Testimony

of

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New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Mental Health, Developmental Disability, Alcoholism, Drug Abuse & Disability Services

on

Oversight: Medicaid Managed Care and Behavioral Health Services

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250 Broadway, 14th Floor Committee Room
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Good morning Chairman Cohen and members of the Committee. I am Dr. Gary Belkin, Executive Deputy Commissioner of the Division of Mental Hygiene for the New York City Department of Health and Mental Hygiene. Thank you for the opportunity to testify on the important issue of Medicaid Managed Care and mental health and substance use services, an area I will refer to as 'behavioral health services'.

The issue before us today is pressing and far-reaching: Medicaid costs in New York State have grown exponentially over the last several decades and are no longer sustainable. The move to managed care for behavioral health services began in New York City in October 2015. Before then, New Yorkers covered by Medicaid with behavioral health conditions had received treatment and other clinical services primarily on a fee-for-service basis, meaning a provider is paid for each specific service they provide an individual without adequate consideration for the quality, necessity, or effectiveness of the care that is received.

Historically, there has also been little systemic coordination of all these individually provided services, and an over-reliance on expensive hospital in-patient services. In-patient hospital stays in New York represent over 50 percent of behavioral health Medicaid costs, and the State has some of the longest lengths of hospital stays in the country. The lack of coordination has also resulted in New Yorkers receiving their behavioral and physical health care separately, often engaging individuals in two distinct systems with different regulations, oversight bodies, reimbursement schemes and data. In addition, because of the common co-occurrence of behavioral health and medical conditions, and the destructive effects of those combinations, behavioral health outcomes have become a key driver of excess costs for physical health care.

Through managed care, the State is working to address these issues. In a managed care approach, the State expects to eventually pay a monthly per person rate to a managed care insurance plan, creating incentives for plans and providers to deliver more preventive services, identify problems earlier, and better coordinate care and recovery, with the end goals of improved overall health outcomes and reduced costs. Better ability and incentive to use outpatient solutions, should reduce inpatient needs and shift resources to support outpatient growth. This is the crucial but perhaps most tenuous aspect of these changes.

While there are potentially substantial gains to be made from this shift, putting this vision into practice is not easy or quick. Since 2011, when overall Medicaid reform began, the Department has been working with the State on the oversight of integrated managed care services, and we have been deeply invested in preparing for how to apply these changes to the New York City behavioral health system. The Department was able to successfully advocate that plans manage and coordinate individuals' behavioral health *and* physical care together. All

Medicaid recipients who need behavioral health services, approximately four million New York State residents, will have their care provided within such Medicaid managed care plans.

In addition, a subset of these plans, known as Health and Recovery Plans, or "HARPS", will also offer an enhanced package of benefits of psychosocial services and supports to eligible New Yorkers with particularly complex behavioral health needs, an estimated 60,000 individuals. All ten Medicaid managed care plans serving New York City have been designated to provide behavioral health services, and eight of these offer the HARP benefit. The Department helped the State to develop the Request for Qualifications (RFQ), which establish standards of care that HARPS should provide. We also participated in reviewing the plans for readiness, and will monitor the quality of care they provide.

The move to managed care has the potential for enormous benefits for New Yorkers with behavioral health needs, but I want to acknowledge that it is not without its risks and uncertainties, and ensuring a successful transition requires a concerted effort by multiple parties on a number of fronts.

First, providers and beneficiaries must understand the new system in order to implement many of these benefits. To that end, since October 2015, the Department has collaborated with the State on various education efforts to improve community knowledge of the behavioral health transition and how it impacts providers and service recipients. These activities include: public forums in Manhattan, the Bronx and Brooklyn; development of translated resource materials for service providers for the State website; and development of the New York State HARP Model Member Handbook that is distributed to members once they are assigned a HARP. However, more needs to be done. Moving forward, the Department plans to work with provider groups and networks as they interact directly with enrollees and who play a key role in engaging and educating them on the new system.

Second, providers need the operational support and resources from the State necessary to adapt new payment structures and related changes to service delivery. In particular, providers that offer Home and Community Based Services (HCBS), which are reimbursable under Medicaid for the first time, may struggle to upgrade and adapt their current systems for case documentation, data collection, and billing. To help with this, the Department successfully negotiated and received $10 million in State funding to implement a two year project to provide electronic billing and health record systems, technical assistance and clinical practice improvement support to approximately 125 qualifying HCBS providers. In order to successfully offer these new services, HCBS providers must also work to modify their business models and train staff. To help them do this, the Department developed the HCBS manual and negotiated with the State to set reasonable reimbursement rates based on analyses of current State aid offered to providers. Also, we serve as members of the State's managed care technical assistance steering committee, which shapes the quality and content of technical assistance and

trainings offered to providers. While the Department is working on a number of fronts to assist service providers through this transition, the State's leadership is critical to ensuring that the transition is successful.

Third, there must be improved cross-systems communication, problem-solving and information sharing among the agencies and organizations that are needed for the managed care system to work. To facilitate this, the Department convenes the New York City Regional Planning Consortium (or RPC), a multi-stakeholder body tasked with monitoring the implementation of managed behavioral health care and identifying solutions to issues raised by RPC members. The RPC is comprised of steering groups with representation from the following key stakeholders: managed care plans, provider groups and coalitions, service recipients, health homes, and New York City Health and Hospitals. Since the RPC's roll out in late 2014, the Department has led regular meetings with these groups focusing on issues related to service efficiency, access, quality and capacity, well as plan performance and system stability. The RPC has discussed issues like ensuring timely payment by Managed Care Organizations, lack of regulatory guidance on billing for certain types of services, referral processes, and unclear eligibility requirements in the health homes. Currently, the RPC is focused on understanding managed care implementation challenges, improving low Health Home enrollment rates and minimizing the number of people who opt-out of the HARP benefit when these plans offer important services that can really improve their lives. Additionally, many providers impacted by the transition and key to its success are also involved in Delivery System Reform Incentive Payment, or DSRIP; therefore, we manage the NYC Behavioral Health Performing Provider Systems Group, or PPS Group, as an RPC steering group. This structure allows these provider systems to communicate directly with managed care organizations and align discussions surrounding payment. The RPC serves as an entry point for vital, real-time feedback and recommendations from key stakeholders for improving the transition of behavioral healthcare into the Medicaid managed care system.

Finally, the Department contributes to the oversight of the transition to Managed Care, along with the State Department of Health, and State Offices of Mental Health and Alcoholism and Substance Abuse Services. While the Department is still in the process of shaping and clearly defining this function in partnership with the State, we are monitoring plan performance and tracking systemic issues related to service delivery. For example, in collaboration with the State we conducted readiness reviews of the ten New York City managed care plans that applied to offer behavioral health services; developed managed care performance metrics to measure service delivery and quality; credentialed 168 HCBS providers; and drafted the behavioral health amendment to the State Department of Health's contract with managed care plans that codifies the standards of service that must be met. Additionally, the Department participates in daily calls with the State to share information regarding provider billing concerns and consumer complaints.

