



## **Reimagining Behavioral Health: Integrating Addiction and Mental Health Services Comments from The Coalition for Behavioral Health**

October 30, 2020

Thank you for the opportunity to provide comments on the potential integration of the New York State Office of Mental Health (OMH) and the New York State Office of Addiction Services and Supports (OASAS). We hope this public comment period is the first of many opportunities for the community to offer their recommendations on the potential integration of OMH and OASAS.

The Coalition for Behavioral Health is the umbrella advocacy association of New York's behavioral health provider community, representing 100 non-profit community-based behavioral health agencies that serve more than 600,000 consumers in New York City and its surrounding counties. In January 2020, The Coalition announced a plan to develop a strategic partnership with the Alcoholism and Substance Abuse Providers of New York State (ASAP) to build a unified voice for behavioral health providers, highlighting that integration is already happening in our field. Together, The Coalition and ASAP represent 250 community-based agencies throughout New York State.

The Coalition and its membership are pleased to see that the State is considering the integration of OMH and OASAS and support the concept of this endeavor, believing that a strong new agency will elevate behavioral health to its appropriate place as a significant part of the public health agenda, not an afterthought. In order to ensure the future success of the new integrated behavioral health agency, The Coalition offers the following strategic vision to guide the State in its agency integration:

- 1) The integrated agency must have equal power with the New York State Department of Health (DOH).**
- 2) It must be given oversight responsibility for managed care.**
- 3) It must have a voice and authority in Medicaid expenditures, reimbursement, and administration.**
- 4) The savings realized from the integration must be reinvested back into the community-based behavioral health service system and services must receive adequate funding that cover the true cost of care.**

Behavioral health is public health and an integral part of maintaining the health and well-being of New Yorkers. Without the equal partnership of the behavioral health system and appropriate funding, New York State will not achieve the goals of its broader healthcare priorities and initiatives including avoiding unnecessary hospitalizations and emergency room visits, increasing access to affordable, high quality healthcare, and reducing statewide healthcare expenditures.

Individuals with behavioral health needs also have extensive physical health needs, including diabetes and hypertension. Most of their healthcare costs are attributed to their physical health needs, not behavioral healthcare.<sup>i</sup> When people get connected to behavioral healthcare when they need it, they

become physically, mentally, and emotionally healthier, having a profound impact on other parts of their lives and the entire community. This not only saves people lives and helps build strong communities, it also saves money.<sup>ii</sup>

In addition, COVID-19 exposed the profound need for behavioral health services. The prolonged isolation, fear, and grief caused by COVID-19 could lead to long-standing trauma. By adequately funding behavioral health providers, we can ensure that providers have the resources and staff necessary to meet this demand and help our communities recover.

The Coalition offers the following detailed recommendations focused on provider agency and service recipient experience. This feedback ensures the integration of OMH and OASAS is successful and allows for the delivery of high-quality mental health and substance use services for New Yorkers.

#### **Client Experience and Access to Care:**

- **Develop holistic treatment and service protocols that are trauma-informed, person-centered, recovery-oriented, and prioritize client choice and clinical judgement.** The driver to integrate OMH and OASAS must be grounded in increasing access to high quality mental health and substance use services for New Yorkers. In the transition, we recommend that OMH and OASAS maintain and sustain programs, initiatives, and protocols that have benefited the community, such as harm reduction services and appropriate discharge protocols that prioritize client choice and clinical judgement, and to continue those efforts through the integration.
- **Create greater flexibility to offer services in the community and through telehealth.** Currently, OMH and OASAS have different rules, regulations, and flexibility around offering services in the community. For example, OASAS clinics operate on the recovery model and have much greater flexibility to provide services in the community, which is a model that should be extended to OMH clinics. Individuals must be able to receive equal and comprehensive access to care, regardless of the licensure of the clinic. In addition, all staff employed in OMH and OASAS licensed and credentialed programs, regardless of their professional licensure or lack thereof, must be able to provide telehealth (through video and audio-only) services and receive the same reimbursement rate as in-person services.
- **Expand services for individuals with dual diagnoses.** Approximately 20 to 50 percent of individuals with a mental health diagnosis have a co-occurring substance use diagnosis, and 50 to 75 percent of individuals with a substance use diagnosis have a mental health diagnosis.<sup>iii</sup> However, there are few integrated, holistic services available for those with dual diagnosis. Co-occurring diagnoses should be considered the expectation, not the exception, and the behavioral health system must become dual diagnosis capable. For example, there are very few services for youth with a dual SMI and SUD diagnosis. In order to provide effective, holistic, and timely care, integrated services must be developed. Moreover, there must be no wrong door when attempting to access care, and all clients, regardless of their behavioral health needs, should receive a comprehensive assessment and get connected to the care they need, whether it be at that agency or referred to specialized services. Individuals must be able to begin to receive care, regardless of having a formal diagnosis. In addition, the State must aid in the development of streamlined referral pathways to ensure that individuals get connected to the appropriate care as quickly as possible.

