CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITY, ALCOHOLISM, SUBSTANCE ABUSE, AND DISABILITY SERVICES

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Chairperson

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A P P E A R A N C E S (CONTINUED)

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[gavel]

CHAIRPERSON COHEN: Alright good morning everyone. My name is Andrew Cohen and I am the chair of the Council's Committee on Mental Health, Developmental Disabilities, Alcoholism, Substance Abuse, and Disability Services. Thank you for attending today's hearing on Medicaid redesign. This committee had its first hearing on New York State's redesign of Medicaid in September 2014. Today we are here again to discuss the redesign and the effect that it's having on behavioral healthcare providers and patients in New York City. Governor Cuomo implemented Medicaid redesign beginning in 2011 to control the increasing cost of Medicaid but also to improve the quality of care and ultimately the health of enrollees. When the Medicaid redesign team made their final recommendations in 2011 it was determined that the fragmented and uncoordinated payment and delivery systems had been contributing to poor outcomes. For example, the team highlighted that people with a serious mental illness died on average 15 to 25 years earlier than the general population. The team also pointed out that 20 percent of patients'

discharged from psychiatric in-patient units were readmitted within 30 days. In addition, only 30 percent of youth ages 14 and older with a serious emotional disturbance were graduating with a standard high school diploma. And the average time between onset and treatment of mental… and the treatment of mental illness in children and the treatment of mental illness was… let's read that again. In the average time between the onset of… and treatment of mental illness in children was approximately nine years between the diagnosis and treatment. Medicaid redesign was intended to address these poor outcomes while simultaneously contributing to Medicaid's budget solutions. Medicaid redesign is… is important to this committee because it is essential that vital mental health services are easily accessible and consistently available to individuals of all income levels. Mental illness is a medical condition and treatment. And treatment should be coordinated the same as all other health matters. The key for a positive outcome is early detection and continuous treatment. Interruption of mental health treatment even temporarily can have lasting effects. In our

original Medicaid redesign hearing many behavioral health providers expressed concern about the transition from fees service to the Manage Care model which is the main component of Medicaid redesign. Since that time the newly designed Medicaid system has gone into effect. Today we hope to hear from some of those providers in order to learn if their preliminary concerns have been properly addressed or if they have identified new challenges that need further attention. Lastly at our first hearing the council recognized that there were unaddressed infrastructure needs for ground level providers during the transition to the new model. As a result, we addressed it as a priority in the fiscal year 2016 budget allocating 500,000 dollars to nine New York City mental healthcare providers. The committee would like to hear from these providers as to how this funding has assisted in their operations and whether there is an ongoing need that requires further assistance. It is our hope through a continued dialogue with a city's providers we can understand their struggles and ensure a successful transition by advocating for resources at both the city and state level.

Additionally, today we are voting upon two bills; Intro 881 A and Intro 883 A. The committee has heard these bills on September 22nd… the 21st of 2015. Introduction 881 directs each agency to designate an employee to coordinate the agency's ADA responsibilities. Intro 883 requires notices and advertisements for events hosted by the city government and city funded organizations to include information on events… venue accessibility as well as whom the individual made contact to request amenities. I am sure the bill's sponsor Council Member Helen Rosenthal would like to say a few words.

CM ROSENTHAL: Thank you so much Chair Cohen for holding the hearing and allowing me to say a few words about the bill. 10 percent of New Yorkers over 800,000 people have disabilities. New Yorkers with disabilities continue to face what are really avoidable barriers in civic and cultural life. And it is my sincere hope that taken together these two bills will begin to break down these barriers. Chair Cohen described intro 881A and I would just note that at the time of our first hearing in October the Mayor's Office of People

with disabilities testified that only three agencies had similar positions filled; DOT, HRA, and Parks. Since then… did I say DOT? I hope I did. DOT, HRA, and Parks. Since then the Department of Buildings and TLC have… have hired an ADA coordinator and emergency management has designated someone to fill that role. Further MOPD is currently working with other agencies who are at various stages of the process for hiring even more staff to fulfill this responsibility. We are very grateful for their work in helping craft the bill 881A and supporting staffing of agencies to more appropriately help the communities of people with disabilities. Into 883A require that all advertisements, posters, invitations, and other publicity materials for events open to the public hosted by city agencies contain information on who to contact for information regarding accessibility at that event and a deadline for when requests for accommodations for people with disabilities must be received by the events' organizer. Furthermore, the bill would require that publicity materials include information regarding the availability of wheelchair accessibility, communication access,

real time translation sign… sign language interpretation, assistive living systems, and any other accommodation. You can imagine how this is the first step to increasing the awareness of the importance for those icon symbols at any event. And increasing the awareness of the need for those symbols in order to encourage more people to be involved in community activities. I want to thank Council Member Ritchie Torres for introducing these bills with me, the mayor who's shown his commitment to issues for people with disabilities, Commissioner Victor Calise and the MOPD staff for being partners throughout this entire process, the speaker and her office, all the staff from the legal drafting unit who work diligently on these bills including Kimberly Williams, Mathew Carlin, and Eric Bernstein, and countless advocates who have been working on this issue for so long it took the time to educate me, my staff on their concerns for making sure these bills adequately address some of those issues and Edward Freeman, an intern in my office, and of course Sarah Mallory, my legislative director and this is her first bill. And I'm really proud of her that this should be… these two bills

should be the one. She did an amazing job. So I urge my colleagues to join with me in support of these two accessibility bills by giving an aye vote today so we can help to ensure more equal and more accessible New York for all. Thank you very much.

CHAIRPERSON COHEN: Thank you Council Member Rosenthal. I just want to acknowledge members of the committee have joined us so far. We have Council Member Vallone and Council Member Grodenchik. Lastly I want to thank the committee staff for their work; Nicole Ebony our new Legislative Counsel, Michael Benjamin our Policy Analyst, and Jennet Meryl who's here some place our new Finance Analyst. And I also want to thank Kate Theobald my Legislative Director. And now we're going to call the administration for our first panel. Thank you.

UNKNOWN: Doctor Gary Belkin. Good morning. Can you please raise your right hand? Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee and to respond honestly to council member questions?

DOCTOR BELKIN: Yes I do.

UNKNOWN: Thank you.

DOCTOR BELKIN: So good morning everyone; Chairman Cohen, members of the committee. I'm 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 this important issue of Medicaid managed care and mental health and substance use services, an area I will refer to as behavior health services. If I could also just digress a second, I want to thank the presence of many providers and advocates that we deal with and who are really central and at the front lines of success and getting through this transition and we rely on a lot to focus our attention best. I also want to thank a lot of my staff for coming… which I don't whether to interpret as support or lack of confidence but I appreciate it. So 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 and receive treatment and other clinical services primarily on a fee for service basis meaning providers paid for each specific service they provided individual without adequate consideration for the quality, necessity, or effectiveness or package of the care that is received. Historically there has also been little systemic coordination, or systematic coordination of all these individually provided services and an overreliance on expensive hospital and patient services. In-patient hospital stays in New York represent over 50 percent of behavioral health Medicaid costs and the state has become the long… some of the… has some of the most longest… longest length of stay… of hospital stays in the country. The lack of coordination has also resulted in New Yorkers receiving their behavioral and physical healthcare separately often engaging individuals in two distinct systems with different regulations, oversight bodies, reimbursement schemes and data. In addition, because of the common core currents of behavioral health and medical conditions and the destructive effects of those combinations,