We also expect to co-convene the Quality Steering Committee (QSC), which will be comprised of representatives from the relevant State agencies and DOHMH to monitor and oversee the quality of behavioral healthcare in Medicaid managed care plans serving New York City residents.

Complementary to our collaborative work with the State offices, behavioral health providers may also be able to benefit from several ThriveNYC initiatives that aim to bolster the transition to more integrated and high-impact models of care. City's behavioral health system infrastructure. We will be establishing a Mental Health Innovation Lab that can gather and share information about, and help providers adopt and implement, best practices. In addition, we are in discussions with managed care organizations and DSRIP PPS's to collaborate with the Department on the development of NYCSupport – an initiative to enhance the capacity of the City's phone-based crisis hotline to also more directly connect people to care. There may also be opportunities for DSRIP PPS providers to further integrate behavioral health services into their primary care settings through the Mental Health Services Corps initiative. At its full strength, this initiative will place approximately 400 recently graduated Master's and Doctoral-level clinicians in primary care practices, substance use programs, and mental health clinics to expand the use of the collaborative care model in high-need communities throughout the city.

The Department is similarly engaged in the changes to managed care for children's behavioral health services, which are expected to take effect January 2017, a year later than previously planned. This transformation will expand eligibility requirements to allow more children access to care; increase availability of community-based step down services; and provide coverage for an array of support services. Additionally, Medicaid redesign will also result in the movement of special populations of children with higher levels of service needs into managed care, such as children with serious emotional disorders, medically fragile children, and children in foster care. This phase in the Medicaid redesign effort will require adequate capacity, quality and accountability in the children's behavioral health system, funding for system development, and education for participating providers and families.

To this end, the Department has provided input in the development of benefit packages, network standards, care coordination, quality metrics, criteria for provider selection and monitoring, and credentialing processes. We continue to advocate for adequate reimbursement for evidence based practices and for sufficient funding for services and provider readiness. Finally, the Department participates in a State-led workgroup that designs trainings to help providers understand and prepare for the transition to managed care. We have also conducted focus groups to understand the information needs of youth and families; our findings will help to inform our outreach strategies to this population.

We believe it is possible that a managed care approach can help individuals in New York City recover from behavioral health issues, reduce hospitalizations, and improve their physical

health outcomes. This transition will in some ways support, and in other ways, pressure, important changes in how behavioral health care is provided and held accountable. It will be complex, evolving, and challenging. We look forward to working with the Council to educate and prepare the community on the impact of these changes and to realize their potential for improved outcomes and care.

Thank you for the opportunity to testify. I am happy to take any questions.

Scott Wetzler, PhD

Vice Chairman and Professor

Department of Psychiatry & Behavioral Sciences

Montefiore Medical Center/

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Testimony to the

New York City Council

February 22, 2016

Thank you for the opportunity to discuss the impact Medicaid Redesign has had on behavioral care. On behalf of Montefiore Health System, I want to thank this Committee and Chairman Andrew Cohen for their focus on this important issue. We could not be more grateful for his leadership.

Simply put, Medicaid redesign has completely changed the delivery of behavioral health care in New York State (NYS), and even more change is ahead. The goal of transformation from a system that rewards volume to one that rewards value is a good one, but operational challenges persist. It is my hope the following testimony will evoke some change to ease those challenges so providers maintain the financial runway to accomplish transformation.

First and foremost, the inclusion of substance abuse treatment and other behavioral services in the basic managed Medicaid benefit is significant. While these services had previously been carved out of managed Medicaid, the new benefit structure offers some opportunities. The main upside to this change is the coordination of behavioral and medical services within the same benefit structure, providing opportunities for true integration. There are however significant challenges for providers who historically only billed Medicaid. They must now develop processes to bill multiple health plans and ensure that they are appropriately reimbursed. For example, although this change went into effect on October 1, 2015, our substance abuse treatment program at Montefiore has received almost zero reimbursement to date. This is due to providers' difficulty with billing, health plans difficulty with receiving and processing claims, or confusion among the health plans' delegated behavioral managed care companies. OASAS is trying to ameliorate the cash flow problem by providing short-term cash advances to treatment programs, but this will not be adequate. It is entirely possible that some of

the smaller programs, without financial resources will not be able to meet payroll. Eventually, these billing processes will be resolved, but I am concerned that providers' collection rates will drop, leading to substantial revenue loss. In the long run, health plans will try to rein in costs associated with substance abuse treatment, just as they have with mental health treatment, and this will pose a significant challenge to all behavioral providers. Finally, I have concerns that the State has not correctly priced the additional premium associated with these new behavioral services, and that the premium that has been allocated to health plans will not flow directly to the providers.

The second major change is the introduction of Health and Recovery Plans (HARPs) for severely mentally ill patients. Again, this change brings behavioral care within the managed Medicaid benefit structure. In doing so, it offers opportunities to improve the integration of medical and behavioral care, especially since the SMI population currently receives inadequate medical care. However, this major change also poses many challenges. Here too, the State has priced the new product under the assumption of cost savings, and the amount of premium, which will flow to providers, is likely to be inadequate. HARPs are very complicated to administer, and there is great danger that some of the most vulnerable people in our society will fall through the cracks. One of the biggest surprises that has occurred during implementation is the fact that one-third of patients who were thought to be HARP-eligible were no longer eligible when the program started. I don't know what happened to these former HARP patients. It may be that these people are no longer covered by Medicaid, which begs the question about how HARP plans will deal with the significant amount of churning that occurs with Medicaid – referring to the large number of individuals who lose and re-gain coverage during the course of the year. I can't imagine that health plans will continue to pay for outreach services to non-covered

members. So, even though one of the aims of HARP is to develop long-term care plans for patients, it is likely to remain episodic. Secondly, eligible members were passively enrolled in HARP, which means that the vast majority of patients were not actively engaged in the program or in their own care planning. The State has the expectation that all HARP patients will receive an in-depth assessment by Health Home care managers, but only a minority of HARP patients are enrolled in a Health Home, and there is not adequate Health Home capacity to conduct these intensive assessments, and certainly not within the hugely optimistic time frame that the State expects. Once the assessment is conducted, there is a cumbersome 3-way process of authorization of Home and Community Based Services that involves the Health Home care manager, the treatment provider, and the health plan, which has significant potential for breakdown and miscommunication. As we know, engaging these patients who may not be terribly self-motivated is a tricky business, and this additional administrative burden will make it that much harder to keep patients engaged. But the biggest threat is that the health plan, which has never previously managed such behavioral services, will have financial incentives to limit patients' access.

