving behavioral health services? ☐ No ☐ Yes → **<u>If Yes, Go To Question 5</u>**

4. Please select the ONE main reason why you are no longer receiving behavioral health services.

☐ a. I no longer needed treatment because the problem that led to treatment was addressed.
☐ b. Treatment was not working as well as expected, so I stopped treatment.
☐ c. Treatment was no longer possible due to problems with transportation.
☐ d. Treatment was no longer possible due to problems paying for treatment.
☐ e. Treatment was no longer possible due to problems with finding time for treatment.
☐ f. Other reason(s) (please explain):

<u>If you have not received behavioral health services in the past 12 months, skip to Part 3.</u>

PART 2: ACCESS and QUALITY OF CARE

The next questions are about all the behavioral health services you got in the last 12 months that were covered by your Medicaid Manged Care plan.

- **Please consider those services when answering the questions below.**

- **Please do NOT comment here about services that are NOT covered by your healthcare plan (e.g., self-help groups).**
- **If you have not received behavioral health services in the past 12 months, skip to Part 3.**

In the last 12 months…	Never	Sometimes	Usually	Always	Not Applicable
5. How often did the people you went to for counseling or treatment explain things in a way you could understand?	○	○	○	○	○
6. How often did the people you went to for treatment treat you with respect and kindness?	○	○	○	○	○
7. How often did you get services at days/times that were convenient to you?	○	○	○	○	○
8. How often did you get services where you needed them?	○	○	○	○	○
9. How often did you get the services you needed as soon as you wanted?	○	○	○	○	○
10. How often did the people you went to for counseling or treatment spend enough time with you?	○	○	○	○	○
11. How often did you feel safe when you were with the people you went to for counseling or treatment?	○	○	○	○	○
12. How often did the people you went to for treatment listen carefully to you?	○	○	○	○	○
13. How often were you involved as much as you wanted in your treatment?	○	○	○	○	○
14. How often were the people you went to for treatment sensitive to your cultural background (race, religion, language, etc.)	○	○	○	○	○
15. How often did the people you went to for treatment tell you what medication side effects to watch for?	○	○	○	○	○
16. How often were the accommodations (for example wheelchair accessibility) you need to obtain services available?	○	○	○	○	○

17. In the last 12 months, how much were you helped by the counseling or treatment you got?

☐ Not at all ☐ Somewhat ☐ Very Much

The following questions are about services that you might receive through your healthcare plan. For each of the services listed below that you received in the past 12 months, please tell us how helpful the services were.

Services you might receive	If you received this service in the past 12 months, how helpful was the service?			
	Very Helpful	Somewhat Helpful	Not at All Helpful	I did not receive this service
18. A Health Home care manager who coordinates your medical, behavioral health, and social service needs	○	○	○	○
19. Peer support services (support and help provided by people who have experienced mental illness and/or substance use disorder)	○	○	○	○
20. Assistance with returning to school or a training program	○	○	○	○
21. Assistance with finding or maintaining a job	○	○	○	○
22. Assistance with transportation other than medical transportation	○	○	○	○
23. Help with finding housing or better housing	○	○	○	○
24. Help in pursuing friendships and personal interests	○	○	○	○
25. Help in figuring out my finances, including getting any benefits I may be entitled to	○	○	○	○
26. Family support and training	○	○	○	○
27. Crisis respite services; i.e., residential care for 7 days or less, during a behavioral health crisis	○	○	○	○
28. Help with developing a crisis or relapse prevention plan	○	○	○	○

PART 3: HEALTH, WELLNESS, AND QUALITY OF LIFE
The next questions are about your health.

29. During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health? *(Please select one)*

None at all	Very little	Somewhat	Quite a lot	Could not do physical activities
☐	☐	☐	☐	☐

30. Have you used tobacco (e.g., cigarettes, e-cigarettes, pipes, cigars, smokeless or chewed tobacco) in the past 12 months?

