Comments Regarding New York State's Implementation of the 1115 Waiver

Thank you for the opportunity to comment on the implementation of the 1115 Waiver "Waiver"). The Coalition of Behavioral Health Agencies (The Coalition) represents nearly 140 community-based, non-profit behavioral health providers that serve over 350,000 New Yorkers of every age. Our members serve the entire continuum of behavioral health care in every neighborhood in New York City, Westchester, and beyond. Coalition members provide access to the whole range of outpatient mental health and substance abuse services, including supportive housing, crisis, peer, employment, Personalized Recovery Oriented Services (PROS), Club Houses, education and food nutritional services, as well as many other supports that promote recovery. Our members have been providing these types of services in the community since the dawn of the deinstitutionalization movement.

We support the goals of Medicaid redesign to reduce inpatient and emergency use; provide eligibility for Medicaid across a broader band of low-income New Yorkers; and implement Delivery System Reform Incentive Payment (DSRIP) funding to increase the quality of services provided across all spectrums. We applaud the use of DSRIP funding to serve larger and more complex Medicaid populations for work on specific issues identified by the Medicaid Redesign Team (MRT) to achieve the goals of its "Triple Aim":

1. Improving the quality of care by focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency and equity;

2. Improving health by addressing root causes of poor health e.g., poor nutrition, physical inactivity, and substance use disorders; and

3. Reducing per capita costs.

Community-based behavioral health providers play an important role in achieving the goals of Medicaid redesign. Comprehensive behavioral health services provided in the community lead to better health outcomes that reduce the overall cost of medical care. These services promote recovery and thereby avoid hospital admissions and emergency room visits; prevent stays in homeless shelters and divert individuals from prisons and jails.

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Capacity and Infrastructure

New York State should invest in community-based organizations (CBO) that show promise with helping individuals living with severe mental illness and substance use disorders to recover and thrive in their communities. By providing consumers living with behavioral issues with access to culturally competent mental health and substance use services in the community, including housing and peer employment services, Coalition members in turn help to address social determinants of health factors like stable and affordable housing, living wage job opportunities, training, food security and access to social supports. We recommend that the State work with CBO's to:

- Develop payment methodologies that incentivize/reward providers provide services to people experiencing challenging social determinant barriers;

- Support infrastructure development, including information technology (IT) systems for billing and the ability to measure and collect data to demonstrate their value, as well as for contracted services, such as fiscal and legal expertise; and

- Create a "design and consultation team" of experts from relevant State agencies, advocacy and stakeholder groups to provide focused consultation and support for on developing value based payment systems.

Integrated Care

According to the Department of Health's Approaches to Integrated Care webpage, "[h]ealth care providers have long recognized that many patients have multiple physical and behavioral health care needs, yet services have traditionally been provided separately. The integration of primary care, mental health and/or substance use disorder services can help improve the overall quality of care for individuals with multiple health conditions by treating the whole person in a more comprehensive manner."

The Coalition wholeheartedly agrees. We believe that true integration, where people can receive their physical and behavioral health care in the same setting, is a goal that we should all work towards achieving. Although pathways to integrated licensure exist, significant barriers stand in the way, which make it extremely difficult (both structurally and fiscally) for community-based behavioral health providers to bring physical health services onsite. The most difficult issues arise in the area of physical plant requirements. The behavioral health agencies are held to the Article 28 clinic standards regardless of the kind of care that they intend to provide. The regulations to provide primary health services at behavioral health sites need to be drastically revised to encourage real integration.

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DSRIP

We agree with overall goal of DSRIP to create a more integrated and efficient service delivery system. The Coalition is concerned, however, about the implementation of DSRIP concerning the meaningful inclusion of community-based providers. Overall planning and funding flows primarily through hospital-based systems. Unfortunately, to date, very little of the DSRIP money has funneled down to the community-based behavioral health providers in Performing Provider Systems (PPSs) networks. This is relevant for both behavioral health initiatives in general, as well the IT capital and systems development necessary for program and outcomes monitoring/reporting. In addition, DSRIP projects require significant workforce development, training and hiring for which there has been little or no funding from the PPSs or public sources.

While PPSs require metrics reporting in order to make corrections in strategies and ensure success, the complexity of the proposed DSRIP reporting requirements and associated measures could hinder implementation efforts. New York's 1115 waiver requires each PPS to be accountable for between approximately 100 and 330 process and outcome metrics, depending on project selection. This creates a heavy administrative burden, taking focus and time away from project implementation.