The third major change is the introduction of Health Home care coordination. The State has proclaimed the importance of care management for all Medicaid patients. This is a critical new feature to Medicaid, especially since behavioral care has historically been so separate from medical care. It would make sense that a care manager should be able to coordinate care delivered by separate providers, and more importantly, that a care manager should be able to track patients' engagement in care and outreach to them when they become disengaged. From my experience with the former Managed Addiction Treatment Services (MATS) program and the current Health Home program, there is much suggestive evidence that patients who are

enrolled in care management do have significantly improved engagement in outpatient care and very significant reductions in inpatient utilization and cost. One of the problems with the Health Home program is that 75-80% of patients who are deemed eligible are not enrolled. Secondly, because people churn through Medicaid, even those who are engaged with their care manager will necessarily be discharged from the Health Home due to ineligibility for reimbursement. Thirdly, the Health Home program has been tasked to achieve too many objectives. In addition to engaging high-need Medicaid patients, Health Homes are also expected to perform assessments for HARPs and Managed Long-Term Care plans. Health Home care managers are expected to be knowledgeable about mental health, substance abuse, and general medical care provider systems; to provide health education to patients; to enhance patients' insight and motivation; and to address basic social needs, including housing, employment, child care, etc. There is no way that a single case or care manager could be skilled in each of these areas, and in fact, there is much disagreement about the credentials and training for Health Home care managers. At Montefiore, we have a diverse care management workforce – some have clinical credentials while others do not, some work in the field and meet patients at treatment programs while others predominantly engage patients by telephone. There is not a one-size-fits-all approach. To make the problem of workforce development even more complicated, the State is introducing a new payment structure, which will require billing health plans, and future revenue is quite uncertain. In the face of such uncertainty, Health Homes are unwilling to invest in a larger workforce to meet the State's volume expectations.

The fourth major change will be full implementation of the Medicaid Delivery System Incentive Payment Program, or DSRIP. The goal of DSRIP is indeed laudable- to reduce avoidable hospitalizations and ER visits through improved integration of systems of care and the

introduction of value-based contracting. Interestingly, patients with mental health or substance use disorders represent the vast majority of patients with avoidable admissions and re-admissions, although most of those avoidable admissions are for medical reasons. That said, behavioral providers are taking a decidedly back seat role in these projects. One of the biggest projects has to do with integrating behavioral care into medical settings. While I fully support this effort to improve access to behavioral care, in my opinion it targets people with less severe behavioral disorders, and thus is not focused on those patients who account for the greatest number of re-admissions. Reverse integration – delivering medical care in behavioral settings – is a much better model for the more severely mentally ill population, but unfortunately few behavioral providers are in a position to develop such programs. The State has tried to promote this reverse integration model and has begun to issue "integrated services licenses" and the Montefiore Department of Psychiatry was one of the first to obtain such a license. At one of our community mental health centers, where we have 1,500 adult patients, we have had great difficulty developing an efficient flow of patients through our primary care service. Internists in our setting see many fewer patients per day, and each patient visit takes longer than in a primary care setting. To make matters worse, although the State approved reimbursement rates for these medical services, they have been unable to require health plans to honor these new rates. Consequently, we have delivered these medical services for one year and received almost no reimbursement. I know other providers who have given up their licensure due to these operational and financial problems. This anecdote displays how the admirable intentions of the state's restructuring can sometimes be undermined by the implementation timeframe offered.

While I have only highlighted the four most important changes associated with Medicaid Redesign, there are many other changes that are occurring simultaneously that have completely

transformed the landscape in which behavioral care is delivered in NY. This would include other components of the Affordable Care Act, the federal Mental Health Parity Law, the introduction of electronic medical records that include behavioral care, and opportunities related to the exchange of health information and rules related to confidentiality of substance abuse information. All of this work and progress is timely given ThriveNYC. I want to commend the First Lady's Mental Health Roadmap, which goes a long way toward de-stigmatizing mental illness, improving connections to care, and developing the necessary workforce to meet the needs of the severely mentally ill. I was especially impressed by her willingness to visit one of our mental health clinics and engage our line staff in discussion on the care for this population.

All of these changes – federal, state, and city -- are very much interrelated and create important potential synergies. Taken together, they represent the move towards accountable care and value-based contracting by providers. Montefiore is certainly at the forefront of this, as we currently have 400,000 people in some kind of full-risk or shared-savings agreement, and expect to have 1,000,000 "lives" in the near future. We have a huge care management workforce and infrastructure, including a large behavioral care management workforce. As such, Montefiore functions in many different roles – as provider of care, as manager of care, and as payor for care. While these various roles can cause tension and confusion, ultimately I believe that only providers, like Montefiore, have the incentive and creativity to be able to truly improve care and reduce unnecessary utilization. In this sense, I agree that value-based contracting is the wave of the future. While each of our value-based agreements is different, having been in this business for over 20 years, we have developed the expertise to understand how to contract with health plans and how to understand the characteristics of different populations. I do believe that we are beginning to "bend the cost curve" and I am convinced that it is being done while we improve the

care delivered to patients. However, with so much change in the last couple of years and with even more change ahead, we need to keep monitoring that patients, especially behavioral patients, receive the care they need. Thank you for giving me this opportunity to share my opinions and perspective.

Testimony of

Jennifer March, Ph.D.
Executive Director

Citizens' Committee for Children of New York, Inc.

Presented to the
New York City Council
Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disabilities Committee

Oversight: Medicaid Redesign 2

February 22, 2016

Good morning. My name is Jennifer March and I am the Executive Director of Citizens' Committee for Children of New York (CCC). CCC is a 72-year-old independent, multi-issue child advocacy organization dedicated to ensuring that every New York child is healthy, housed, educated and safe.

I would like to thank Chairman Cohen and the members of the City Council Committee on Mental Health, Developmental Disability, Substance Abuse and Disability Services for holding today's hearing on New York State's Medicaid Redesign.

CCC is also thankful for the City Council's long time commitment to mental health services for children and youth. In particular, we thank the Council for your consistent support and countless restorations for the mental health of children under five initiative and for being champions of school-based mental health services.

CCC is also grateful to the de Blasio administration for its recent effort to launch and implement the Mental Health Road map, which is designed to not only reduce stigma, but also to improve access to screening, assessment, and referrals to mental health services.

The City and the City Council have a role to play in monitoring the Medicaid redesign transition and its impact on the City's children and families. Your state level advocacy and city budget decisions will also play a role in ensuring that the service delivery system is prepared for the transition, that needed services are supported and expanded upon, and that NYC residents in need, in particular children, are able to access high quality services in a timely manner.

Background:

In 2011, Governor Cuomo initiated a systemic overhaul of the state Medicaid program in an effort to achieve the triple aim of more effective, higher quality, and less expensive care. This effort will result in the movement of special populations of children who currently receive services through fee-for-service Medicaid and/or daily per diems, such as children with SED, developmental disabilities, and children in foster care, into Medicaid managed care.

As part of the Medicaid Redesign Plan, New York will initiate a series of dramatic changes to its children's behavioral health system, starting this fall. These changes include:

- Starting in September 2016, 174,000 children with multiple health and behavioral health needs will be eligible to enroll in the state's new Health Home program that provides care coordination services. The adult Health Homes have experienced many challenges and are not organized around the special care and support needs of children and their caregivers. A worrisome weakness in the model is around the disconnect between care planning, case management, and clinical services and supports.