behavioral health outcomes have become a key driver for excess cost for physical healthcare as well. So through Manage Care the state is looking to address these issues. In a Manage Care approach the state expects to eventually pay a monthly per person rate to a Manage Care insurance program creating incentives for plans and providers to deliver more preventive services, identify problems earlier, better coordinate care and recovery with the end goals of improved overall health outcomes and reduce costs. Better ability and incentive to use outpatient solutions should reduce in patient 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 actually putting this vision into practice will not be 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've been deeply invested in preparing for how to apply these changes to the New York City behavioral health system. The department for example is able to successfully advocate that

plans manage and coordinate individuals' behavioral health and physical healthcare together. All Medicaid recipients who need behavioral health services approximately four million New York state residents will have their care provided within such Medicaid Manage 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, estimated at 60,000 individuals in New York City. All 10 Medicaid managed care plans serving New York City have been designated to provide behavioral health services. And eight of these will offer the HARP benefit. DOHMH has helped the state to develop the RFQ that establishes the standards of care that HARP should provide. And we also participated in reviewing the plans for readiness and we'll continue to monitor the quality of care they provide. The move to Manage 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. I would like to highlight a few. First, providers and beneficiaries must understand the new system in order to implement and participate in any 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 and development of the New York State HARP model member handbook that is distributed to members once they are assigned to HARP. However, more needs to be done. Moving forward for example DOHMH plans to work with divider groups and networks as they interact… because they interact directly with enrollees and thus can play a key role in engaging and educating them on the new system. Second, providers need the operational support and resources from the state that are necessary to adapt to new payment structures and to related changes in service

delivery. In particular providers that offer the HCBS, the home and community based services, which are reimbursable under Medicaid for the first time a 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 dollars in state funding to implement a two-year project to project to provide electronic billing and health record systems, technical assistance and clinical practice improvement, support to approximately 125 of the 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 I mention and negotiated with the state to set reasonable reimbursement rates based on analysis of current state aid offered to providers. Also we serve as members of the state's Manage Care technical assistance steering committee which shapes the quality and content of technical… technical systems trainings that are offered to providers. While the department is there for a

working on a number of fronts to assist service providers through this transition the state's leadership is none the less critical to ensuring that that transition is successful. So therefore third there must be improved cross systems, communication, problem solving, and information sharing among the agencies and organizations that are needed for the Manage Care system to work. To facilitate this the department convenes the New York City Regional Planning Consortium or RPC which is a multi-stakeholder body tasked with monitoring the implementation of manage behavioral healthcare and identifying solutions to issues raised by RP… RPC members locally. The RPC is comprised of steering groups for the representation from the following key stakeholders; Manage Care plans, provider groups and coalitions, service recipients, health homes, and city agencies including New York City health and hospitals. Since the RPC's rollout in late 2014 the department has led regular meetings with these groups focusing on issues related to service efficiency, access, quality, and capacity as well as plan performance and system stability. The RPC has discussed issues like

ensuring timely payment by Manage Care organizations, lack of regulatory guidance on billing for certain types of services, referral processes and unclear eligibility requirements in health homes. Currently the RPC is focused on understanding manage… several Manage Care implementation challenges including improving 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 the delivery system reform incentive payment program or affectionately known as DSRIP. Therefore, we manage… our department manages the New York City behavioral health performing provider systems group, or PPS group, as part of the RPC. This structure allows these provider systems to communicate directly with Manage Care organizations and align discussions surrounding payment. The RPC therefore serves as a potential entry point for vital real-time feedback and recommendations from key stakeholders for improving this transition of behavioral healthcare

and to the Medicaid Manage Care system. Finally, the department contributes to the oversight of the transition to Manage Care along with the state agencies, state department of health, state offices of mental health, and alcoholism and substance abuse and services. While the department is still in the process of shaping and clearly defining this function of 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 10 New York City Manage Care plans that applied to offer behavioral health services. We develop Manage Care performance metrics to measure service delivery and quality. We credentialed 168 HCBS providers in New York City and drafted the behavioral health amendment to the State Department of Health's contract with Manage Care plans that codifies the standards of services that must be met. Additionally, the department participates in daily calls with the state… with these state agencies to share information regarding… regarding provider billing concerns and consumer complaints. And so we welcome provider

bill… to hear about provider billing concerns and consumer complaints. We also expect to co-convene a new structure, the quality steering committee, which will be comprised of representatives from those three state agencies and DOHMH to monitor and oversee the quality of behavioral healthcare and manage… and Medicaid Manage Care plans serving New York City residents. Complimentary to this collaborative work with the state offices behavioral health providers may also be able to benefit from several thrive NYC initiatives that aim to bolster the transition to more integrated and high impact models of care… the kind of models that they are being challenged to be part of under Medicaid. We will be establishing a… for example 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 Manage Care organizations and the district networks to collaborate with the department on the development of NYC support; an initiative to enhance the capacity of the city's phone based crisis hotline capability to also more directly connect people to care. There may also be

opportunities for district providers to further integrate behavioral health services into their primary care settings to resources that will come through the mental health services core initiative. At its full strength this initiative will place approximately 400 recently graduated masters and doctoral level clinicians in primary care practices, substance use programs, and mental health clinics. To expand among other things, the use of the collaborative care model for integrating primary care, behavioral health in high need communities throughout the city. The department is similarly engaged in the changes to Manage Care for children's behavioral health services which are expected to take affect January 2017 which is a year later than previously planned. This transformation will expand eligibility requirements to allow more children to access care, increase availability of community based step down services and provide coverage for an array of support services. Additionally, Medicaid redesign will result in the movement of special populations of children with higher levels of service needs and to Manage 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, and funding in the children's behavioral health system. As well as education for participating providers and families. So 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 of… and credentialing processes, processes. We continue to advocate for adequate reimbursement for evidence based practices and for sufficient funding for services and funding for provider readiness. Finally, the department participates in a state led work group that designs trainings to help providers understand and prepare for this transition to Manage Care for children. We have also conducted focus groups to understand the information needs of youth and families which whose findings will help to inform our outreach strategies to this population. We believe it is possible that a Manage Care approach can help individuals in New York City recover from behavioral health issues, reduce

hospitalizations, and improve their physical health outcomes as well. But this transition will in some ways… and this transition will in some way support but in other ways it will pressure important changes in how behavioral healthcare 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… the impact of these changes and to realize their potential for improved outcomes and care. Thank you again for this opportunity to testify on this subject and I'm happy to take any questions.

CHAIRPERSON COHEN: Thank you for your testimony. You mentioned several points where DOHMH is interacting with the providers to… through several of these committees. Could you talk about the feedback that you're getting, that some of the current obstacles that the… you… that you think the service providers are facing that you know that maybe we should address to try to make sure that this transition goes as smoothly as we hope.

DOCTOR BELKIN: Yeah so we're still early in. And so a lot of the initial sorts of things we… we've been surfacing are basically

uncertainties about processes and billing plans or billing code issues and some differences across plans. There's concern and therefore we've been trying to work with the plans on timely payment. And we have offered to at least all the providers that we have contracts with that through those contracts we can forward payment if… if there was… there… if there were cash flow issues. So I think those are the sorts of things…

CHAIRPERSON COHEN: I didn't understand. It… in terms of payment… because I've heard delays in payment have been an issue so…

DOCTOR BELKIN: We… we've… we… we're… pays… delays in payment are an issue we have not had specific concrete complaints about that. We have tried to preemptively work with plans and providers to preempt that. But we have various forms and opportunities and we… and as I said we want to hear about that. Given the opportunities we now have to regularly engage the state to troubleshoot those things.