Value Based Payments (VBP)

The Coalition supports the concept of payment methodologies to incentivize payment mechanisms for CBOs that enable individuals living with severe mental illness and substance use disorders to recover and thrive in the community. As previously mentioned, comprehensive behavioral health services provided in the community effects better health outcomes, which reduce medical expenses overall, particularly from averted hospitalizations and inpatient care admissions.

Sustaining behavioral health providers as we enter into VBP should be a priority given the historical lack of sufficient reimbursement for behavioral health services. The current reimbursement rates available for Medicaid in both fee-for-service and managed care environments are unsustainably low. If bundled or capitated rates, which will be based on these historic rates, are too low, this could lead to more and greater financial instability. The State should make additional funding available to CBOs to help prepare for participation in value based payment arrangements. A successful transition to VGP required funds being available for investment (and reinvestment) into developing innovative partnerships to achieve the MRT Triple Aim.

The Coalition urges that VBP payments to community-based providers include MCO/PPS rate guarantees that ensure that community based providers are reimbursed with actuarially sound rates. These rates must fully support the cost of efficient care that meets quality standards. We must underscore that the partnerships between large stakeholders (hospitals and MCOs) and

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CBOs necessitates creating a payment system that compensates the participants fairly for the true value of the services provided as well as the resources expended in achieving positive health outcomes.

We appreciate that the value based payment Roadmap recognized that addressing the social determinants of health is necessary to achieve high value care. However, The Coalition is concerned that all State agencies, including the Office of the Medicaid Inspector General, recognize this change in policy and hopefully, a concomitant change in New York State Social Services law.

The Model Contract

We strongly urge that the process to revise the Medicaid managed care Model Contract be transparent, because so many components of the 1115 Waiver will be implemented through it. In addition, the Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS), must be closely involved in the development and oversight of the Model Contract sections that deal with behavioral health care, as they are the State agencies with the subject matter expertise. Finally, The Coalition advocates strongly that the State provide an opportunity for stakeholders to comment on the Model Contract before it is finalized, as was previously the recommendation of the Regulations Committee. This public comment period will ensure the inclusion of metrics that are representative of the successful work many are already engaged in.

Consumer Access and Input

The Coalition is also concerned about the ability of clients to navigate the health care system. The recommendations of the Advocacy and Engagement Subcommittee to the MRT must be implemented, such as:

- ensuring that plans and providers communicate information to consumers that explains the incentives that different payment mechanisms generate;
- providing consumer education and promoting patient activation around what is meant by a "high value provider," as well as the right to question their providers, seek second opinions, and obtain consumer assistance services;
- assistance if a client is denied service and wants to appeal; and
- assuring that the State's Independent Consumer Advocacy Network (ICAN) and any and all consumer assistance programs are equipped to provide assistance.

It is critical that the Waiver allow robust stakeholder engagement, which includes input from consumers/clients, providers, and advocates. An advisory committee is supposed to meet to monitor and if necessary modify the Waiver, but it does not appear that such a committee has been developed. If it is the MRT committee, it has not met in a long period of time.

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Health & Recovery Plans (HARP)

- We appreciate that there will be no copayments mandated for HARP enrollees, which would be a disincentive for individuals seeking care and burdensome for providers to collect.

- We believe that the new 12-month eligibility for individuals in certain circumstances will greatly assist continuity of care for clients, especially with regard to medication access.

- We strongly agree with the New York State Department of Health's proposal to the Centers for Medicare and Medicaid to enroll individuals who are incarcerated for Medicaid within 30 days of discharge. Again, this is essential for individuals to immediately access the necessary behavioral health services and medications upon release from jail or prison, which will help to combat recidivism.

- There is concern that there will be inadequate capacity of substance use disorder services available in areas that are not geographically convenient for HARP enrollees to access.

- To date, individuals with HARP eligibility are not enrolling at the rate that was originally calculated. Without sufficient enrollment, the network, particularly for home and community based services, will not be adequate or efficient, and this entire proposal could fail. The State and provider community should review this issue to determine what can be done to increase HARP enrollment to cover all individuals eligible for and willing to enroll.

Home & Community Based Services (HCBS)

The ability for providers to offer HCBS to consumers that require them is a cornerstone of recovery and meeting the MRT's goals. Unfortunately, HCBS rates are insufficient for certain services, particularly crisis services. Furthermore, we question the appropriateness of including crisis service as part of a service plan. Crisis services should not be in HCBS, but rather have its own category. One of the primary goals of DSRIP is to reduce hospitalization and emergency room use; that goal will not be achieved absent the provision of robust crisis services.

