New York's 1115 Waiver Programs Downstate Public Comment and PAOP Working Session

Comments of Christy Parque, MSW

President and CEO

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The Coalition for Behavioral Health, Inc. (The Coalition) is the umbrella advocacy and training organization of New York's behavioral health community, representing over 140 non-profit community-based agencies that serve more than 450,000 consumers. Our members serve the entire continuum of behavioral health care in every neighborhood of New York City, and communities in Long Island, Westchester, Rockland, and Orange counties. Coalition members provide access to the range of outpatient mental health and substance use services, supportive housing, crisis intervention, peer support services, employment readiness, Personalized Recovery Oriented Services (PROS), Club Houses, education and nutritional services, as well as many other supports that promote recovery, reduce emergency room use, hospital readmissions, shelter stays and divert sentencing from prisons and jails. The Coalition trains on average 500 human services providers monthly on cutting edge and proven clinical and best business practices and receives generous support from the New York State Office of Mental Health, the New York State Office of Substance Abuse Services, the New York City Department of Health and Mental Hygiene, the New York City Council, and in conjunction with foundations and leaders from the behavioral health sector.

SUPPORTING SYSTEMIC TRANSFORMATION

The Coalition lauds the New York State (NYS) Medicaid Redesign and 1115 Waiver initiatives implemented over the past several years that have improved access to quality care and

facilitated integrated behavioral health and physical health care for Medicaid beneficiaries while reducing costs to the health care delivery system.

New York's 1115 waiver has been the driver for transformation of the behavioral health system by using Medicaid funds to expand community-based behavioral health services, create innovative managed care models to cover people with significant behavioral health needs, finance delivery system reforms and advance behavioral and physical health integration.

Although the use of 1115 waivers to restructure NYS's Medicaid program has achieved measurable improvement in health outcomes, sustainable cost control and efficiencies in the health care delivery system, continued system transformation will depend on fully utilizing the expertise and strength of our behavioral health providers to address social determinants of health and the mental health and substance use disorders and other needs in communities across the State.

REGULATORY MODERNIZATION FACILIATATE INTEGRATED ARRANGEMENTS

The Coalition has supported NYS's use of 1115 waiver authority to create new models of care that reduce fragmentation and improve outcomes in the behavioral health system by introducing managed care arrangements and accountability for behavioral health providers and by streamlining regulatory requirements to enhance integration of behavioral and physical health and coordinated care. Doing so has the added benefit of allowing for "one stop shopping" which facilitates client access.

The regulatory reform efforts by NYS DOH, OMH and OASAS to simplify the license process for providers that exceeded licensure thresholds who would otherwise have to be licensed by more than one agency have been welcomed by Coalition member organizations interested in providing both behavioral health and primary care services. New York is one of eight states that received federal funds to demonstrate the Certified Community Behavioral Health Center model which integrates primary care and FQHC services into community behavioral health clinic settings. While too soon to document outcomes, it is a promising model being tested in 13 New York sites. Should it prove its value, replication of the model will undoubtedly be facilitated by licensure modernization.

Significant challenges still remain for behavioral health providers due to the requirements of multiple State agencies in licensing and certification, physical plant standards in Article 28 facilities and billing inflexibility for physical health services on behavioral health claims.

- **We would support recommendations of the State's regulatory modernization workgroups to create a limited integrated license allowing existing Article 28, Article 31 and Article 32 outpatient clinics to provide a specific array of primary care services and full complement of mental health and substance use disorder services without obtaining a second license.**
- **Additional clarification may be warranted on the degree to which billing for behavioral health screening and treatment is reimbursable when behavioral health services and primary care services are provided during a single visit.**

Telehealth:

We seek to eliminate barriers for clients so that they can access their care that crosses between systems. There should be no wrong door for entry. We also support modification of the State's telehealth statute and regulations to include a patient's home as an eligible originating site, facilitating greater access to behavioral health consultations and care and an integrated care team to manage patients unable or resistant to accessing a clinic-based treatment site.

- **We strongly urge an alignment and standardization of the various state agency regulations that govern telehealth including the NYS Department of Health (DOH), NYS Office of Mental Health (OMH) and the NYS Office of Alcohol and Substance Use Services (OASAS).**

SUPPORT ACCESS TO HEALTH HOMES AND HOME AND COMMUNITY BASED SERVICES

Effective treatment, recovery and resiliency for people with behavioral health disorders includes an array of services that fall under the banner of social determinants of health. Our comments focus on how those services are provided and integrated into clinical service, and the problems our member agencies have identified with how those services were designed, the ramifications of not addressing those concerns, and potential ways to improve those deficits. Many of these recommendations are a revisit to our previous recommendations.

I would like to begin, however, by acknowledging the prescience of the NYS DOH in recognizing the importance of these services to realizing the goals of the Triple Aim, ensuring that the DSRIP program includes social determinants of health services, and the recent improvements in contracting and providing payment for those services by the PPSs.

Behavioral Health organizations play a key role in providing comprehensive care coordination for clients with mental health and substance use disorders and physical health co-

morbidities. They also directly provide or link them to recovery and services such as supportive housing and income assistance that are critical to addressing social determinants of health.

- **This expertise should be recognized and rewarded.**

Yet, several community based BH organizations have raised concern that they do not have sufficient client volume to support the staffing resources and infrastructure necessary to assess clients for Health Home eligibility and interest or make referrals for Home and Community Based Services (HCBS). For example, one of our members reported that for every $1.00 received they incurred $4.00 in costs. Another member shared that they have invested hundreds of thousands in agency dollars participating in both HCBS and DSRIP contracts but the return on investment is not there. They are not sure how much longer they can sustain supporting these programs.