CHAIRPERSON COHEN: In your testimony you talked about a 10-million-dollar fund for

implementation. Could you talk about what that money specifically for and how much of it is spent?

DOCTOR BELKIN: Yeah. So the… the dollars are largely for subsidizing or really covering licensing fees for providers to either purchase or upgrade existing software that allows them to bill code and… and therefore really participate fully in the Medicaid process. What we're adding to that is providing technical assistance not only to optimize use of those tools but also in terms of billing efficiency but also to use them to help as much as possible and in redesigning bottlenecks in their workflow maybe redesigning some of their delivery designs to be more efficiently consistent with the sorts of services that the plans are really going to be wanting to pay for and the kind of results that are going to… that are wanting to see.

CHAIRPERSON COHEN: And what is… what is the status of that funding?

DOCTOR BELKIN: So have we… do we have it? Yes. Tell everyone…

CHAIRPERSON COHEN: You have to identify yourself.

Yes…

DOCTOR BELKIN: …who you are and how wonderful you are.

YOSHITA PINNADUWA: I'm Yoshita Pinnaduwa. I'm the Senior Director for Policy and Planning in the Division of Mental Hygiene in a Bureau called Systems Access and… So we have received the grant in terms of the contract being signed between us and the Forum for Public Health, the funding actually comes from the state Department of Health… state Department of Health through the Forum for Department Health to the New York City Department of Health and Mental Hygiene. We're still in the process…

CHAIRPERSON COHEN: It… it's state money that we're administering?

YOSHITA PINNADUWA: Yes. And we are still in the process of conducting for wider needs assessments. So we are looking to serve about 125 small providers through this grant. And we have built… so it… it's sort of grant where we have to bill on a quarterly basis. So we… I believe we have received the first quarter payment for the deliver… completed to date.

CHAIRPERSON COHEN: So you… you believe you've spent about two and a half million dollars?

YOSHITA PINNADUWA: I believe so.

DOCTOR BELKIN: We've received two million…

YOSHITA PINNADUWA: We've received…

CHAIRPERSON COHEN: But so my understand… if I understood your testimony correctly though you… you get reimbursed for money that you expend, is that…

DOCTOR BELKIN: We… we get disbursements from the state on the quarterly basis. That's not terribly interesting. What you want to know is what has… has reached the… [cross-talk]

CHAIRPERSON COHEN: Has any of this money…

DOCTOR BELKIN: …reached the ground and that… that we would have to get back to you about exactly how much money has left the… the building. We… this is… this is just… this is new and has been a long process. This is just not money given to us by the state. This… this was wrestled with the state and it was proceeded by surveying quite a number of providers to understand what the needs

were and gaps were so we asked smartly you know what… what we sort of wanted to be able to bring to them through this program. So we just finalized the M.O… the MOU I think like a month or two ago? The contract was just finalized like a month or two ago. So we're really just to the beginning of dispersing…

CHAIRPERSON COHEN: No we're 100 percent on… being paid…

DOCTOR BELKIN: Yeah, yeah… no, no… I'm just trying to give you the… what we know factually as to where it's at.

CHAIRPERSON COHEN: I… I think… this is the first I'm hearing of it and I think it's you know very important funding and it's… you know may be the number one thing that I've gotten feedback from the service providers is you know they accept that this is happening and this is… but… and ultimately maybe that they will do better on… in… in a Manage Care model then a fee for service model but there was no… there was no resources for the… the startup cost of this transition. So I think that that's… that's phenomenal news that… that's phenomenal news that…

DOCTOR BELKIN: Yeah. And what we… what we'd like to do is not just help pay them for software so they can bill and… and make it in this environment. We'd… we'd like also to help provide technical support for them to use that as a tool to optimize their operations and succeed in this environment, not just be part of it.

CHAIRPERSON COHEN: I… I think that that is fundamentally important. As long as we're on budget issues what do you see is the impact of Medicaid redesign on the RFP process for existing service providers?

DOCTOR BELKIN: Which… can you explain which…

CHAIRPERSON COHEN: In other words…

[cross-talk]

DOCTOR BELKIN: We… we have lots of RFP process…

CHAIRPERSON COHEN: Yes but we had a fee for service model which I… you know when we were… when you were issuing a contract it was built into it that they… provider would bill Medicaid for provided services. Do you think there will be an

impact now in this Manage Care model on the way those RFPs working… [cross-talk]

DOCTOR BELKIN: In terms of our… our… our contract?

CHAIRPERSON COHEN: Yes.

DOCTOR BELKIN: So our contracting was generally for non-Medicaid services precisely because we couldn't… we wouldn't pay for services that otherwise could be billed for. And it's a lot of those… those services… and I think this is what you're asking and this is a really crucial issue, a lot of those services will now be part of these HCBS services. So now Medicaid will be paying for them. A big unknown is then what's going to happen to our… the dollars we've been giving to providers to provide them if now Medicaid can be billed for them. And we're starting to have those discussions with the state and I don't think… and I think for now the question has sort of been left open for the next year or two. We've been told that our current contracts and stay day flows shouldn't change in that short term. But what shifts are going to be in the long term is something we want to stay ahead of. We think there will be no shortage of needs for

those dollars. And… and so we'd like to use them where they're needed.

CHAIRPERSON COHEN: Okay. Can I also… in your testimony you talked about the length of stay for people seeking mental health services that it was significantly longer than the nationwide average. Why do you think that is?

DOCTOR BELKIN: That's a good question. And I'm curious to hear what a lot of people in this room think about that. New York state is I think the bottom you know 48, 49, 50th depending on what… what rankings you look at in terms of length of stays. In terms of patient… pay… census per… people per hospital… psychiatric hospital days were triple the national average in New York City. So we… we really relatively speaking overuse in-patient resources. I think that there are many factors to that. I think one is a cultural practice. As a practitioner when I came here from elsewhere it was just… it struck me just how clinicians rely on… on in-patient services more. But I think part of that is because other places have invested better in an array of out-patient services. And I think… and I… I said in my… my

testimony that the strategy of Manage Care is to shift resources from in-patient to out-patient. The reality of the robustness of that shift, who's included in that shift is something that we're all nervous about and want to be sure happens, and leaves us with the sort of system and community based capacity that does well by well and just doesn't succeed in saving in-patient cost.

CHAIRPERSON COHEN: Doctor Belkin will you indulge us for one second while I open the… and ask the clerk to call the… the roll on the two pieces of legislation that we have here?

DOCTOR BELKIN: Sure.

COMMITTEE CLERK MARTIN: William Martin, Committee Clerk. Roll call vote; Committee on Mental Health Introductions 881A and 883A. Chair Cohen?

CHAIRPERSON COHEN: I vote aye.

COMMITTEE CLERK MARTIN: Crowley.

CM CROWLEY: [off mic] I vote aye.

COMMITTEE CLERK MARTIN: Vallone.

CM VALLONE: Aye on all.

COMMITTEE CLERK MARTIN: Grodenchik.

CM GREDENCHIC: Aye on all.

COMMITTEE CLERK MARTIN: By a vote of four in the affirmative, zero in the negative, and no abstentions both items have been adopted.