We are also disappointed by the exclusion of people living in shelters from HCBS, since they are often in most need of these enhanced services. Additionally, the complicated and stringent rules regarding access to HCBS are a serious disincentive for providers to engage consumers/clients in these services. The process must be streamlined in order for Medicaid redesign to be successful.

Children's Medicaid Managed Care & Health Homes

Clarity is needed for providers that primarily serve children on how the new children's Health Homes will be incorporated. The timeframe for children's managed care transition is on a different trajectory than adults and we are concerned about the Medicaid "cap" with regard to

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children's services since they will be brought online subsequent to the general movement of behavioral care to Medicaid managed care. In addition, since many existing children's waiver providers, both in the OMH waiver and the Office of Children and Family Services (OCFS) waiver, will transition to the new waiver structure, there should be consistency between the two State agencies in how and when the transition will occur, with regards to the timeline for requiring new CMS requirements regarding conflict free decision-making. They should be put on the same time schedule, one that reflects the changes to come, so that providers do not have to go through two conversions within a short period of time.

Supportive Housing

The Coalition has serious concerns regarding the references to Housing and Vocational Opportunities in the VBP Roadmap. Although we absolutely agree that "[o]ffering a stable, safe, and accessible housing environment can be highly efficient and improve outcomes for vulnerable, homeless Medicaid members," it must be understood that supportive housing is considered permanent housing. If Medicaid were to pay for supportive housing, it must be structured to be permanent and flexible.

In addition, the VBP Roadmap states that "DSRIP offers the chance to introduce credentialed positions such as Community Health Care Workers and Peers, which offer a continuum of vocational opportunities to people living with chronic conditions." In order to bill for these services, many housing providers will have to implement more sophisticated billing systems, since to date, supportive housing has been funded pursuant to state contracts. In addition, the Roadmap provides that "[t]o further acknowledge that housing plays a critical role in overall health and patient behavior, the State is determined to collect standardized housing data for purposes of rate setting and appropriate intervention research and analysis." Again, in order to provide this type of information, supportive housing providers will need a funding source to build the necessary reporting systems.

Ensuring Outcomes

New York State's interest in measuring outcomes and encouraging creativity with incentive programs, specifically its plans to analyze and collected data to identify best practices, and making this information publicly available, will be a boon to all agencies to help them develop more effective programs.

However, in the State's recently released VBP Roadmap, there is little information regarding the measures that are being advanced by the Clinical Advisory Groups (CAGs). Without that information, it is difficult to determine whether those measures will be effective; are reasonable; and can be implemented on a timely basis. The Coalition strongly believes that public comment on the Model Contract could help shape the recommended measures.

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One measure that the Department of Health is using is the Healthcare Effectiveness Data and Information Set (HEDIS), which is a tool used to measure performance on important dimensions of care and service. We believe that HEDIS measures are heavily weighted toward physical health. If the transformation project is going to be successful, community-based safety net providers must thrive and we need metrics that reflect the contributions of behavioral health to outcomes. Basing the determination of incentives solely or primarily on avoiding emergency department and/or inpatient stays for medical care will not generate sufficient savings or health outcomes to justify this vast influx of Medicaid dollars.

The emphasis on metrics is critically important in efforts to address social determinants of health, but meaningful and effective support to community-based agencies has not been sufficient to provide the necessary data. In addition, the behavioral health community has not been involved in developing these metrics, although we are the experts in what is needed to develop successful population-based health strategies. Care must be given to assure that as service models and reimbursement change, there is monitoring of how this shift affects vulnerable populations and people without access to health insurance.

Finally, outcomes are also important because the Department of Health is required, "to reinvest funds allocated for behavioral health services, which are general fund savings directly related to savings realized through the transition of populations covered by this section from the applicable Medicaid fee-for-service system to a managed care model…for the purpose of increasing investment in community based behavioral health services..." (*Social Services, art. 11, § 365-m [5], as added by L 2014, ch 60*) This reinvestment of funds can be crucial for stabilizing the community-based behavioral health system and ensuring consumers/clients access to care. However, the attribution of savings must be accurately and fairly assessed, which will require the participation of OMH, OASAS, providers and other experts to develop effective measures.

We thank you again for this opportunity to comment on the State's 1115 Waiver programs. We look forward to working with you to ensure an implementation that will benefit all stakeholders.

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