- The State is also in the process of revising the CANS-NY decision-making tool that will help determine acuity for health home care management and rate assignment, provide information to help determine whether a child meets the criteria for SED or Trauma, and determine the need for Home and Community Based Services offered within the new managed care benefit package. Basically this tool will allow the state to identify children who qualify for the children's health home.

- Between January and July 2017, New York plans to transition the children's behavioral health Medicaid benefit into mainstream managed care. This will result in the movement of special populations of children who currently receive services through fee-for-service Medicaid and/or daily per diems into Managed Care. This includes children who are diagnosed as SED, children with developmental disabilities, medically fragile children and children in foster care. The shift from fee-for-service and per diem payments and bifurcation of services and care coordination/case planning demands a complete shift in business and frontline practice for all child-serving agencies. It also necessitates close collaboration, information-sharing and joint planning to reduce hospitalizations, ER visits and achieve better child outcomes.

- NYS recently submitted the Draft Medicaid State Plan Amendment for children and Children's Health Home SPA to CMS. The proposed Children's Medicaid Benefit expands coverage for a number of services that are already offered but are not always Medicaid-funded, consistently available and easy to access. This includes: crisis intervention, psychosocial rehabilitation, community psychiatric supports and treatment, family peer support services, youth peer advocacy and training as well as for coverage for services provided by non-physician licensed behavioral health practitioners.

Current state of the field:

Importantly, while Medicaid reforms offers an opportunity to address existing system weaknesses and strengthen information sharing, and care management planning, the children's behavioral health system is currently facing significant fiscal and workforce-related challenges and many providers are now experiencing additional stress related to Medicaid transition-related activities.

- The four-year transition to managed behavioral health care has exacerbated serious underfunding and inadequate reimbursement for community-based behavioral-health services that has left many outpatient clinics on the verge of closure. Surviving clinics have become dependent on part-time, per diem staff who are paid hourly. This kind of staffing limits provider ability to respond to complex behavioral health needs.

- Inpatient providers are also under pressure to reduce hospital length of stay and are discharging patients to severely limited intensive outpatient clinical services, which has created a revolving door of hospitalizations, emergency room visits and disruptions in school and foster care placements.

- Workforce shortages also contribute to long wait times for first and subsequent appointments, especially for families trying to access child psychiatrists or early childhood mental health specialists.

- As a result, emergency departments have emerged as the mental health safety net, despite lacking the appropriate staff and space to best meet the needs of children in psychiatric crisis.

- Efforts to ensure client safety through the NYS Justice Center and proper financial practice through the OMIG have also added significant compliance responsibilities and significant additional cost burden to behavioral health and child-serving provider organizations with no change in reimbursement rates.

- Multiple ongoing Medicaid reforms (DSRIP, Health Homes, MMC, HARPs, DISCO) have placed a heavy workforce and administrative burden on children's behavioral health and child welfare providers many of which lack the resources and/or staff capacity to implement key requirements of the transition (such as workforce training and program development). In addition, these providers are expected to cover the costs incurred during the planning process, all while maintaining existing caseload capacity.

- Similarly, the strong emphasis on cross-system integration and information sharing will require providers to invest resources in health information technology. This will ensure interoperability and clear communication with a range of providers, managed care companies and Health Homes. A properly functioning EHR/HIT system can take up to a year to come online, from the time the system is selected and purchased, to user training, data migration and alignment, and final pilot testing. Potential costs include: hardware (database servers, computers, printers, and scanners), EHR software and interface modules, implementation assistance (IT contractor, electrician, chart conversion, network installation, and workflow redesign support), staff training, and ongoing network fees, software updates and general maintenance.

In addition, because the behavioral health system should help get children back on their developmental trajectory, we need to ensure that Medicaid reform results in support for a robust infrastructure of outpatient and intermediary levels of care that reduce the need for more intensive and costly hospital-based interventions. This would include:

- A robust benefit package that serves children across the child welfare, mental health and medical systems with coverage for new services including: crisis intervention, psychosocial rehabilitation, community psychiatric supports and treatment, family peer support services, youth peer advocacy and training as well as for services provided by non-physician licensed behavioral health practitioners.
- Support for and development of new models that integrate mental health awareness and services in education and early childhood settings such as schools, Head Start, daycare, pre-kindergarten, and home visiting programs, to ensure early identification and treatment;
- Adequate rates of reimbursement for services delivered in a wide range of settings including homes, child care centers, pediatric offices and schools;
- Financial and programmatic support for preventive interventions in schools and primary care settings;
- Expansion of all outpatient clinical interventions including crisis intervention, day treatment, partial hospitalization, evidence-based interventions provided at home or in schools including family based treatment to decrease reliance on emergency room and inpatient care; and
- Creation of Medicaid "family of one" designation to ensure that non-Medicaid children who meet Level of Need or Level of Care criteria have access to State Plan services, Health Homes and HCBS, regardless of parental income.

Opportunities for state level advocacy:

There is a real opportunity in the current state budget negotiation process to ensure that resources are committed to ensure the child serving field is prepared for the transition of special populations to Medicaid managed care and the creation of children's health homes.

To address workforce, IT and health home readiness needs of the child serving system, CCC's has been advocating at the State level for the resources needed to make the transition successful. Our State FY'16-17 budget priorities include requests to:

- **Add $30 million for children's behavioral health capacity building and start up needs**, comparable to funds dedicated to adult behavioral health, to support workforce development and training, credentialing fees, and expand the existing provider network.
- **Add $10 million**, comparable to investments made in the adult-serving system, **to support workforce and technology needs related to the creation of children's health homes.**

- **Add funds to support adequate rates for home and community based waiver services** and to protect and strengthen service capacity during the Medicaid reform transition.
- **Allocate 25 percent of the $195 million allocated to health facility transformation to safety net community health providers** (e.g. behavioral health, family planning, health home providers, and Federally Qualified Health Centers) in order to ensure their essential participation in health service transformation efforts.

To begin to address system capacity needs, CCC's SFY-16-17 state budget priorities include the requests to:

- **Support the SFY'16-17 Executive Budget's proposal to add $7.5 million to create six new children's mental health services** in the Medicaid program including: crisis intervention; community psychiatry support and treatment; psychosocial rehabilitation services; family peer support services; youth peer training and support services; and services from other licensed practitioners, and
- **Support the SFY'16-17 Executive Budget proposal to reinvest $16 million in savings from the downsizing of State psychiatric centers in to community based services** (ensuring funds support children's mental health services).

Conclusion

New York State is in a unique position to design, plan, and implement a transformation of the children's mental health system. Given the average early onset of mental illness and the array of negative life outcomes that follow when these needs go unaddressed, we must prioritize strengthening the behavioral health care systems ability to provide timely access to appropriate levels of care. **In CCC's view, it is critical that the advocacy community, direct service providers, City administration and New York City Council echo the call for state resources to support workforce and IT preparedness, the establishment of children's health homes, as well as commitment of resources to develop sorely needed service capacity.**

Beyond, state advocacy, **the City administration and the City Council also have a significant role to play in protecting and expanding City investments already in place early childhood mental health, school based mental health, as well exploring opportunities to test new models of child and family services**. Furthermore, the success of the City's Mental Health Road Map efforts, specifically its ability to successfully reduce stigma, improve access to screening and assessment, and secure timely referrals to appropriate levels of care, hinges both on support for existing City funded services as well as a smooth transition to Medicaid managed care for special populations of children. We look forward to continue to work with you on this critical issue.