CHAIRPERSON COHEN: Can… can we keep the… the roll open? Thank you. I'm sorry Doctor Belkin. Thank you. Can you talk about… a little bit about what the administration hope you know in terms of taking this problem on of the… of the long term stay with… you know if there's anything in Thrive NYC or… or what we hope to do in the future in terms of… on our… you know on our own?

DOCTOR BELKIN: Yeah so you know… I see identified new directions that we think should be more payed attention to and resourced that involved community based solutions through various ideas like opening up who can be… you know who can be a provider and part of a chain of pair. The mental health services core which not only will add capacity we think 400,000 hours into the system but will be an opportunity to accelerate testing different kind of delivery ideas that we hope and so far with some success have gotten interest of Manage Care plans to look at as a… as a way for them to test new payment models etcetera that

they've been hesitant to do especially to… for globally support integrated. But at the end of the day the… a lot depends not just on building some new capacity around the edges and driving new models but really in payment… really supporting both in allowing innovation but also inadequately funding the capacity that we need. And that needs state leadership. And while we have defined… we described various ways that we have been engaging with the state to move the needle we really need… This is… this is… this is their program. And so those decisions are ones that we're trying to influence but that we look to them for.

CHAIRPERSON COHEN: I… I have additional questions but Council Member Vallone did you have a question or two?

CM VALLONE: Good morning Doctor.

DOCTOR BELKIN: Good morning.

CM VALLONE: I think you're a fixture at almost everyone of our hearings on all the committees now so we're just going to have to have a chair for you…

DOCTOR BELKIN: I'll just stay… I'll just stay here.

CM VALLONE: That's why your whole staff came because they're worried about which committee you were actually coming to. Alright so thank you for all of this. I felt like I was back in law school there for a moment with… and waiting for the ultimate question. And how would you fix the system as… implement and all the kids would have failed. You outlined some important things for us. And I think your testimony… we have participated in reviewing the plan for readiness. I love that plans for readiness. Which will monitor the quality of care they provide. Are you satisfied where we are today on as we prepare?

DOCTOR BELKIN: If it's a yes/no question… [cross-talk]

CM VALLONE: No, it never is.

DOCTOR BELKIN: …the answer is yes. However, I mean so the… the plan readiness for example. So that was a long exercise. We devote a lot of staff to that. We went through all the plan applications. We had a score card. We did site visits with the state. And… and yes we think that the plans that… and… and actually some plans got feedback back and had to revise what they did and…

and some plans didn't make it through. But we also learned a lot of things you know that we want to make sure we keep an eye on. And some of these things are no surprise to people who've worked around Manage Care. I mean one is the network… network adequacy. We felt… very… a real range of robustness and seriousness about the networks that these plans assemble which at the end of the day is really where people experience care as not just who's in the network but how easily they're accessible, that they capture the broad array of services that people are entitled to with the capacity that really will meet the need of the enrollees by plants etcetera. So that… so it highlighted issues like that that… that we really want to keep an eye on.

CM VALLONE: I think that that's one of my concerns. When you said the level of care that people are entitled to and the services that are provided is… the knowledge to get to the person that as there's a transition there may be a different title of the services, there may be a different place, doctor, provider… so the… the… getting that information to those who are so

dependent on this is one of my key… and I see that you have an… this New York City regional planning… another acronym I will… RPCs… consortium… has that been fruitful in helping in that process?

DOCTOR BELKIN: So far. I mean again it's been really up and running for a couple of months since the end of last year. We mentioned testimony. A couple of the issues that have started to service that we're taking on there but in terms of you know the point that you…

CM VALLONE: How often is that group going to…

DOCTOR BELKIN: Well it feels like it's meeting constantly. We have…

CM VALLONE: Like my office.

DOCTOR BELKIN: Yeah. We have these five or six steering groups that… that reflect different stakeholders and we meet with them at least on a… on a monthly or bi-monthly basis. And then from then surface issues that they want to work cross group. So for example, on health home enrollment which is a concern of a lot of people that service that now we joined a group with providers, plans, and health homes to try to troubleshoot that. What

can the… what can we do at a local level to try to address that?

CM VALLONE: What's the ultimate goal of the RPC? Is there going to be analysis data, anything that can be provided? I… I'd… I'd like… unless you're going to be the conduit at future hearings but I think those are important for us on the council to know what the group's coming up with.

DOCTOR BELKIN: Yeah so I… I… that's a good question whether we're going to report out by certain issues that are of concern to the community comprising the RPC or others or do an annual report sort of state of Manage Care we haven't settled on yet but right now we're really… we just really put the machinery together. The… I just want to circle back to your echoing the point of that people get what they're entitled to and get… and get what they need adequately. One issue that… that has come up in this… and in our regular calls with the state is they're about… we think there are 60,000 people who are presumably HARP eligible. We know that 8,000 have opted out. So they… they are told you're HARP eligible do you want to participate and they opt

out. We're not comfortable what… what that's about. [cross-talk] …really know what they were opting out of, do they… so we're trying to troubleshoot that. So a lot of these kind of access coverage and eligibility issues are really the ones preoccupying us now as this thing gets started. That all the people eligible know they're eligible that they're in… and that they've… you know have start… they've been successfully enrolled.

CM VALLONE: The mechanism that's allowing them to opt out, when and how does that happen?

DOCTOR BELKIN: So the state has… so again this is… this is us trying to really… how much can we leverage what is ultimately a state operation. So the state has engaged a… a… a vendor that informs and it enrolls and gets the opt in from… from individuals. And…

CM VALLONE: We… we should kind of narrow… [cross-talk]

DOCTOR BELKIN: …we're trying to… [cross-talk] drill down into what is that process really about, what kind of information are they getting, etcetera.

CM VALLONE: I think Chair that would be a good focus for us to coordinate with our brethren in Albany as to what the vendor is using during that process that's resulting in this large dropout. You know what is the actual question, what is the actual procedure involved, and the process involved that's allowing… creating this dropout, and what are those… who… opting out them being provided with. So I think that's…

CHAIRPERSON COHEN: I agree with your concern on that.

CM VALLONE: Are we getting any type of help from the vendor there or…

DOCTOR BELKIN: We eventually always do.

CM VALLONE: Sounds like my house. Eventually we'll find out what's going on, we're not quite sure. So is there a timeframe as to how often the group will be circling back or is there every month… quarter… So… right so the steering groups meet on a month or two bases. The work groups are more ad hawk to address issues that rise in those groups. And then each of the working groups identify two people to represent their stakeholders in an advisory board to us which meets

I think every other month, quarterly or every other month. And so that's our… that's our kind of governing structure, try to keep issues going back up and down. Because it can be a sprawling… sprawling set of stakeholders. And then we take what things we don't think we can solve locally to the state in… in our regular conversations but we hope more formally in this quality steering committee that we're near agreement with them on in establishing.

CM VALLONE: Well if you could I'd really appreciate some type of summary outline of those meetings to keep the committee appraised as to what's going on. There's a lot of good work going on and… [cross-talk]

DOCTOR BELKIN: Sure.

CM VALLONE: …love… hate to reinvent the wheel that's already coming out. And we could then see and then we could follow up what's necessary from our side.

DOCTOR BELKIN: Absolutely.

CM VALLONE: Thank you very much.

CHAIRPERSON COHEN: Thank you very much. Just to follow up on… we don't have data on why

people are opting out yet, we're… we're trying to get that information from the state is that…

DOCTOR BELKIN: Correct.