- **Several of our members who provide these services expressed they are considering giving up their contracts.**

Similarly, they function on minimal margins, making it difficult for them to assume any form of risk or diminished reimbursement which may be passed down from their upstream partners.

Our members expect that starting an enterprise is time consuming and costly but are concerned that the rates for these services are insufficient and do not reflect the time, effort and costs of providing quality services.

- **We urge NYS to make funds and technical support available to develop the infrastructure to support data collection and analysis, contracting and credentialing, and importantly, adoption of electronic health records and participation in health information sharing platforms.**

The Coalition believes there are ways to drive access and volume through streamlining and efficiencies and standardization, expanding billable services, and accounting for secondary costs such as travel time.

- **Potential efficiencies will reduce staff burden, produce cost savings and increase quality. NYS DOH should consider the following adjustments:**
  - Standardizing protocols for prior authorizations, submitting claims, credentialing providers and contract language across managed care organizations.
  - Standardizing assessment and care plans tools and allowing additional types of providers to conduct them.
  - Allowing robust bottom up enrollment of potential HARP members.

- Pre-populating forms when possible, for example, using information from the HARP eligibility assessment to populated the HCBS assessment.
- Aligning workforce expectations with financial resources; for example, include travel time, allowances for tracking down no-shows, and compiling data reports in reimbursement rates.

WORKFORCE SUSTAINABILITY

We understand that achieving fully integrated behavioral and physical health care will take time and require changing administrative and operational processes and acquiring health technology systems to increase efficiency and improve outcomes for the clients we serve. Resources for our behavioral health providers will be critical to the success of this delivery system transformation. During the November 16, 2017 1115 Waiver Programs Downstate Public Comment and PAOP Working Session, a response to a question about "what was the biggest chunk" of PPS spending was Workforce and Health Information Technology. Community organizations have the same situation but have fewer options as community based organizations have historically been underfunded and have less resources.

- **Level the playing field with resources for behavioral health providers with our partners on the health care side so we can succeed together.**

Resources to support workforce development, training and wages that are comparable to other sectors will be essential for these community based behavioral health organizations to enable them to provide the clinical services and meet the requirements of managed care plans and health homes with which they are contracted. Without a vital robust workforce, consumers would be denied their right to high quality services and the objectives of Medicaid Redesign will be unrealized. Our members have consistently identified the discrepancy between salaries paid by other sectors, such as managed care organizations and government, as a real problem in recruiting and retaining good staff. Non-competitive salaries exacerbate the challenge of providing direct care to a high need vulnerable population with fewer staff, and the failure to secure an assured COLA exposes behavioral health provider staff to a diminished life-style as the cost of living continues to rise at an unprecedented pace.

- **Besides providing competitive salaries and regular cost of living increases, we believe there are ways to incentivize the behavioral and social services workforces through loan forgiveness programs, tuition reimbursement for aspiring non-profit sector professionals and reduction or forgiveness of licensing and other profession related fees.**

Similarly, the development of quality metrics that are widely used by the health care industry and factored into financial incentives should include measures that reflect the intensity of the work BH organizations perform in stabilizing clients and working with them over an extended period and that capture improved functionality and resilience and the impact on social determinants of health. With the numerous metrics required to be reported, we recommend prioritizing metrics for behavioral health and consider offering payment incentives to ensure provider and payer commitment to those measures.

The benefits or successes of the work of behavioral health agency staff are often not realized in a short period time such as monthly or quarterly, or even yearly. This has both an impact on creating an equitable business model in a value based system but also negatively affects the morale of the staff as they struggle to see the impact of their work if the benchmarks don't accurately represent the timeline or cycle of change from a clinical perspective. We recommend also capturing milestones that appropriately reflect the continuous work done by agency staff.

- **As we further develop behavioral health metrics we must bear in mind that sometimes the most difficult measures to define and apply are the most challenging but are the <u>right ones.</u> We are committed to working with our government and healthcare partners to develop thoughtful and meaningful metrics that reflect both the work of the behavioral health sector and the physical health sector.**

CHILDRENS TRANSITION TO MANAGED CARE

The Coalition looks forward to working with the State as it implements the comprehensive 1115 waiver amendment for children with significant behavioral health and home and community based service needs. Lessons learned from the adult behavioral health transformation and use of Medicaid managed care, health home care management and integrated care will be invaluable to improving clinical and recovery outcomes for children and youth and achieving efficiencies in the behavioral health care delivery system. Our experienced community based behavioral health providers who have historically provided quality care to these vulnerable populations must continue to be integral to the system as it transitions.

Within children's redesign we must protect the historical strength of these services and programs, their uniqueness and success in providing services to high need children.

- **We must make every effort to ensure that any transition does not result in gaps in behavioral health services or coverage for a child or their family.**

CONCLUSION

As we rapidly redesign the delivery and financing of Medicaid and cross the barriers into unchartered territories, our members encounter numerous barriers to innovating services, constructing and licensing delivery sites, and merging, integrating and cooperating with new and unfamiliar forms of partnerships. That being said, I want to make clear, that The Coalition and its members are absolutely committed to the vision and opportunities to provide truly holistic and client centered care that is afforded in the spirit of the 1115 Waiver.

We grateful for the funds that have been made available for infrastructure development and urge that this financial commitment continue. On behalf of The Coalition of Behavioral Health Agencies, I thank you again for the opportunity to provide you with our comments.

Respectfully submitted by:

Christy Parque
President and CEO