Thank you for the opportunity to testify.

AMIDA CARE
ABOVE AND BEYOND FOR YOU

Testimony submitted at the New York City Council Oversight: Medicaid Redesign Hearing

Committee on Mental Health, Developmental Disability, Alcoholism, Drug Abuse and Disability Services

February 22, 2016

Good morning Chairperson Cohen and distinguished members of the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services. Thank you for the opportunity to testify on behalf of Amida Care. My name is Jason Lippman, and I am the Director of Public Policy and Government Relations. Amida Care is a not-for-profit health plan that specializes in providing comprehensive health coverage and coordinated care to New Yorkers with chronic conditions, including HIV and behavioral health disorders, as well as those experiencing homelessness. We serve Medicaid and Medicare members throughout New York City.

Established in 2003 by several non-profit community-based health organizations, Amida Care developed a highly effective, specialized model of care to provide individualized attention and support to people living with HIV/AIDS and other complex health issues. Today, Amida Care has the largest special needs plan (SNP) in New York State as well as three growing Medicare plans.

Amida Care plays a pivotal role in State Medicaid redesign and policy initiatives aimed at improving health outcomes that will derive further Medicaid cost savings. By providing

improved access and retention in care to our members, Amida Care prevents avoidable hospitalizations and emergency room visits, which results in substantially lower Medicaid costs overall. Amida Care has generated many impressive health outcomes that save lives and produce cost savings, including a 74% decrease in hospital admissions/readmissions and a viral suppression rate among HIV-positive members approaching 75%.

Health Care Delivery System Reform

As of October 2015, Amida Care is certified to offer Health and Recovery Plan (HARP) services to our SNP members living with the most serious behavioral and physical health challenges. While Medicaid redesign is complex and multifaceted, and the assessment and enrollment process for Home and Community Based Services (HCBS) under HARP ramps up, I would like to provide you with an overview of a set of initiatives that we have been involved with under Medicaid redesign and the State's Delivery System Reform Incentive Payment (DSRIP) program.

Amida Care is an active partner in New York State's Delivery System Reform Incentive Payment (DSRIP) program. Amida Care supports collaboration among performing provider systems (PPSs) with their Domain 4 HIV/AIDS population health programs and Project 11 patient activation measures. We are also eager to work with the City and State, as well as community partners on the implementation of value-based payment purchasing in the coming year.

In 2014, Amida Care was supported by a State Department of Health planning grant to develop a set of recommendations for community-based projects that are aimed at addressing the social determinants of health and behavioral health through meaningful transformation of the chronic illness sector. Planning efforts focused on meeting the needs of Medicaid beneficiaries

living with HIV/AIDS, severe mental illness and substance use disorders or who are homeless, by engaging the community-based groups that serve them. In our final report which was submitted to the State and shared with various PPSs, detailed justification is provided to implement the following initiatives: 1) peer health navigation services; 2) crisis bed diversion and hospital step-down transitional housing units; 3) integrated care learning collaboratives; and 4) viral load suppression programs. These recommendations can be tailored or expanded by the PPSs to meet the needs of their community partners and populations served.

Peer Workforce Incubator Project and Ending the AIDS Epidemic in New York

Amida Care has a proposal before the City Council to create living wage jobs for people living with HIV and chronic behavioral health conditions who are successfully engaged in care, on medication, virally suppressed, healthy and ready to work. Peer services not only create this opportunity but build pathways for newly diagnosed individuals or people out of care to overcome barriers like homelessness and behavioral health disorders, and connect them to primary and behavioral health care services. This is a priority for achieving the Blueprint to End the AIDS Epidemic in New York by 2020.

As a member of Governor Cuomo's Task Force to End the AIDS Epidemic in New York State by 2020, to bring new HIV infections down from over 3,000 per year to below 750, Amida Care worked with community partners on a Blueprint to End the Epidemic that was presented to and endorsed by Governor Cuomo in June of 2015. If the Blueprint is fully implemented, we can reduce new HIV infections to zero. The Blueprint, among other things, calls for steps to identify undiagnosed New Yorkers living with HIV and link them to care, retain people diagnosed with HIV in care to maximize viral load suppression, provide access to Pre-Exposure Prophylaxis (PrEP) to prevent individuals at high-risk from contracting HIV, and make essential housing and

services available to low-income New Yorkers with HIV. Full implementation of the Blueprint requires strong partnerships between the community and the City of New York, along with our State partners.

Amida Care applauds the City Council for allocating $6.6 million in funding for HIV prevention strategies that reach the most at risk, as well as its work with Mayor de Blasio to secure $23 million to combat HIV/AIDS and expand access to pre-exposure prophylaxsis (PrEP), which prevents HIV infection, and anti-retroviral therapy for people living with HIV/AIDS. These measures will help to address the socioeconomic drivers of the epidemic, including severe mental illness and substance use disorders, homelessness and unemployment.

Conclusion

On behalf of Amida Care, I thank you for the opportunity to testify on Medicaid redesign and building a collaborative system that will enable and empower individuals with chronic behavioral health conditions to live healthier lives and stay out of the hospital, maintain housing and employment stability, and End the AIDS Epidemic in New York State by 2020. We are available to inform and answer any questions that you may have.

Respectfully submitted,

Jason Lippman
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Remarks of Phillip A. Saperia, CEO
The Coalition of Behavioral Health Agencies, Inc.

"Oversight – Medicaid Redesign Part II"
February 22, 2016

Good Morning Chairman Cohen and members of the NYC Council Commitee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services.

I am Phillip A. Saperia, CEO of The Coalition Of Behavioral Health Agencies. The Coalition is the umbrella advocacy organization of New York's mental health and substance abuse agencies that serve more than 350,000 clients/consumers in neighborhoods throughout New York. Our member agencies are front-line safety net providers. We treat some of the neediest individuals, including those with dual diagnoses of mental health and substance abuse. Our providers serve the homeless and the formerly incarcerated, as well as victims of trauma and abuse, and across the the entire age spectrum from early childhood to the elderly. They are in every Council District and neighborhood in the city.

I would like to thank you for holding this second hearing on the Medicaid Redesign process in New York. Although we are very early in the transition, we are pleased to present our thoughts on how Medicaid Redesign implementation has affected the community-based behavioral health sector to date.

First of all, we would like to thank Chairman Cohen and the Council for initiating the Medicaid Redesign Transition Initiative for this fiscal year. Although the funds have been slow to materialize, we believe that it will have a positive impact on the ability of the agencies that receive this assistance to meet the new billing and data requirements necessary in the Medicaid managed care environment.

Although most of my remarks relate to State issues, we would very much like to have your strong support for our agenda when you visit Albany and speak with your colleagues in the State legislature.