CHAIRPERSON COHEN: Okay so we don't really… Just to circle back to this… the state grant… do we have any kind of needs assessment of what we think service provider sort of costs are generally going to be related to this transition?

DOCTOR BELKIN: No we survey… the survey I mentioned was specifically about their IT needs and their billing capabilities and… and some of those more finer capabilities. To be able to project financial impact I think is tenuous and frustrating to a lot of providers because the next two years although now a year and seven months is the… the fee for service structure remains similar to what it had been. What is a big unknown is the payment system that… that follows that which is now under a discussion at the state level with varying participation including by us?

CHAIRPERSON COHEN: That… that's related to mental health… in terms of sort of…

DOCTOR BELKIN: Correct.

CHAIRPERSON COHEN: …traditional physical health we've already… that's been rolled out and is… is taking affect now.

DOCTOR BELKIN: Right. But what will evolve… there's still a fee for service payment now. So it will evolve as a more per person payment… a kind of lump payment that then the plans with providers have to within that sort of per person budget provide all their services. How that's going to work is still under development. And… and that's… makes lots of us anxious and makes it hard for us and providers to project out how to redesign what we're doing.

CHAIRPERSON COHEN: You know I would say in the you know 10s of billions of dollars that we spend on Medicaid you know the state's commitment of 10 million dollars and as you know the council made a commitment of 500,000 dollars to try to help some of the service providers. You know I… the impression I get from the service providers is that this is… that there is a substantial cost involved in… in making this transition and ultimately you know as we all talk about the need to maintain quality care on the ground the… the health status

of the service providers is key to that. If we… if we don't have a strong network of service providers we're not going to be able to deliver the kind of services to New Yorkers that they need, that they're entitled to, and that we want to. And so I would hope that we would continue to do an… you know an ongoing sort of you know what can we do to help in this transition to make it you know viable.

DOCTOR BELKIN: Absolutely. And… and exactly the issues you just described were… were… where we put initial eggs in our basket around focusing on networks, eligibility, enrollment, and for providers on the basic tools that they're telling us… particularly HCBS providers who are new to this… many of which… not all of which but many of which are new to this whole billing game have the basic tools they need to play there. But the question I… I heard, and I was also answering is… is moving forward there are a lot of issues about staff development, training, delivery design, work flows, scope of services that will be affected by sort of the next evolution of payment that are still evolving.

CHAIRPERSON COHEN: Could… could you just give us a brief sort of update. In terms of the… the implementation of HARP and DSRIP and for… you testified that behavioral health for children… like what is the status of… of those aspects of the plan, some of them I guess you mentioned that for young children the rollout has been delayed until 2017. In terms of HARP and DSRIP where are we at with that?

DOCTOR BELKIN: So HARPs… so the Manage Care plan for adults… the plans became operational in October. The ability to bill and receive HBS services which really the core HARP services began in January. DSRIP is part of the larger strategy of Medicaid transformation but isn't as directly involved related to Manage Care per say. So DSRIP if you recall an invest… a reinvestment of dollars into the system from Medicaid cost savings. So the state saved some money on Medicaid and negotiate with the federal government to get a chunk of it back if they structured in a way that health systems would spend it to presumably innovate care to further reduce Medicaid expenditures, particularly acute in-patient and emergency

services. For healthcare providers to get those billions of dollars they needed to sign onto doing certain projects that would… that pass muster at the state and federal level as likely to indeed redesign the system in ways that… that… better outcomes and lower costs. A lot of that activity, those projects that these new systems that… that organize themselves, these new what we call PPSs that organize themselves to get these dollars and to do these projects, a lot of that activity is around behavioral health. So all the PPSs in New York City signed on to do a project around integrating behavioral health and primary care. So this is an influx of resources and attention and system reorganization for behavioral healthcare that's pretty unprecedented and… and quite an opportunity. However, it's time limited. It's a time limited amount of dollars. I think it's fair to say there's variation across the PPSs in their… in the vigorousness with which they're thinking innovatively. And so we have been convening all of these PPSs around the… their behavioral health work to try to share best practice and also really encourage that we push this envelope as much as we

can. But what we also want to do is if they're making the effort to try to redesign the system like more integrated primary care we would like the system to pay them for it moving forward through Medicaid. And so we're trying to connect those dots. Again these are authority's decisions that ultimately lie with the state. And so we are using the various points of contact that we have to try to connect those dots. And we have gotten great interest and… and I think great… great willingness by PPSs… some… some represent… members and representatives whom are in this room to move the system that way, to try to take mutual and converging advantage of these different things. But it's… it's going to take a lot of work and there's some risk to them to do this. Because the cart may not exactly follow the horse in… in that alignment.

CHAIRPERSON COHEN: Finally, could you just talk briefly about the upcoming state budget and you know there's talk of substantial cuts to the city's Medicaid and what you think that that… you know how you think that's playing out so far.

DOCTOR BELKIN: So you… the… the budget is still under negotiation as far as I understand.

And we… and I think all of us in the city look to the state to take on the leadership that it needs to take for that to resolve well.

CHAIRPERSON COHEN: Anybody else? Going once? Doctor Belkin thank you very very much for your testimony this morning.

DOCTOR BELKIN: Thank you.

UNKNOWN: The next panel will be Jennifer March, Scott Wetzler, and Jason Lippman.

CHAIRPERSON COHEN: Please? You can just… anybody… anybody who's ready.

SCOTT WETZLER: Thank you… is it on? Thank you for the opportunity to discuss the impact of Medicaid redesign as had on behavioral care. On behalf of Montefiore Health Systems I want to thank this committee and Chairman Cohen for their focus in this very important issue and we cannot be more grateful for your leadership. Simply put Medicaid redesign has completely changed the delivery of behavioral health care in New York State. And even more change is ahead as Doctor Belkin has indicated. The goal of transformation is the transformation from a system that rewards volume to one that rewards value is really a good one but

there are a lot of operational challenges that are persisting. And it's my hope in the giving the testimony that will evoke some of the change to ease some of those challenges for providers so… so that we can maintain a financial runway… again as Doctor Belkin alluded to to make sure that the cart does follow the horse to accomplish the transformation. First and foremost, the inclusion of substance abuse treatment and other behavioral services in the basic manage Medicaid benefit was a significant one. These… while these services had previously been carved out of manage 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 many challenges for providers who historically only build Medicaid and certainly Chairman Cohen you've been questioning about this really providers now must develop processes to build multiple health plans and ensure that we are appropriately reimbursed. For example, although this change went into effect on October 1st, 2015 our substance abuse treatment programs at

