THE

90 Broad Street
New York, NY 10004
Phone 212.742.1600
Fax 212.742.2080
www.coalitionny.org

REMARKS OF JAMIN R. SEWELL
COUNSEL & MANAGING DIRECTOR FOR POLICY AND ADVOCACY
THE COALITION OF BEHAVIORAL HEALTH AGENCIES

OVERSIGHT:
"MEDICAID REDESIGN"
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Good Morning, Chairman Cohen and members of the NYC Council Commitee on Mental Health, Developmental Disabilties, Alcoholism, Substance Abuse and Disability Services. I am Jamin R. Sewell, Counsel & Managing Director for Policy and Advocacy for The Coalition Of Behavioral Health Agencies. I am joined by Patricia Gallo Goldstein, The Coalition's Chief Operating Officer. The Coalition is the umbrella advocacy organization of New York's behavioral health community, representing over 130 non-profit community-based behavioral health and substance abuse agencies that serve more than 350,000 clients/consumers throughout NY. Our member agencies are on the ground, front-line safety net providers. The vast majority of the individuals served pay for services with public insurance plans. We treat some of the most needy individuals, including those with dual diagnoses of mental health and substance abuse problems. Our providers serve the homeless and the formerly incarcerated as well as victims of trauma and abuse. The agencies we are represent are in every Council District and neighborhood in the city.

On behalf of our Chief Executive Officer, Phillip Saperia, who regrets that he cannot attend today, and the Coalition Board, I would like to thank you for this opportunity to present our thoughts on Medicaid Redesign.

Integral to the process of Medicaid Redesign is the concept of integration. The Coalition's members have been practicing care in a bifurcated system for many years, where the medical/primary care is organized under managed care while the behavioral health services for people with serious mental illness and chronic addictions have been "carved out" and remain in a fee-for-service mode. It is clearly time to integrate services—mental health services and substance abuse services within behavioral health, and behavioral health with primary care—and The Coalition is fully supportive in concept of this important change in public policy. It is good for the client/consumer and it is good for the system to be able to access the full range of care, primary and behavioral. It also is cost-effective by reducing hospitalizations and emergency room

visits and providing holistic preventive care. Many persons with less complex behavioral health conditions, having been served under managed care as part of the overall Medicaid benefits for mental health and substance use issues, already access some integrated care and we expect that this would continue and hope it will improve access and coordination of care.

While the Medicaid Managed Care transformation (full carve-in to managed care plans; Health Homes, Health and Recovery Plans (HARPS) and Fully-Integrated Duals Advantage programs (FIDAs) for the populations our members serve); is happening in a compressed timeframe other system transformations and dislocations resulting from the implementation of the Affordable Care Act (ACA) and New York State-initiated reforms are occurring simultaneously, affecting many of the same community-based providers. Furthermore, ACA will make even more consumers eligible for Medicaid at a time when the safety-net system is shrinking and off balance. The two goals of savings and access to care were also the driving objectives of the implementation in New York State of Health Homes under the Affordable Care Act. (The Federal Government paid the State 90% of the costs in the first two years—normally New York splits Medicaid costs on a 50/50 basis. The roll out of the Health Homes, even in this advanced phase, has been challenging and uneven for providers and clients/consumers, and affords us with a problematic test case that gives us even more reason for concern as we move rapidly toward an April 1 managed care carve-in for adults in New York City (postponed from an original January 1 date).

Hugely disruptive State-mandated clinic rate modifications, the loss of Comprehensive Outpatient Services (COPS) reimbursements and changes in Medicaid regulations that have required funds to be returned to government, already have impacted negatively on the clinic programs, engendering significant numbers of clinic closings and made many other programs vulnerable. We worry that other closures seem imminent. We are aware of 14 agencies forced to close, in some instances, multiple adult and family behavioral health clinics in the past several years. Dozens of school-based mental health clinics have closed as well. Entire agencies and other non-clinic programs have been downsized or closed because of inadequate State and City funding. Vital community-based programs such as certain rehabilitation programs, club houses and psycho-social clubs as well supportive housing have are in financial distress.

The introduction of managed care organizations to Medicaid as part of the redesign process will, without a doubt, be an extremely difficult transition. It is worth noting here that no other State has implemented and all-in; all at once carve-in. While some States have some successes, others have registered some failures in the pilot programs they have implemented. The Coalition and its providers are racing to keep up with and extremely rapid time frame for change and its multiple complex parts.

The Coalition is fearful that the safety net system will be destabilized beyond repair and that needy consumers could be lost to care—counteracting the very premises of the transformation that would move people from inpatient and emergency services to preventive and recovery oriented community based-services. This behavioral health safety net consists now of community based providers in every City Council district and neighborhood of the city. The safety net comprises providers who provide specialized high touch, legs-on-the ground care for high needs clients/consumers. We do not

believe that the behavioral health safety net can be recreated in hospitals and other primary care settings.

Again, The Coalition recognizes and supports the movement to integrate behavioral health, substance abuse treatment, and physical healthcare. Integration should lead to better outcomes for patients and more seamless interactions between providers, insurers and regulators. We are concerned, however, that the implementation of integration be effectuated in a thoughtful, careful and measured manner, otherwise the outcome could be the denial of needed care for patients and overburdensome regulations for providers.