The Transition to Medicaid Managed Care for Behavioral Health Services
On October 1, 2015, in New York City,individuals
receiving behavioral health services on a Medicaid fee-for-service basis, people on Medicaid who live with serious mental illness and/or chronic addictions, were carved into the managed care system. . We support this transition to managed care, which we hope will lead to more positive outcomes for individuals struggling with behavioral health

issues, but in the near-term we have some serious concerns about potential disruptions likely to affect consumers/clients and their community based providers.

Promote Transparency in the Medicaid Redesign Process

We are strongly advocating that the NYS Office of Mental Health (OMH),the Office of Alcoholism and Substance Abuse (OASAS) and the NYC Department of Health & Mental Hygiene (DOHMH),as the Local Govermental Unit, the most knowledgable agencies in regard to behavioral care for vulnerable individuals, should be given meaningful oversight over the Managed Care Organizations (MCOs) and monitoring authority for compliance, network adequacy, continuity of care and evidence-based behavioral health outcomes. Since the New York State "O" agencies have been barred by CMS from signing the statewide "model contract" with DOH and Managed Care Companies (MCOs), we are urging that internal Memorandums of Understanding (with legal force) be signed among the State oversight agencies, officially giving monitoring and supervision authority for behavioral health services in managed care to the "O" agencies.

Oversight of MCO issues (contract language, network adequacy, evidence- based practices, , access, payment, denials, evidence of maintenance of effort) with respect to behavioral health should rest with OMH, OASAS and DOHMH. These agencies, using their comprehensive understanding of behavioral systems, are both statutorily charged with the responsibility for and have a long history of working with safety net providers and high needs consumers. Vesting them with joint authority with DOH over Medicaid Managed Care behavioral health matters would give providers and consumers/clients a needed level of comfort and stability and assure meaningful standards of care.

In order to evaluate the progress of the transition to Medicaid manged care, we are calling for the NYS legislature to require the Medicaid Redesign Team (MRT) and the New York State Department of Health (DOH) to release a public annual report, with specific information as to how the numerous MRT funds are being spent (e.g. DSRIP, BIP), the rollout of that funding, and to whom funds are being provided. In addition, the report must identify where Medicaid funds are being saved and where they are being reinvested.

Only with this information can we determine if the goals of the MRT are adequately being met and if community based safety net services are being funded to meet the needs of consumers/clients and help them maintain their community based rehabilitation and recovery.

In addition, we seek assurance from the NYS Legislature that as the system moves to value based payments, DOH, OMH, OASAS and DOHMH should establish standardized metrics to determine savings attributable to medical and behavioral care savings realized by virtue of hands-on community based supports and behavioral health services, will result in reinvestment of those savings into behavioral health.

We need the Council's voice in calling for needed transparency in the Medicaid Redesign and for fair reinvestment of saving created by behavioral health providers back into the behavioral health sector.

Support for Children's Behavioral Health Services in a Managed Care Environment

Children and adolescents diagnosedwith serious mental illness and/or chronic addition will be enrolled in Medicaid Managed care on January 1, 2017 for children in New York City.

As the very complex system of care for children, adolescents and families moves toward managed care, the State should adopt rigorous, child and youth-focused behavioral health metrics that monitor plan and network access and performance, ensure high quality care and gauge short and long-term outcomes; commit to periodically convening plans, networks and providers to work with State and local government to publicly issue reports on utilization, capacity and other quality and performance measures.

The Coalition is urging New York State to increase the funding for technology and workforce development for the launch of Children's Health Homes and transition of children to Medicaid managed care. Funding comparable to investments made in the adult-serving system, should be provided to the children's system to support the workforce and technology needs related to the creation of children's health homes.

We are advocating for a two-year, Children's Behavioral Health Capacity Building and Start-Up grant program, similar to the $30 million program established for adult providers, to establish new services under the State Plan Amendment, including workforce development, training and credentialing fees and expansion of the provider network.

We support adding $7.5 million to create six new children's mental health services in the Medicaid program

Finally, in our advocacy for the children's behavioral health system, we support reinvesting $16 million in savings from the downsizing of State psychiatric centers into community based services (including children's mental health services).

Any assistance the Council would provide on these children's behavioral health provider issues would be greatly appreciated.

Ensure the Viability & Sustainability of the Behavioral Health Sector

Government Rates

The Coalition is strongly urging New York State to extend government rates through 2021 when Value Based Payments will be in full effect. This would be the most effective approach to ensure the health and stability of the community-based behavioral health safety net. We could very much use the Council's support in prevailing upon its colleagues in the State to extend these rates.

COLA

The Governor's FY 2016-2917 budget proposes an inconsiderable 0.2% COLA. Instead, we seek a 3% across the board COLA for all OMH and OASAS contracted providers—the same percentage as is being given to Managed Care companies—and

help providers stabilize for the coming transformative changes in care delivery. If you agree this is as unfair as we do, we hope you will join us and advocate for a fairer COLA for community-based behavioral providers.

HCBS Services

Part of the next wave of Medicaid Redesign with regard to behavioral health is to implement Home and Community Based Services (HCBS). HBCS are Medicaid-funded services and supports provided in non-institutional residential settings that address the social determinants of health. The crux of these services, is to provide person-centered care, rehabilitation and recovery services that will reinforce the strengths, preferences and needs as well as the desired outcomes of the individual. The Coalition strongly supports the person-centered approach provided through HCBS, but calls on the State to provide adequate rates in order to strengthen and ensure a robust capacity for services. DOH's first rate proposal vastly undervalued the services and, consequently, without changes, there will be few providers willing to provide them.

Again, we encourage the Council to reach out to colleagues in the State legislature to support our advocacy for increased rates.

HIT & Capital Investment

The Coalition was the among primary advocates for capital for funding for health information technology (HIT) and other costs related to the transition to managed care in the current fiscal year's budget. The vast majority of federal funding for HIT—particularly Federal HEAL grants—so necessary for this transition and compliance with record keeping and information exchange mandates, has gone to hospitals and physical health providers.

While the State is working to implement and distribute its grants, we believe that significantly more funding is necessary to build the infrastructure for behavioral health providers, especially in OASAS-licensed facilities, to meet the demands of the new billing and electronic health environments. Such technology is also vital for providers to track data on outcomes which will be needed in the new MMC environment.

The Council's Medicaid Redesign Transition Initiative is one of the few sources of funding that has reached behavioral health providers. We would very much like to see it restored and enhanced in the coming NYC budget.

The Coalition looks forward to working with the Council to help ensure that people with serious behavioral health issues and their safety net providers come through these monumental changes with a stronger and more sustainable community behavioral health system that highlights rehabilitation and recovery.

Again, thank you for convening this hearing and for joining with us to shore up the community based services sector.

The Jewish Board
Health and Human Services for All New Yorkers

Testimony of John Kastan, Chief Program Officer,

The Jewish Board

New York City Council Hearing of the Committee of Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

Oversight Hearing on Medicaid Transition Redesign; February 22nd, 2016

Good afternoon Council Committee Chair Cohen and members of the Committee. My name is John Kastan, and I am the Chief Program Officer of The Jewish Board. The Jewish Board is the largest social services agency in New York City and the largest community-based mental health provider in New York State.