Montefiore have received almost zero reimbursement to date. I think it's something only order of about seven million dollars of receivable which even at a place as large as Montefiore tends to get noticed. This is due to providers… our own problems with… difficulty with billing but also some great difficulty by health plans in receiving and processing the claims that are submitted as well as confusion among some of the health plans behavioral Manage Care companies. Oasis has stepped up to try to ameliorate some of this cash flow problem by providing short term cash advances to treatment programs but this really won't be adequate. And it's entirely possible that some of the smaller programs without financial resources will not be able to meet payroll. Eventually I'm confident that the billing processes will be resolved. But I'm concerned that provider's collection rates over the long term will drop. Today for example at Montefiore when we bill Medicaid for substance abuse services our collection rate is something on the order of close to 97 percent which obviously is quite good. And it's just difficult to imagine with the health plans getting involved that it will stay

at that same level. So there's going to be some substantial revenue loss. In the long run also I do believe 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 for all behavioral providers. Finally, this is an issue that hasn't been addressed so much yet by… in Doctor Belkin's testimony. But I… I'm concerned that the additional premium that's associated with these new behavioral services is inadequate and that that premium is really being allocated to the health plans and of course whether that will flow directly to the providers is… is in doubt. The second major change as Doctor Belkin indicated is the introduction of HARPs for severely mentally ill patients. Again this change brings behavioral care within the manage Medicaid benefit structure. And in doing so it offers opportunities to improve the integration of medical and behavioral care especially since as Doctor Belkin indicated this SMI population currently receives inadequate medical care. However, this major change also poses many challenges here too. The state has priced the

product under the assumption that there will be cost savings. And the amount of the premium which will flow to providers is unlikely to be at… it's not likely to be adequate. The other thing is that HARPs are very complicated to administer. And there's great danger that some of the most vulnerable people in our society will fall through the cracks. One was the issue of whether they even sign up for it and is… is obviously one… one thing. But there are many other administrative complexities that are… that are an issue here. One of the biggest surprises that has occurred during the implementation of HARP is the fact that one-third of the patients who were thought to be HARP eligible who were not proven to be eligible when the program actually 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 is why they are no longer HARP eligible which begs the question about how HARP plans to deal with significant amount of churning that occurs with Medicaid. That refers to the large number of… of individuals who lose and regain coverage during the course of a year. And I can't imagine that health

plans will be willing to pay for outreach service to non-covered members. So even though one of the aims of HARP is to develop long-term care plans for patients it's 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 not engaged 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 Health Home. And there's not adequate health home capacity to conduct these intensive assessments and certainly not within the hugely optimistic timeframe the state expects. Once the assessment is conducted there is a cumbersome three-way process of authorization for the HCBS services that Doctor Belkin was describing that involves the health home care manager, the treatment provider, and the health plan and there's significant potential for breakdown in miscommunication between these various parties. 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 is 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 and care and outreach to them when they became disengaged. For my experience as a former manage addition treatment service or MATS program which ultimately evolved into the health home. There's much suggested evidence that patients who are enrolled in care management do have significantly improved engagement in outpatient care which is the main aim of the program. And there is a very significant reduction in patient utilization and

costs. One of the problems with the health home program though is that somewhere almost 80 percent of the patients who were deemed eligible do not actually get enrolled in the health home. Secondly because people do 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 the HARPS as I mentioned for manage long term care plans have an assessment health home care managers expected to conduct that. Health home care managers are expected to be knowledgeable about mental health services, substance abuse, general medical care, and their provider systems to provide health education to patients, to enhance patients' insights and motivation and to address basic social needs including housing, employment, childcare. There's no way that a single case manager could be skilled in each of these areas and in fact there's much disagreement about the credentials and training for

the health home care managers. At Montefiore we have a diverse care management workforce. Some have clinical credentials and engage some of the… some of the most complicated cases, others do not. Some work in the field and meet patients at treatment programs and engage them there while others predominately 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 isn't… soon will be introducing a new payment structure for health home which will require billing health plans and future revenue is quite uncertain for health homes today. In the face of such uncertainty health homes are unwilling to invest in a larger workforce to meet the states volume expectations. The fourth major change will be the full implication… implementation of DSRIP, goal of DSRIP is indeed laudable which is to reduce the avoidable hospitalizations and ER visits through improved integration of systems of care and the introduction of value based contracting. Interestingly as we discussed before patients with mental health or substance abuse disorders represent the vast majority of patients

with avoidable admissions and readmissions. Although most of those admissions are for medical reasons, not behavioral reasons. That said behavioral providers are taking a decidedly backseat role in many of the DSRIP projects. One of the biggest projects. One of the biggest projects has to do with integrating behavioral care into medical settings as Doctor Belkin indicated. And while I fully support this effort to improve the access to behavioral care in my opinion it targets people with less severe behavioral disorders and thus it's not focused on those patients who account for the greatest number of readmissions. A model called reverse integration which is delivering medical care for the… in behavioral settings is a much better model for… to meet the needs of the severely mentally ill population. But unfortunately few behavioral providers have the… 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 in fact the Montefiore department of psychiatry has begun… has… was one of the first to obtain such a license. And at one of our community mental health

centers where we have begun to implement this for about a year now we have about 15 hundred severely mental ill adult patients we've had great difficulty developing an efficient workflow in our primary care service… It's much different than where we deliver medical care in the traditional primary care setting. …in our setting see many fewer patients per day and each patient visit takes much longer than at a primary care setting. To make matters worse although the state approved rate codes and reimbursement rates for these new services they've been unable to require health plans to honor these new rates and consequently here's another service where we've received almost no reimbursement even though we've been delivering it for over one year now. I knew… I know… I know of other providers that received the same licensure that have actually given up that license due to the financial and operational problems. So this anecdote is meant to illustrate how the admirable intentions of the state's restructuring can sometimes be undermined by the implementation timeframe offered. While I've 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 New York. This would include other components of the affordable care act, the federal mental health parody 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 thrive New York City. I want to commend the first lady's mental health roadmap which goes a long way towards destigmatizing mental illness, improving connections to care, and developing the necessary workforce to meet the needs of our severely mentally ill. I was especially impressed with her willingness to visit one of our mental health clinics and engage or align 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 service arrangement. And who we expect to have one million lives in the near future. We have a huge care management workforce, an 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 payer 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 the 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 now 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're beginning to bend the cost curve. And I'm convinced that it's 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 the patients, especially our behavioral patients, receive the care they need. Thank you for giving me the opportunity to share my opinions and perspective.

CHAIRPERSON COHEN: Thank you. I have questions but I'd like to go through the whole panel. Thank you.

JENNIFER MARCH: Good morning. I'm Jennifer March, the Executive Director for Citizens' Committee for Children. Thanks for the opportunity to testify. My testimony is going to focus on children's needs and the needs of the child serving behavioral health system. While much of the attention to date at the state and local level has been on the adult transition to Medicaid Manage Care this is a very important year for children in New York state. Starting in September 2016 174,000 children with multiple health and behavioral health needs will be eligible to enroll in children's health homes to provide care… coordinated care and services. The state is also in the process of revising the CANS New York Decision

Making Tool. It's essentially a tool that allows the state to identify whether or not a child is eligible for child health home… the child health home and home and community based services. We know two as Doctor Belkin mentioned between January and July of 2017 New York plans to transition children's behavioral health, Medicaid benefit into mainstream man… mainstream Manage Care. And this is going to impact particularly vulnerable children, children with social emotional disturbance, developmental disabilities, medically fragile children, as well as children in foster care. And then we know that New York state has recently submitted a draft Medicaid state plan amendment for children and children's health homes which is awaiting federal approval which will allow the state to expand the types of services offered to children. And this is important because we know that there's a shortage of services in the community for a whole host of child and family related services that produce better outcomes for children. In terms of the current state of a… of the field while Medicaid reforms offer an opportunity to address existing system weaknesses

and strengthen information sharing, care management, and the development of new services the transition to date has placed a lot of stress on the existing child serving system. It's exacerbated serious underfunding and inadequate reimbursement that we experience at the community based level. And many community-based clinics are on the verge of closure. We know too that in patient providers are also under pressure to reduce hospital lengths of stay and are discharging patients with severely limited intensive outpatient services available at the community level. We know that there are workforce shortages that persist and contribute to long wait times for first and subsequent appointments and that there's a lack of childhood mental health specialists and child psychiatrists in the state in New York City. As a result, emergency rooms have become emerged as a mental health safety net. We know too that efforts to ensure client safety which are good have added significant compliance responsibilities and significant new cost on an already burdened child serving system and then that there are multiple ongoing Medicaid reforms, DSRIP, health… HARPs,