Recent draft regulations promulgated by the New York State Department of Health (SDOH), Office of Mental Health (OMH) and Office of Addiction and Substance Abuse Services (OASAS) regarding licensure for Integrated Outpatient Patient Services give us some concern. The streamlining of the licensing process for agencies that desire to expand the focus of their current services to substance abuse treatment, mental health and/or physical health is a worthy goal and one that we strongly support. The proposed regulations, however, in our opinion, fall short of this goal. Rather than a streamlining of the regulatory burdens of licensure (and for that matter compliance), the proposed regulations graft existing regulations for each sector (i.e. physical, mental health and substance abuse care) without any significant reduction in the mandates for each to comply with licensure requirements. Due to the highly regulated nature of DOH-licensed providers relative to the environment and space requirements, the integrated license application process for Article 28 providers (e.g., Hospitals and Diagnostic & Treatment Centers) will be vastly simpler than it will be for OMH and OASAS licensed providers who seek to add physical health services.

In our view, the regulations, as currently drafted, are primary care centric. (This is a general concern in the behavioral health community regarding the entire Medicaid Redesign process.) Whether by design or problematic drafting language, the proposed regulations do not address the scenario of behavioral healthcare community based providers, i.e. Article 31 and Article 32 providers who seek to expand their services within the behavioral health setting. They *only* address the physical-mental health, physical-substance abuse models. This is a real opportunity to have more integration between mental health and substance abuse treatment that has been missed in the draft regulations.

Some Coalition members have commented that these regulations do not deal with the financial realities of integrated care. The current reimbursement rates do not create a level playing field between Article 28 providers and Article 31 and 32 providers, nor will they cover the costs associated with integrated care. The same physical health care service, if performed in an Article 28 clinic, will provide far greater reimbursement for that clinic than a comparable service performed in an Article 31 clinic. Providers should be allowed to bill comparably for comparable services.

Thus far, the State has not proposed any regulatory relief with regard to these new “integrated” licenses and, given the differences between providers, the State should be allowed to waive certain provisions, if that waiver would not affect the quality of care provided. Physical plant provisions, in particular, may require waivers.

On the positive side, we are pleased that the State has delayed the full carve-in of behavioral health services to April 1, 2015 from January 1, 2015. This will provide more time for the behavioral health community to be adequately prepared.

Even more important, is that the current payment rate system, called Medicaid Ambulatory Patient Groups (APGs) will remain in effect for 2 years from the full carve-in. After that point, (now April 1, 2016) behavioral health agencies will be required to have contracts with individual managed care organizations *including negotiated rates* in place. Apart from the inherent imbalance of power between these community based organizations and managed care insurance carriers, we have myriad concerns about the viability of behavioral health clinics in this new environment.

At this moment, there is no standardization between managed care organizations with multiple and unique requirements for request for authorizations, claims procedures, documentation requirments or appeals processes. With large behavioral health agencies reporting on how complicated it is to function in the current managed care environment, we fear it will be even more difficult for small and medium sized agencies to implement practices that will comply with the varied and disparate paperwork and processes that will be required in order to bill multiple plans in the new managed care world.

Our members have some experience dealing with managed care organizations through comercial insurance contracts, and they note that lack of standardization—even within the same company for different product lines—is staggering. Varied forms, delayed authorizations, delayed payments and low rates of reimbursement are the norm. In fact, our members have told us that because of the low reimbursement rates and convolulted procedures of private managed care plans they are seeing far fewer clients/consumers with private coverage.

As I mentioned earlier, many clinics are *currently* in financial distress and large numbers have in fact closed. Our small and medium size members report that cash flow is a frequent problem that has led to larger caseloads, layoffs and even inability to make payroll. If the experience with private managed care plans is similar in the new environment with regard to delayed approvals and payments when Medicaid managed care is implemented, we fear that our currently distressed members will suffer and more safety net behavioral health providers will close.

What can we and, specifically, the Council and the de Blasio administration do to adress this crisis? The Coalition has several proposals we respectfully request that you consider and advocate for with your State counterparts.

1. The SDOH, OMH and OASAS must maintain strict oversight of the managed care organizations beyond 2016 to ensure that claims are not innapriopriately denied and paid in a timely manner. We think the New York City Department of Health and Mental Hygiene (DOHMH), specifically the Division of Mental Hygiene, also has a Plan oversight role.
2. The DOHMH has been incredibly active and supportive of behavioral health providers with advocacy to the State on the entire Medicaid redesign process.

DOHMH has been a source of information and education for providers on Medicaid redesign including a series of sessions hosted at The Coalition targeted for varying types of behavioral providers. We strongly encourage DOHMH to remain viligant and proactive in its discussions with the State over the implemenation of Medicaid Managed Care for behavioral health.

3. From what we have seen from the transition to Health Homes, is that the insurers have had nearly as difficult time getting up to speed as the providers, which has led to delayed or even failure to pay claims, therefore the State should fund a special pool of dollars apart for community-based behavioral health agencies that are in financial distress.. Several of our providers have told us that delayed payments over a 90-day period could lead to more programs being closed.
4. The Council and the de Blasio administration should consider partnering with the State onfunding to ensure that distressed safety net providers are able to make the transition from fee for service to the managed care environment. Funds could be used for reorganization and reengineering to encourage back office efficiencies through collaboration, co-location and even merger.

Again, thank you for convening hearing on Medicaid Redesign. We look forward to working with the Council and the Administration to ensure that our safety net providers continue to provide the high quality of services that will allow individuals with behavioral health issues to thrive in our communities.