ASSEMBLY STANDING COMMITTEE ON MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
PUBLIC HEARING

SUBJECT: Housing for individuals with a mental illness or developmental disability

Comments of Christy Parque, MSW

President and CEO

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My name is Christy Parque and I am the President and CEO of The Coalition for Behavioral Health, Inc. (The Coalition). Thank you for this opportunity to testify.

The Coalition is the largest umbrella advocacy and training organization of New York's behavioral health community, representing 140 non-profit community-based agencies and approximately 35,000 workers that serve more than 450,000 New Yorkers.

Our members provide access to the full range of outpatient mental health and substance use services, supportive housing, crisis intervention, care management, peer support services, employment readiness, Personalized Recovery Oriented Services (PROS), Home and Community Based Services (HCBS), Club Houses, education and nutritional services in every neighborhood of New York City, and communities across Long Island, Westchester, Rockland, and Orange counties.

The Coalition wholeheartedly supports the recommendations of the Bring It Home: Better Funding for Better Care campaign. I will direct my remarks both to the necessity of adequately funding of OMH funded housing and the overall state of the sector preparedness to withstand sector transformation and historical funding inadequacies.

The behavioral health field in New York State is in the midst of a transformation that places a greater emphasis on meeting the needs of people in their communities, and at the same time seeks to improve efficiencies and outcomes in the delivery of Medicaid services. The Coalition thoroughly embraces these goals and is an active partner with the State in ensuring that this is accomplished in a manner that enhances community stability and protects the viability of clinics and other service providers, including housing providers. Our members comprise an intricate network of safety-net

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providers throughout the neighborhoods they serve, caring for the most vulnerable among us. It is critical that this network remain strong and intact if the State hopes to reach its goals.

New York has long been a leader in the supportive housing field and is looked to by other regions for our success in creating real solutions for housing instability for our most vulnerable New Yorkers. **The public message that we send with this visionary commitment is that we understand that housing is vital to overall wellbeing and that physical health and behavioral health is integral to stability .** We have shown that people who were formerly forced to endure living in institutions or on the streets because there were no other solutions available, can now be welcomed back into our communities to live a life of recovery and productivity.

For over three decades New York has developed a viable and fiscally sound model of supportive housing development that has the great confidence of the developers, lenders and housing investors. Supportive housing now has "brand confidence" to borrow a term from the marketing world. [1] Research has never been able to establish a link between supportive housing sites and decreased property values or increased crime. To the contrary, community based providers' commitment to the fidelity to the model of supportive housing increases community confidence, and often times community opposition is won over after seeing the positive impact on the lives of the tenants and the frequently stabilizing effect on the community itself. Without fidelity and commitment to this model we lose the great benefits of supportive housing and also break our social contract with our partners—the developers, communities and neighbors and most importantly the clients and tenants. They deserve the opportunity to thrive that this model offers. **In order to ensure fidelity, sufficient resources must be committed to operate the program and building at levels consistent to tenants' concepts of what housing stands for,including important, but costly expenditures like staffing, maintenance, security, administration and of course program.**

In last year's SFY 17-18 budget we saw further proof of the State's commitment and vision to a model of community care via the $2.5 billion for affordable housing that was released to build 6,000 units of supportive and 100,000 units of affordable housing units over the next five years. New York State is on track to build 20,000 units over fifteen years under the new Empire State Supportive Housing Initiative (ESSHI). **Undoubtedly a tremendous commitment** This commitment is further evidenced by the announcement last week of the creation of the Bureau of Social Determinants of Health within The Office of Health Insurance Programs (OHIP). This bureau will be charged with focusing "its work on the social determinants of health (SDH) and the important role it plays in the health outcomes of New York's most vulnerable populations."