DISCO, and the list goes on… that place a heavy workforce and administrative burden on children's behavioral health providers and child welfare providers in particularly. And then similarly there's a strong emphasis on cross system and integration and information sharing that also results in new costs for the child serving system. In addition to sector and workforce and IT needs there are clearly capacity needs. The behavioral health integration into Medicaid reform should offer the opportunity to create a robust benefit package for children to support and develop new models and integrated mental health awareness and services reaching children in service settings like schools, head start, day care, pre-kindergarten through home visiting programs. We know it also offers an opportunity to provided more adequate rates of reimbursement for services, to invest in preventative interventions in schools and primary care settings and to expand outpatient clinical interventions. As well it creates an opportunity to create what we would call a family of one designation so that even non-Medicaid eligible children that reach a certain level of need should

have access to state planned services. I believe that there's really strength in numbers and there's an opportunity during the state… budget negotiation process to ensure that resources are committed this year to help prepare the child serving field for the transition. So in order to address workforce, IT, and health home preparedness we're asking for an additional 30 million dollars to be invested in children's behavioral health capacity building and start up. These will go to community based providers for workforce development training, credentialing fees, and to expand the existing provider networks we're asking as well for 10 million for workforce and technology needs related to the actual creation of children's health homes. We'd like to see the state add funds to support adequate rates of reimbursement while people are worried about the elimination of fee for service. Those rates don't currently… and I'm sure if many of the providers in the room could talk adequately… providers from those services that they're rendering. And then finally we would also like to see at least 25 percent of the 195 million the state is allocating to help facility transformation

to go to downstream safety net health providers, behavioral health family planning, health home providers federally qualified health centers. If we want the community providers to be part of the health transformation efforts, they need to to benefit from those capital dollars. In terms of beginning to address system capacity needs we're supporting the state executive budget's proposal to add 7.5 million to create six new children's mental health services but this is really a drop in the bucket. I think that there's a real opportunity for the city council and the city administration in the coming years to really champion the expansion of capacity on the ground so that we can keep children out of hospitals and if they are hospitalized ensure that they transition to a service delivery system in a community that can't adequately address their needs. And then finally we're supporting the executive budget's proposal to reinvest 16 million in savings from the downsizing of state psychiatric centers sent to community based services hoping that some of those funds will go into children's mental health services. Lastly I would say that the city council is launching… early childhood mental

health services. Time and again you've restored the zero to five mental health budget allocation every year and you've been real champions of school based health services. I would think in addition to monitoring the transformation of Medicaid redesign the city council has a real opportunity to make sure that the city administration and city council are advocating jointly at the state level for needed resources for children's mental health and that we're protecting the city dollars that already exist and are supporting children's mental health services. So thank you for the opportunity to testify.

JASON LIPPMAN: Good morning chairperson Cohen and distinguished members of the committee. My name is Jason Lippman, I'm the Director of Public Policy and Government Relations at Amida Care. Amida Care is a non-for-profit health plan specializing in providing comprehensive health coverage and coordinated care to New Yorkers living with chronic conditions. That includes HIV, severe mental illness, substance use, and those experiencing homelessness. Amida Care serves both Medicaid and Medicare members. And we are currently

the largest special needs plan or SNP in New York. We've been playing a pivotal role in New York state Medicaid redesign and policy initiatives aimed at improving health outcomes and creating further cost savings. In fact, through our high touch model of care Amida Care has reduced hospital admissions among our members by 74 percent and we have also attained and we're approaching an HIV viral load suppression rate of 75 percent. As of October 2015 we are certified to offer HARP services to our members. These are people living with serious behavioral health challenges. And we are currently working with the state to ramp up these services to those who qualify for them. Amida Care has also been and is currently a partner with the state in implementing DSRIP. We are currently collaborating with provider performing systems, PPSs, in the city on coordinating HIV… for population health programs. And we're also working on statewide project 11 initiatives to work with the PPSs on patient activation measures. In the coming year ahead we are also eager to work with community partners on implementing value based payment models. In 2004 Amida Care was offered… well Amida

Care was supported by a state department of health DSRIP planning grant. And that was to develop community based projects to address the social determinants of health like housing, mental illness, substance use, unemployment, food insecurity, etcetera. We worked to create four… four pillars and programs and… and our final report details these programs so that PPSs could adopt these initiatives or even expand them. And what they cover is peer workforce health navigation services, crisis by diversion, and step down housing units. Integrated care learning collaboratives for community based providers and this has been a topic that's been addressed throughout the hearing regarding the integration. And this is learning collaboratives that we envision where small to medium sized providers who offer single licenses or double licenses but not all three primary mental health and substance use could come together and work on various collaborations and how to work together and maybe even form… process which would be better for patient care and might help sustain these types of providers. And the last one involved fire load

suppression programs. We are currently working on a peer workforce incubator project. And we have submitted a proposal before the city council to foster a new program that would create living wage jobs for people living with HIV and severe behavioral health conditions who are successfully engaged in care and are now ready to work this is not only good for people who are… are… are doing the… the right thing taking their medication, seeing their doctor, and now are ready for the next step but also for newly diagnosed people or people coming into the system that are new, isolated, and dealing with barriers to care such as homelessness, mental illness, and substance use. It's a win/win situation basically for the peers and for the people they helped. And we're hopeful for the council's support in this process. Further development of peer workforce is a priority amongst achieving New York state's blueprint to end the age epidemic in New York state by 2020 which Amida Care is an active member of the state's taskforce. We are thankful to the city council for its commitment and sponsorship of its own innovates initiatives to help address the social economic drivers of the

epidemic such as mental illness, substance use disorders, homelessness, and unemployment. And together if we form strong partnerships we could end this epidemic once and for all. I thank you for the opportunity to testify on behalf of Amida Care's work on Medicaid redesign and building a collaborative care system that will enable and empower individuals living with HIV, severe behavioral health conditions to live healthier lives, stay out of the hospital, maintain housing and employment. And I am available to answer any questions or inform you of more information that you may have. Thanks.

CHAIRPERSON COHEN: Thank you. I do have some questions but I just want to say as a… you know one of the good things about being a council member, I really appreciate the… you know the quality of this panel, that all you guys bring me, the… the testimony… the sub… nature of testimony is really sorely appreciated. I think you sort of all three sort of universally testified to the challenges. In terms of… as the serve… the service providers do you think it's logistical? Are there hard infrastructure costs being faced that… or is

it really more training? Doctor Belkin talked about software but what are the… the… the barriers we see to… to the transition on the ground?

JASON LIPPMAN: I was referring before about… in terms of substancy which I'll just give you by way of example. Our substance use programs we have 4,000 enrolled patients. Every single one of them individually you have… we have to input what their insurance coverage is. We have to do that accurately. And… and then we have to input into our billing systems the ability to identify how to bill to the… each health plan and each health plan may have its own particular way of receiving the bill. In particular, on substance abuse services…

CHAIRPERSON COHEN: That… that's true though, that was true before…

SCOTT WETZLER: Before we just billing Medicaid, one bill to Medicaid, never had to bill health plans.