New York State has developed a multi-faceted Medicaid reform plan, which includes a focus on improving behavioral health and physical health outcomes for Medicaid recipients. In a variety of ways the Plan acknowledges the critical role that community-based providers play in preventative care, patient wellness, recovery, and moving the healthcare system away from an over-reliance on inpatient and emergency services. What the plan has not adequately provided is resources to support this transition for community-based providers.

While the managed care transition has not yet replaced the existing fee for service structure, and currently the Medicaid managed care plans are required to pay the same reimbursement rates that the State had been paying for clinic and PROS services, this arrangement will be changing in the next two years. Currently, it is planned (and reflected in statute) Medicaid managed care rates will be negotiated by providers and Plans. Further, the State is implementing a transition to a value-based payment financial model that potentially will put providers at financial risk for providing services based upon measurement of clients' health outcomes

This value-based approach requires not just an increased array of services but also greater collaboration amongst established health care institutions and community-based organizations. In this new model, community-based providers such as The Jewish Board are responsible for many critical community-based supports such as case management and crisis intervention services that can provide comprehensive care currently offered in a fragmented, piecemeal system. Successfully creating this new paradigm requires robust resources for community-based providers to adequately serve the needs of the most vulnerable and survive under a value-based payment reimbursement model.

The challenge for behavioral health community-based providers to comply with the Medicaid managed care reforms is that the community-based sector has been subject to financial contraction the last few years due to governmental budget cuts and increased costs. In order to "play" in the managed care arena, community-based providers must invest in creating a trained, skilled workforce equipped to

address the complex needs of low-income individuals with behavioral health challenges and often multiple chronic medical needs.

This requires recruiting new staff, such as peer specialists who help manage the needs of clients with serious mental illness, and care coordinators who know how to access relevant community services like vocational training that some clients will need. These employees will need to be trained and supervised, and often because of the work they do in the community, are being equipped with technology to enhance their work effectiveness.

All of this human resource, training, and technical assistance work requires significant financial investment unavailable through direct client services reimbursement. Further, a key to the success of this work is having adequate numbers of psychiatrists, psychiatric nurse practitioners, licensed social workers, and other licensed professionals. Our sector is experiencing a workforce shortage, in part due to the fact that reimbursement rates are not keeping with the costs of service delivery.

Beyond the increased personnel costs, Medicaid managed care billing systems require a large capital investment to create the needed data management and analytic resource information to receive reimbursement. This includes an extensive re-tooling of providers' financial and clinical tracking systems required to receive payments based upon proven outcomes of care. Administratively, managed care requires new capabilities for patient registration and billing. This means that instead of all Medicaid claims being sent to the state for payment, providers are dealing with several different managed care companies, each with their own policies and procedures and systems that providers must learn. As a result, there have been payment delays during this transition that have severely affected some providers' cash flow and compounded the financial challenges of many providers who already operate with inadequate funding.

The resources that the Council has provided and we hope will continue to provide are essential. A flexible source of funding to assist in the years-long transition to Medicaid managed care cannot be overstated. I thank Council Member Cohen for his leadership in creating this new Medicaid Redesign Transition initiative. Providers must invest in the requirements of the new Medicaid managed care system and the City Council funding has been a tremendous resource for otherwise un-reimbursable costs.

Thank you for this opportunity to testify.

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MEDICAID REDESIGN TESTIMONY: FEBRUARY 22, 2016

Good afternoon. I'd like to thank the Chair, Councilmember Andy Cohen and members of the Committee on Mental Health. My name is Wendy Geringer. I am the Chief Officer for Medicaid Redesign, Research & Evaluation at New Alternatives for Children (NAC). NAC is a leading child welfare agency that, for the past 34 years, has exclusively served children with complex behavioral and medical needs, as well as their families. More than 50% of NAC's children have multiple medical diagnoses, and 75% have emotional or mental health issues. Diagnoses of the children include cancer, cerebral palsy, spina bifida, muscular dystrophy, sickle cell disease, HIV/AIDS, traumatic brain injury, autism spectrum disorders, ADHD, developmental delays, and intellectual and physical disabilities.

These child welfare-involved children are by far the most vulnerable in New York City: they and their families live in the poorest neighborhoods and often go through periods of homelessness; they face tremendous stressors including domestic violence, street violence, substance use, and food insecurity. Compounding their situation, parents must deal with their children's substantial healthcare needs.

Despite these overwhelming odds, NAC has had tremendous success in keeping the children it serves safe, in the community and out of long-term institutionalized care. Without NAC, thousands of vulnerable children would be left without a safety net.

Many other agencies would say these children are too difficult to serve, but not NAC. We are an agency that believes in abilities and not disabilities; we consistently go above and beyond in treating the children in our care as if they were our own. This extra effort and care makes all the difference. NAC's programs and services are integrated and comprehensive, designed to meet the unique needs of every child and family who walk through our door. Each client is assigned a Master's level social worker and a pediatric nurse to coordinate their care and services. Through NAC's continuum of services, children and families have access to a team of eight Educational Specialists that support children's academic progress; recreational services; year-round clothing, toy, and food banks; a Resource Specialist that helps families access direct financial assistance and homelessness prevention services; and wheelchair-accessible vans that bring children to therapy and medical appointments. NAC has two, onsite state licensed clinics: an Article 28 pediatric clinic under the direction of a Developmental/Behavioral pediatrician who specializes in treating medically/behaviorally complex children; and an Article 31 mental health clinic with a broad range of behavioral specialists and services for children and their families.

MEDICAID REDESIGN

Medicaid Redesign offers enormous promise for the children that NAC serves: the highest cost, highest need children. Underlying Redesign initiatives is a focus on early intervention, expanded medical and behavioral healthcare services, coordinated care management, and community based supports and services that address children's unique and complex healthcare needs. While the Redesign model offers great hope, it also comes with major challenges for the agencies that are providing services under this new system.

Medicaid Managed Care. Under Medicaid Redesign, beneficiaries are transitioning from fee-for-service Medicaid to Medicaid Managed Care plans that are supposed to promote better and more efficient healthcare services. NAC is credentialed with all Medicaid Managed Care Organizations (MCOs) serving NYC residents, assuring that we will be reimbursed for the healthcare services we provide through our Article 28 and 31 clinics. We are aware that, in recognition of the importance of integrating behavioral and physical healthcare services, the state is creating a system whereby behavioral and physical health services are managed under a single MCO (in some cases, plans contract out behavioral health services to a separate entity). NAC has long understood the necessity of integrated medical and physical health services. Since our clinics were licensed in 2007, our providers in both clinics have worked together to provide coordinated services to our clients. While MCOs' joint management of behavioral and physical health care services moves the needle in the right direction, the challenges of Medicaid Managed Care for agencies and the Medicaid clients remain.