#### **Licensing, Oversight, and Audit:**

- **Combine licensing and regulations to simplify process for providers.** A merged agency must have one set of regulations and licenses that apply to all programs.

- **Develop a fully integrated mental health and substance use clinic license to allow for treatment of individuals with single or multiple diagnoses and remove the classification of primary diagnosis.** Currently, New York State has four different integrated care models (DSRIP 3.a.i, Integrated Outpatient Services (IOS), Collaborative Care, multiple licenses) with varying regulations, utilization thresholds, billing, and oversight authorities. Regulatory burdens and billing restrictions make it difficult for our providers to sustain integrated care services. Many individuals assisted by the behavioral health service system have a comorbid mental health and substance use diagnosis. In order to effectively serve the entire individual, services must be integrated in order to reduce duplicative care, break down arbitrary silos in the service system, and holistically help and individual achieve their health and recovery goals. In addition, the classification of primary diagnosis must be eliminated. Individuals must be able to receive services where they feel most comfortable with providers they trust, and not be limited to what the service system considers as their primary diagnosis. In addition, providers can attest for specialty services or client populations (such as high, medium, or low acuity which already exists in the Health Home system) to identify the clients they are best able to serve.
- **Establish unified and streamlined telehealth applications, regulations, and oversight.** We greatly appreciate OMH and OASAS providing substantial telehealth regulatory flexibility due to COVID-19. This allowed providers to transition their services to a telehealth delivery model and maintain services to individuals when in-person services ceased to be a safe option. As OMH and OASAS have developed new streamlined processes for permanently implementing telehealth, the new integrated agency must create one set of telehealth applications, regulations, and oversight to reduce provider burden such as duplicative processes and administrative paperwork.
- **Develop a unified and streamlined audit process.** Our providers have mentioned differences between the OMH and OASAS auditing processes including reporting, analysis of quality of services, and service authorizations. In order to ensure the State receives the necessary information for an audit and to reduce provider burden and duplicative processes, one streamlined audit process must be developed. There should be a unified audit division, and providers should not have to respond to multiple audits from multiple areas.

#### **Billing and Reimbursement:**

- **Ensure the same rates of reimbursement for parallel mental health and substance use services and maintain the prevailing rate.** Currently, OMH and OASAS have different rates for some analogous services. For example, OASAS offers a higher reimbursement rate for the initial assessment diagnostic and treatment plan than OMH. Some of our providers who have an IOS license can only bill the lower OMH rate since their primary license is with OMH, even if they are serving a client with a substance use need. In order to achieve parity across the two systems, all analogous services must be paid at the same rate and the higher rate must be maintained.
- **Expand the Certified Community Behavioral Health Clinic (CCBHC) model in New York State.** The CCBHC model has allowed several Coalition members to offer integrated services in the community that are financially sustainable through the prospective payment system methodology. In addition, the model and reimbursement system foster true integration of services and enables programs to allocate their staff efficiently. For example, for clients with a dual diagnosis, CCBHC's do not need to have two different certified peers working with one person. In addition, the model helps remove client stigma, since a client who has a substance use and mental health need can have their services addressed in one agency by the same staff.