☐ Yes ☐ No ☐ Prefer not to answer

	Yes	No	Not Applicable
31. Have you experienced any difficulties as a result of your tobacco use in the last 12 months (e.g., health, social, legal, or financial problems)?	○	○	○

32. Have you experienced any difficulties as a result of your alcohol use in the last 12 months (e.g., personal/family conflict, job instability, legal problems, and/or injuries)?	○	○	○
33. Have you experienced any difficulties as a result of your drug use in the last 12 months (e.g., personal/family conflict, job instability, legal problems, and/or injuries)?	○	○	○

The next group of questions ask about how satisfied you feel, using a zero to 10 scale. Zero means you feel no satisfaction at all. 10 means you feel completely satisfied. The middle of the scale is 5, which means you are neither happy nor sad.

How satisfied are you with…… ?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
34. the things you have? Like the money you have and the things you own?	○	○	○	○	○	○	○	○	○	○	○
35. your health?	○	○	○	○	○	○	○	○	○	○	○
36. what you are achieving in life?	○	○	○	○	○	○	○	○	○	○	○
37. your personal relationships?	○	○	○	○	○	○	○	○	○	○	○
38. how safe you feel?	○	○	○	○	○	○	○	○	○	○	○
39. feeling part of your community?	○	○	○	○	○	○	○	○	○	○	○
40. how things will be later on in your life?	○	○	○	○	○	○	○	○	○	○	○

Please tell us if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each statement below.

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
41. I am aware of community supports available to me.	○	○	○	○	○
42. My living situation feels like home to me.	○	○	○	○	○
43. I have access to reliable transportation.	○	○	○	○	○
44. I have trusted people I can turn to for help.	○	○	○	○	○
45. I have at least one close relationship.	○	○	○	○	○
46. I am involved in meaningful productive activities.	○	○	○	○	○

PART 4: BACKGROUND INFORMATION

The following information is collected to help ensure that services meet the needs of all individuals. Please do not share your name. Please check the boxes and fill in the blanks as applicable.

1. What is your age? _____

2. What was sex were you assigned at birth, on your original birth certificate? ☐ Female ☐ Male ☐ Unknown

3. Current gender identity – How do you describe yourself? (check one) ☐ Female ☐ Male ☐ Transgender
   ☐ Do not identify as female, male, or transgender ☐ Prefer not to answer

4. How would you describe your sexual orientation? ☐ Heterosexual or Straight ☐ Homosexual, gay or lesbian
   ☐ Bisexual ☐ Other
   ☐ Not sure ☐ Prefer not to answer

5. In what language do you prefer to communicate with your health care providers?
   ☐ English ☐ Spanish ☐Other (please specify)_____

6. In what language do you prefer to read things about your health care?
   ☐ English ☐ Spanish ☐Other (please specify)_____

7. Are you of Hispanic/Latino Origin? ☐ Yes, Hispanic or Latino ☐ No, not Hispanic or Latino

8. What is your race? (Select all that apply)
   ☐ White ☐ American Indian/Alaska Native ☐ Asian
   ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other

9. What is your highest level of education completed?
   ☐ Less than High School ☐ High School diploma or GED ☐ Business or technical school
   ☐ Some college, no degree ☐ College degree or higher

10. Are you currently enrolled in school? ☐ Yes ☐ No

11. Are you currently enrolled in a job training program? ☐ Yes ☐ No

12. Have you been employed in the past 12 months? ☐ Yes, I am currently employed
    ☐ Yes, but I am not currently employed ☐ No

13. Please indicate whether the following things affect your ability to work or your decisions about working. Select all that apply to you.

a. Lack of good jobs	○
b. Concern about losing benefits (e.g., Medicaid, etc.)	○
c. Lack of transportation	○
d. Physical health condition	○
e. Mental health condition	○
f. Arrest history	○
g. Lack of job training / education	○
h. Medication side effects	○
i. Workplace attitudes about mental illness and/or substance use problems	○
j. Retired and no longer looking for work	○

14. Have you been arrested in the past 12 months? ☐ Yes ☐ No

15. Have you experienced any difficulties with your housing over the past 12 months (e.g., 3 or more moves, having no permanent address, being homeless, living in a shelter)? ☐ Yes ☐ No

THANK YOU FOR COMPLETING THE SURVEY