[1] https://shnny.org/research-reports/research/neighborhood-impact/

OPPORTUNITIES TO SUCCEED

We welcome these opportunities to truly transform care through Medicaid Reform for those we serve, and improve outcomes with higher efficiency and decreasing costs. **However, this innovation comes with great peril and risk to those closest to the clients—community based behavioral and physical health providers, and housing providers.**

Lack of adequate indirect funding across human services contracts has made it difficult for nonprofits to recruit and retain staff, , invest in professional development, upgrade technology, make necessary building repairs, and even for paying rent and utilities. Adding to the burden is increasing oversight that has financial implications and further stretches budgets to include compliance with a panoply of audits and auditing agencies. **Indirect funding is crucial to fiscally responsible and financially stable organizations.**

We recognize the commitment to bring standards to indirect funding through the study commissioned by the Governor's office and executed by the Rockefeller institute. We hope this information will lead us to important changes and investments including **1) using the federal rate where ever applicable; 2) setting universal standards that do not mask budget cuts; 3) with standards in place, set an adequate default rate; and 4) fund contracts to bring the rate up the standard.**

Although some state contracts may permit up to 15% administrative or overhead rates, that is rare, and does not include regular contracted increases or increases indexed to inflation despite escalating costs. It means that we are forced to make untenable choices between robbing from programming, leaving positions vacant, or not offering competitive or adequate salaries in order to cover operating and administrative costs. This includes things like maintaining facilities and other largely unfunded, or inadequately funded mandates.

Non-profit community based organizations have traditionally been under-resourced and are asked to do more with less. We are now being asked to engage in innovative models of funding and eventually assuming risk, while building upon an unstable foundation of past fee for services models that have never covered the costs of programming, operations and recruiting and retaining our heroic staff. Our sector, while both embracing the opportunities to better serve their communities through these funding changes, also subsist 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.

Worth noting is that this is not a new concern. A 2014 study, New York Health Care Cost and Quality Initiatives Payment Reform Survey[2], looked at pilot programs by New York health insurers to move to value-based provider payments and other initiatives to reduce health care costs and improve quality. A key finding that identified a barrier to reforms was that "Approximately half of the barriers identified by the surveyed insurers concern logistical obstacles, including information technology (IT) constraints, health information availability, difficulty of providers to maintain National Committee for Quality Assurance (NCQA) certification and lack of staff skill."

Fast forward to nearly 2018, and we are facing the same barriers to success the insurers faced although they were more financially sound with profits and reserves to mitigate risk to the operations. We are grateful for the SFY18 final budget inclusion of $500 million for the Statewide Health Care Facility Transformation Program and the set aside of $75 million to assist community based behavioral health clinics to prepare for integrated primary and behavioral health care. **However, this must be seen as a floor, and not a ceiling for CBOs. To succeed we must be equal partners in the both sides of the equation for successful participation in incentivized payments structures and integrated care.**

Necessary to transformation will be having the technology and appropriately trained staff in place to develop and measure sound and meaningful measurable outcomes. For community providers to make their programs sustainable, it will be necessary to fund and support technology needs and drive up the volume and reimbursement for services.

- **The State should expand funding opportunities and technical support available to further develop the infrastructure to support data collection and analysis, contracting and credentialing, and adoption of electronic health records and participation in health information sharing platforms.**

WORKFORCE SUSTAINABILITY

We recognize that to fully transform or "disrupt" the system will take time and require changing administrative and operational processes as well as 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[3], a response

[2] http://www.dfs.ny.gov/reportpub/payment-reform-report.pdf

[3] http://www.totalwebcasting.com/view/index.php?func=VIEW&id=nysdoh&date=2017-11-16&seq=2

to a question about "what was the biggest chunk" of PPS spending was Workforce and Health Information Technology. We have the same concern but have fewer options to address it.

- **We must 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. 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.**
- **The state should honor its commitment to continue the 3.25% Enhancement for Direct Care and Direct Support Staff in OMH, OASAS, and OPWDD Systems including the second 3.25% enhancement for Direct Care (Consolidated Fiscal Report (CFR) code series 100), Direct Support Staff (CFR code series 200), and Clinical Staff (CFR code series 300) on April 1, 2018 and reinstate the statutory COLA.**

CONCLUSION

While there is a growing demand for additional OMH housing and as people seek to be served in communities that are familiar and support their autonomy, current housing is threatened by inadequate funding. We laud the State's commitment to expanding its housing portfolio but we cannot let our existing OMH funded housing stock crumble. We cannot afford to lose one unit because of our inability to pay for a safe and a well operated building, unit and program. These are not just units or buildings—these are people's lives, health and recovery.

We must shore up existing housing resources while we continue to fund new supportive housing options. We cannot do one without the other.

Thank you for this opportunity testify today and I am happy to answer any questions.