- **Allow for Medicaid reimbursement for the purchase of telehealth equipment and time spent assisting clients to access telehealth platforms.** The speedy adoption of telehealth across the State due to COVID-19 allowed providers to continue to offer care. However, not all individuals across the State had equal access to telehealth care, due to lack of equipment, such as computers, smartphones, and tablets, limited internet reception, and limited data plans and minutes. COVID-19 demonstrated that access to technology and technological literacy is a social determinant of health. Currently, Medicaid offers coverage and reimbursement for health equipment, such as a home blood pressure monitor. We recommend that savings from the State agency integration be used to allow for Medicaid reimbursement for behavioral telehealth equipment, such as tablets, cameras, and smartphones, and for time staff spend training and assisting clients to use the equipment and software.
- **Develop a fully integrated Medicaid/Medicare managed care plan.** As the population in New York State continues to age, connections to behavioral health services for the older adult population is imperative since lack of access to appropriate behavioral health services in the community drives up overall healthcare costs and makes it more difficult for individuals to age in place. Moreover, adults with SMI and SUD are living longer, due to access to better care. Currently, dual eligible clients are not allowed to access to Home and Community-Based Services (HCBS), which negatively impacts older adults who become dual eligible and have already received HCBS and must stop services before they have completely their health and recovery goals.
- **Reduce the number of managed care plans in a single region and eliminate problematic managed care plans and behavioral health organizations (BHOs).** In order to effectively integrate care, reduce State and provider administrative burden, and ensure New Yorkers get access to quality behavioral healthcare, the State must reduce and consolidate the number of Medicaid managed care plans. Currently, there are 18 Medicaid managed care plans across New York State. Every region in New York State has at minimum two Medicaid managed care plans, and some regions, such as New York City, have 10 managed care plans. Community-based providers who serve the Medicaid population are in contract with multiple managed care plans, especially in New York City. Since every managed care plan has its own processes, staff must spend an incredible amount of time learning every plan's processes and procedures, which wastes time and money. Providers want to be in contract with the plans their clients are enrolled in to ensure continuity of care and access to services, and clients frequently change their plans annually in areas where there are multiple plans. In addition, some plans fail to pay providers on time and have not updated their systems with the appropriate billing codes and reimbursement rates, which negatively impacts community-based organizations that rely on timely payment to sustain their programs. The State must eliminate problematic Medicaid managed care plans and BHOs that are causing instability to the behavioral health service system.
- **Allow behavioral health provider attribution for value-based payment (VBP) arrangements for the SMI and SUD population.** Many clients with SMI and SUD are served primarily by behavioral health service providers who they see on a routine basis and much more frequently than their primary care provider. Since behavioral health providers are working with these individuals extensively, and studies show that connections to behavioral health can greatly improve overall healthcare outcomes, behavioral health providers must be able to receive the majority of shared savings.

**Workforce:**

- **Develop unified core competencies and trainings for behavioral health staff.** Currently, OMH and OASAS have different professional qualifications across their programs. For example, some roles in the OMH system require a master's degree whereas similar roles in the OASAS system do not require advanced degrees and prefer individuals with lived experience. In addition, certain roles, such as CASAC's, do not have a counterpart in the mental health system. In the transition, staff must be able to maintain their roles without needing to acquire additional credentials. In addition, we recommend that the integrated agency develop unified training and establish unified core competencies for staff in order to develop cross-trained staff.

#### **Integrated Behavioral Health State Agency Internal Organization:**

- **Develop a unified philosophy and treatment approach.** Currently, OMH and OASAS have separate philosophies and treatment approaches. In order to truly integrate care and serve all the behavioral health needs of New Yorkers holistically, the integrated agency must have a unified philosophical approach to treatment, including how staff at various levels and professional backgrounds engage, serve, and develop treatment goals with clients. We recommend that the integrated agency adopt a trauma-informed, person-centered, recovery-oriented philosophy and treatment approach to care and services and advance best practices from both OMH and OASAS.
- **Create a steering committee including State and provider leadership to monitor and oversee the entire agency integration process.** In order for the agency integration process to be successful, the State must have buy-in and meaningful participation from the community in the planning and monitoring of the integration process. The fall 2020 listening sessions are a good opportunity for stakeholder feedback, however we recommend that the State develop a steering committee with State and provider representation to review and make recommendations to the State on the OMH and OASAS integration plan, and to monitor and evaluate the outcomes and impact of the integration on the service provider system and client care.
- **Propose new person-centered, performance outcome measures, publish the data online, and update on a routine basis.** Current behavioral health metrics do not fully capture the impact of behavioral health services on an individual and ways they help an individual attain their health and recovery goals. In order to understand the impact of integrated services on the community, meaningful data must be available to providers and the public. In addition, the State must publish data on the rate of dual mental health and substance use diagnoses by county or zip code to allow providers to understand where the gaps in care exist and develop ways to better engage individuals who are not receiving treatment.

We thank the State for the opportunity to share our feedback and recommendations to ensure the successful integration of OMH and OASAS. To achieve New York's long-term healthcare and Medicaid goals, the State must prioritize access to high quality behavioral healthcare since this is a fundamental component of public health. With an integrated behavioral health agency, the State will be able to dedicate more resources and attention to the behavioral health needs of all New Yorkers.

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<sup>i</sup> Thorpe, K., Jain, S., & Joski, P. (2017). Prevalence and spending associated with patients who have a behavioral health disorder and other conditions. *Health Affairs*, 36(1). Retrieved from <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0875>

<sup>ii</sup> Davenport, S., Gray, T. J., & Melek, S. (2020). How do individuals with behavioral health conditions contribute to physical and total health spending? *Milliman*. Retrieved from <https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx>

<sup>iii</sup> National Association of State Mental Health Program Directors. (2019). Integrated systems and services for people with co-occurring mental health and substance use conditions: What's known, what's new, and what's now? Retrieved from [https://www.nasmhpd.org/sites/default/files/TAC\\_Paper\\_8\\_508C.pdf](https://www.nasmhpd.org/sites/default/files/TAC_Paper_8_508C.pdf)