MCOs are paid a flat monthly fee for services provided to their covered members. Our experience with Managed Care thus far raises strong concerns about the potential of Medicaid Redesign. We are justifiably worried that, given limited per member financing, MCOs will restrict children's access to needed services by tightening eligibility requirements and/or imposing utilization thresholds. With respect to providers of healthcare services like NAC, MCOs could move to lower reimbursement rates wherever possible. The latter would not only affect agencies like NAC directly, but indirectly affect our clients who receive healthcare services from subspecialists who will have little incentive to stay in – or join – an MCO where the reimbursement for their services is low.

The issue of which behavioral and physical healthcare providers are in the various MCOs is another concern. At NAC, we have observed what happens to NAC families when they are moved from Medicaid fee-for-service into Managed Care. These families have found themselves auto-assigned to one of many MCOs. Although letters are sent out from the state notifying Medicaid-covered families that they must enroll in a Managed Care plan and asking them to select one, more often than not the families do not read or understand the letters and ignore them. The result is that they are auto-assigned to a plan that their existing providers may or may not accept. While NAC social workers and our Resource Specialist work closely with families around obtaining appropriate coverage, this is just not a priority for families struggling with so many psycho-social issues and chaotic living situations.

NAC has worked hard to promote the utilization of healthcare services by our children and families and to enable the management of their chronic conditions to avoid complications, ER visits and hospitalizations. Our onsite clinics facilitate healthcare utilization and our team of nurses make regular home visits to support families in managing their child's or children's behavioral and medical conditions in the home. However, the children NAC serves have many, co-occurring chronic conditions and face barriers to accessing health care; our clinicians need to refer children to providers in their community as well as to subspecialists working in the city's hospitals and academic medical centers.

Under Managed Care, a child must go to a Primary Care Provider (PCP) who accepts their plan and obtain a referral to subspecialists also in their plan. The consequence of shifting from Medicaid fee-for-service to a Managed Care plan, is that the PCP that the family previously went to, as well as the medical and behavioral subspecialists treating the medically fragile child or children, may not accept the specific Managed Care plan they are enrolled in. These are families that struggle to access the care they need as it is. Losing the providers that they had some connection to greatly increases the risk that the children's already complex medical/behavioral needs will go unmet.

New Children's Services. While I have highlighted the problems inherent in the transition to Managed Care, there are many reasons to be excited about the new services offered through Medicaid Redesign. These include the initiation of the health home care management model for children, the implementation of six new children's behavioral health services, and the shift of Home and Community Based Services for children from the 1915c Waiver programs to MCOs and its expansion to all eligible children receiving Medicaid.

The Children's Health Home program is one of the major new initiatives of Medicaid Redesign. For children with behavioral and/or medical complexity who meet specific criteria, a complex system is being set up that will allow for the provision of intensive care management services. NAC and many other child welfare agencies (as well as other

agencies serving children with special needs) are working with "health homes" to provide care management services to their own clients as well as other children on Medicaid with special needs. This program portends to be enormously beneficial to the medically and behaviorally fragile children NAC serves because it will provide for a "care manager" to identify, refer, and monitor the behavioral, medical and social services that meets each child's unique needs. The child's Plan of Care is developed by the Care Manager in concert with the child's various providers. NAC, as a care management agency, will be reimbursed for providing these services through the child's MCO. The challenge here is the number of staff and amount of staff time required to successfully implement this program. NAC staff have been working with the Collaborative for Children and Families, a health home comprised of most of the child welfare agencies in the city, for more than two years to prepare for this program. The Children's Health Home initiative will impact every department at NAC. We have an internal "readiness" committee, made up of representatives from all our departments, that meets regularly to plan for the initiation of children's Health Home enrollment next September. These "readiness" activities have posed substantial burdens on agency staff that are already stretched thin. And, as Health Homes start up, the agency will have to expend a lot more resources.

Another children's Medicaid Redesign program will offer six new behavioral health services targeted largely at young, at-risk children. The program, delivered in natural community-based settings where children and their families live, emphasizes prevention and wellness and a better integration of behavioral health--focused services in a child's early care. Its goal is to prevent the need for more restrictive settings and intensive services as a child gets older. NAC is very enthusiastic about our children having access to these crucial services.

A final Redesign initiative involves the existing Home and Community Based Services (HCBS) that are currently in the 1915c children's Medicaid Waiver programs. These will be aligned into one array of HCBS benefits and shifted to Managed Care. NAC currently provides many of these HCBS through the Bridges 2 Health (B2H) Waiver program. HCBS will be expanded to include all children covered by Medicaid that meet eligibility criteria.

So far, the state has informed us that the new Redesign programs, I just described, will be available to Medicaid-eligible children who meet specific criteria. However, the eligibility criteria for each of these programs have yet to be fully defined. There is a lot of discussion among children's advocates, affected agencies and providers, and the state agencies (NYSDOH, OMH, OASAS, OCFS) regarding this issue. The challenge will be, not only the eligibility criteria specified by the state, but how much latitude the MCOs will have in interpreting eligibility rules. It is the MCOs who will ultimately be in the position of authorizing or not authorizing what services will be covered, and for whom. That is, will some of the children NAC serves who would clearly benefit from these services be deemed ineligible by the MCOs? Or, will a threshold be placed on the number of such services they can utilize? Further, NAC has the interdisciplinary team of clinicians qualified to provide many of the new children's behavioral health services; and, we already provide the Home and Community Based Services (through B2H) that we hope to provide under the new Medicaid Redesign HCBS benefit. Providing these services directly will allow for better service coordination and continuity for our clients, and it will serve as a potential, much needed, new revenue source for the agency. However, we do not yet know the level of reimbursement for delivering these services and are concerned that, if rates are low, it will be a financial burden for NAC to deliver the services our children need.

NAC is significantly affected by the ongoing transformation in the way Medicaid services are delivered in New York State. Under the umbrella of Medicaid Redesign, these initiatives are designed to reduce costs, improve healthcare outcomes, and increase efficiency in the delivery of care. It is assumed that through a unified, integrated approach to their care, children on Medicaid are more likely to achieve better management of co-occurring chronic behavioral and medical conditions, remain out of hospitals and other institutional care settings and reside in the community; thus, improving health outcomes and reducing Medicaid costs. This is the promise of Medicaid Redesign. However, we will not realize the goals of Redesign if the state does not adequately fund the Managed Care Plans; the MCOs, in turn, do not authorize – or limit -- the delivery of adequate services to the children who need these services; and the MCOs fail to reimburse the agencies and providers for services they deliver at sustainable rates.

Thanks to the City Council, especially Councilmember Cohen and the Committee on Mental Health for supporting crucial Medicaid Redesign readiness activities that are so necessary to NAC in preparing to meet the challenge of Medicaid Redesign.

THE COUNCIL
THE CITY OF NEW YORK

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Name: Dr. Gary Belkin

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I represent: Excutive Deputy Commissioner, Division of Mental Hygiene

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I represent: Amida Care

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Name: Dr ~~Mark~~ Wendy Gorsenger

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I represent: New Alternatives for Children (NAC)

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