



Comments from The Coalition for Behavioral Health on the HARP BH HCBS Transition to Behavioral Health Adult Rehabilitation Services (BH ARS)

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. The Coalition recently 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, highlight integration as the future of our field, and improve care for individuals with co-occurring mental health and substance use disorders. Together, The Coalition and ASAP represent 250 community-based agencies throughout New York State.

The Coalition for Behavioral Health is committed to partnering with the State as various transformations to the State Medicaid system move forward, including the behavioral health transition to managed care, the shift to value-based payments (VBP), and efforts to integrate both physical and behavioral health services. The Coalition supports the New York State Department of Health in its effort to secure an 1115 Demonstration Waiver to transition the current Adult Behavioral Health Home and Community-Based Services (HCBS) to Behavioral Health Adult Rehabilitation Services (ARS).

The Coalition and its membership are pleased to see the State is transitioning HCBS to ARS to streamline the workflow and increase access to ARS. Since the introduction of adult HCBS in New York State in 2016, there have been many barriers in getting Health and Recovery Plan (HARP) members access to HCBS. According to NYS Office of Mental Health (OMH) data from May 2020, there are 177,437 HARP eligible members statewide, however after over four years, only 8,343 people have received HCBS, nearly five percent of the total possible eligible individuals.

We thank the State for working with providers and localities over the past four years to help improve access to adult HCBS, which has helped increase enrollment and retention in HCBS. Some of the actions the State took include: removing the requirement of completing the full HCBS assessment, authorizing managed care plans to provide the level of service determination verbally, allowing care managers to complete a brief plan of care to initiate HCBS, creating Recovery Coordination Agencies and allowing clients to access HCBS without enrolling in a Health Home, and investing funds into HCBS by maintaining the enhanced/productivity HCBS rates and creating the HCBS quality and infrastructure funds.

Among The Coalition's membership, approximately 41 members are designated adult HCBS providers, 30 are adult care management agencies, one is a lead Health Home, and one is a

Medicaid managed care plan. Some of the barriers our providers and their clients have experienced include:

- The multilayer, overly complex, extensive workflow that requires the Health Home care manager, managed care plan, and HCBS provider to all work in concert and ensure that the client be fully engaged throughout the entire HCBS workflow process. This process can take months and includes enrolling into a HARP, enrolling into a Health Home, being assigned a care manager, completing the HCBS assessment and plan of care, and being connected to. Some clients lose interest in obtaining HCBS or fall out of contact with providers at each step of the workflow, making it more difficult to connect clients to care.
- Lack of uniform training, education, and experience among care managers, leading to misunderstanding of and incorrect referrals to HCBS.
- Difficulty in identifying and engaging HARP-designated clients into Health Home care management and HCBS.
- Overly burdensome administrative and assessment requirements, causing high turnover among care managers and clients to fall out of care.

The Coalition supports the transition to ARS and has some key recommendations to ensure the success of ARS and to avoid some of the challenges that plagued HCBS. ARS is intended for individuals who have a serious mental illness (SMI) or substance use disorder (SUD), who are some of the most difficult individuals to engage and most costly to the Medicaid system, have fallen out of care, and not received the appropriate services they need. People want to receive services in the community when they need them, usually during a time of crisis, and do not want to be inhibited by confusing and cumbersome workflows that delay services and beneficial health outcomes. In addition, providers want to deliver services to clients when they need them, and do not want to delay initiation in care due to administrative burdens and state-mandated processes that do not enhance treatment.

The Coalition offers the following recommendations to improve the ARS waiver application. These recommendations help ensure expedient access to ARS, which will ultimately keep those with SMI and SUD in the community and out of the emergency room and other expensive and unnecessary care.

Client Outreach, Engagement, and Enrollment into ARS:

- **The ARS workflow and services must be person-centered and aid in recovery, rather than impeding care.** The workflow must allow for immediate ARS referral and service initiation and the State must remove any unnecessary steps or barriers that inhibit access to care.
- **Provide clear guidelines on identifying and engaging HARP members in ARS.** Care managers face incredible difficulties finding HARP-eligible clients in the community and engaging them in HCBS. Although ARS will allow any licensed practitioners of the healing arts (LPHAs) to refer to ARS, this will still require LPHAs to identify clients who are HARP enrolled or eligible, most likely by checking eMedNY or PSYCKES before every session with every client with an SMI or SUD. This would be overly burdensome and time consuming for staff.

- **Develop a statewide training and materials on ARS for LPHAs, Health Home care managers, and other ARS referral sources.** In order to ensure clients are connected to ARS, all potential referrers must have a comprehensive understanding of the benefits of ARS to effectively raise their client's interest in these services.
- **Allow a ground-up community referral process for HARP.** Currently, the State determines who is HARP eligible through SMI and SUD diagnosis and other risk factors and clients are notified of their eligibility through the mail. There is not a process for providers to refer clients to HARP, even if the client meets all eligibility requirements. A HARP community referral process would allow for immediate engagement in ARS since the practitioner could engage clients who are interested in receiving ARS.
- **Do not require an additional ARS assessment for HARP clients already enrolled in a Health Home.** Many questions relevant to assessing someone's need for ARS are already included in the Health Home Comprehensive Assessment, which is already quite lengthy and detailed. Any additional or duplicative steps can cause the client to lose interest in services or fall out of care.
- **Monitor and ensure MCOs provide approval and authorization for ARS in a timely manner.** Providers have reported delays from MCOs in receiving authorization for HCBS. Any delay can cause clients to lose interest in the service and fall out of care. MCOs must be able to provide timely responses to ensure the client can access ARS as quickly and expeditiously as possible.

Billing and Reimbursement:

- **Maintain HCBS enhanced/productivity rates for ARS and develop a capitated rate for ARS.** Although the volume of clients receiving HCBS has increased over the past four years, the reimbursement rates are difficult for providers to sustain since the number of clients served by each provider has remained low. Currently there are 228 HCBS providers throughout the State, however only 8,343 clients have received HCBS since 2016. In addition, much of the mandatory work HCBS providers do to deliver the service is not reimbursable, such as collateral contact, engagement with the care manager or MCO, or engaging potential clients before they are enrolled in HCBS. A case rate, which Health Homes currently receive, would allow providers to predict revenue and cost for the service each month and scale staff depending on demand for ARS.
- **Allow for continuity of care for duals eligible clients (Medicare/Medicaid) in ARS.** Currently, dual eligible clients are not allowed to access 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.
- **Authorize reimbursement for ARS delivered through telehealth and telephone and permanently maintain COVID-19 telehealth and telephonic regulations.** During COVID-19, HCBS providers have successfully engaged clients through telehealth and telephonic care, helped people stay on track with their health and recovery goals, and kept people out of the emergency room during the height of COVID-19. Ongoing, clients and providers must be able to determine when a visit will be through telehealth, telephone, or a face-to-face based on client choice and clinical assessment.

Service Delivery and Definitions:

- **Ensure the transition from HCBS to ARS is streamlined and uncomplicated for providers who are already HCBS-designated.**
- **Provide additional funding (such as Behavioral Health Information Technology funding) to help providers transition their electronic health records (EHRs) from HCBS to ARS.** ARS will merge five services under the Psychosocial Rehabilitation (PSR) umbrella which will require providers to update their EHRs. Many providers do not have the resources to update their EHRs and need financial support in order to make these changes.
- **Develop a crosswalk for providers to ensure current HCBS staff meet the educational and employment qualifications to deliver ARS.** With the transition to ARS, PSR will have a focus on educational and vocational goals. Providers need guidance to ensure their current HCBS staff meet the criteria to provide ARS.

Impact of the Transition on Health Home Care Management Agencies (CMAs) and Staff:

- **Define the role of the Health Home care manager in ARS.** Since care managers will no longer be the sole referrer to ARS, the State must define the role of care managers in ARS. Currently, all CMAs have structured their programs based on the HCBS workflow. Changing the regulations to allow any licensed practitioner to complete eligibility assessments may stunt the continued financial viability of these roles and potentially lead to turnover.
- **Identify the individual who is responsible for navigating the client through the ARS workflow:** It is unclear if the ARS referrer or provider is responsible for ensuring the client receives authorization for ARS from the MCO after the assessment is complete and completing the plan of care. Without specialized staff, such as current Health Home care managers, overseeing the ARS referral and plan of care process, it is possible that fewer clients may get referred and connected to ARS.

We thank the State for the opportunity to share our feedback and recommendations to ensure the success of ARS. To increase client access, enrollment, and engagement in ARS, the workflow must be as streamlined and simple as possible, and all behavioral health providers must be aware of the services and able to discuss them with their HARP-eligible clients.

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