CHAIRPERSON COHEN: Okay.

SCOTT WETZLER: Not a problem. One… it was easy.

CHAIRPERSON COHEN: No but… but Montefiore does know how to build health plan…

[cross-talk]

SCOTT WETZLER: But not… but not for these services. So all of that is new. It's a whole different benefit structure. Secondly, they have… you actually bundle the services. You have to go through a third party to bundle the services in a particular way so that the bill goes out properly. So we actually have a… so we have our own software which is actually different than the Montefiore software for billing. We… a completely independent operation. That bills get it together, they go to a third party vendor, the third party vendor finally submits it, health plans have different capacity to receive them, and… and respond in some way. So it is… it's not so much the cost, it's much more the processes that… that are the problem from… from our perspective.

CHAIRPERSON COHEN: Just to… infrastructure in terms of managing the billing?

SCOTT WETZLER: Correct, yes.

JENNIFER MARCH: And… and I would just say… So if it's difficult for Montefiore with all

due respect just think about how it is for your community based Article 31 clinics or your child welfare providers or even the Omar DD clinics [sp?] that have never had to do this right. And… and are also serving a particularly fragile, vulnerable population, of children.

SCOTT WETZLER: And I just want to add one more thing. So Doctor Belkin kept alluding to and it's very important is that we do want to get involved in value based arrangements with health plans. And that requires a whole lot of other data that we have access to that… that'll be crucial to un… to… to… for… for providers either as large as Montefiore or as small as some of the Article 31s to… to… take risk in… in that way. And so you really have… there… there will be a… a lot of knowledge that has to be accumulated in how to handle that risk.

CHAIRPERSON COHEN: Well I… I will say that you know anecdotally I mean it seems that a lot of… or almost universally mental health providers are looking for at least partners in terms of delivering physical health services. And that integration is happening. So I'm concerned you

know as someone who's sort of maybe ahead of the curve that the challenge is… that haven't even been breached yet by some of the smaller service providers. You know I'm just curious from Montefiore… because Montefiore also has a Medicaid HMO. So in some… in some services you're on both ends of the equation. So you know I guess how much money you have or… you know I don't know in terms of delivering those services that you're… how… how that is integrated but how does that impact…

SCOTT WETZLER: That's… that's the key point here. So we have about 400,000 people today that we are both the… the provider of care the manager of care, and the payer. And that is a complex though I think a very creative tension on how to manage all three of those rolls. And we have a big infrastructure to do it and… but I think that's where the opportunity is for identifying savings and… and higher… and better efficiencies are… through… by… by playing all three rolls. Because right now we want to be able to get the maximum amount of the premium dollars so that it can go to the… out for the care, especially for outpatient care.

CHAIRPERSON COHEN: Well again the examples of… you provided where you haven't received any payment. Does the… the CMO have the money, or does the state have the money, or…

SCOTT WETZLER: So… so… so we have as much as a payer Montefiore CMO has as much difficulty paying for claims as the health plans. So we've had no greater success at collecting internally than we have externally. Though I will say that… that the majority of our collections are for… are due to outside payers not to… not from Montefiore.

CHAIRPERSON COHEN: Is that just… is that a… behind me… like you testified that you hope to have a million people enrolled in the CMO. So ultimately that balance… [cross-talk]

JASON LIPPMAN: I would actually… oh were you moving on to… [cross-talk]

CHAIRPERSON COHEN: Please.

JASON LIPPMAN: So I thought of answering that question from like two perspectives. One, Amida Care is a health plan. So from the health plan perspective larger than HARP and outside of HARP there's always issues with

timeliness and adequacy of rates with the state that we're dealing with on that end. The other thing that happened originally in the HARP process SNPs were allowed to go forward and apply to be standalone HARPs. And we went through that entire process. And it's a very thorough and cumbersome process. In the end you wind up sending up boxes of binders like up to the state… So we were happy to go through with that because we wanted to offer these services to our members. But after that happened and midway through the process it was changed that SNPs would no longer allow to be standalone HARPs. And instead we were going to have the HARP benefits brought into the SNP plan and offered as benefits in there and not stand alone. And that's a whole different change to the model we had prepared the staffing and the administrative ramp up. And this was all happening before… in between submission and HARPs going live. So that was definitely a barrier for us. In speaking about our provider network I would say that there's a lot of change happening at once with limited resources. And that's one reason we… we proposed the learning collaboratives to have another way… an innovative

way of getting providers together and maybe on their own trying to strengthen themselves for the new world. And one reason that Amida Care applied to be… applied for DSRIP money originally… originally planning grants were awarded to hospitals and Amida Care. Amida Care was the only entity awarded a planning grant that was not a hospital. And we did this because we wanted to be in the game to make sure that community based programs were being offered as part of DSRIP because we thought they would not receive the focus they would have received if it's all just hospital based. So we proposed community based alternatives to bring the… the community sector in… in… in more and… and go towards that direction and also help probably with the flow of funds if it's in… involves more community based providers. And then with value based payment coming up which will be a big change for providers to… to build for their services we're in… involved and hope to be involved with the innovator programs that are coming up and to lend a more community based perspective to that too.

CHAIRPERSON COHEN: Do you have any thoughts on… you know about this opt out phenomena that Commissioner Belkin testified about?

JASON LIPPMAN: I would need to know more about the opt outs. I'm not sure how much this is affecting us yet because we're… although we're certified for HARP services there's still some stuff we're working out to ramp up… involving the assessment process in rates. So I don't think we're at that level we're experiencing people opting out yet because we're… we're just at the very beginning. But as far as with the larger system I would have to get more information on that for you. I could also speak to our behavioral health staff in the plan to see what they know and… and I'm happy to follow-up with that.

CHAIRPERSON COHEN: I really do want to thank the panel for their testimony. It was very helpful. Thank you.

JENNIFER MARCH: Can I add one more thing? I'm sorry.

CHAIRPERSON COHEN: Please.

JENNIFER MARCH: I would just say the… the other challenge, kind of the elephant in the

room in the child serving sector is that we know that there's not enough capacity on the ground to address children's needs now. And while the benefit package that has been created has been you know fully informed by conversations with many many people and is a good package at some point the state needs to begin to actually invest a profound amount of resources in building the things that we know produce better outcomes for children. So they've identified the right types of services but the 7.5 million that they're allocating this year is a drop in the bucket. And we actually need to be prepared if we're transitioning all these children next January to actually serve them well. So anything you can do to help us there would be greatly appreciated.

CHAIRPERSON COHEN: Thank you very much. Could I ask the clerk to continue the vote?

COMMITTEE COUNSEL MARTIN: Introductions 881A and 883A Council Member Johnson.

CM JOHNSON: I vote aye on all.

COMMITTEE COUNSEL MARTIN: Vote now stands at five.

UNKNOWN: The next panel will be John Kastan, Philip Saperia, and Doctor Wendy Garringer.

JOHN KASTAN: Start?

CHAIRPERSON COHEN: Please.

JOHN KASTAN: Okay thank you. Good afternoon. I think it's afternoon. It's still good morning. Good morning Councilman Cohen and the committee. My name is John Kastan. I'm the Chief Program Officer of the Jewish Board. Jewish Board is the largest social service agency in New York City and the largest community based mental provider in New York state. New York state has developed a multifaceted Medicaid reform plan which you've been hearing about which includes a focus on improving behavioral health and physical health outcomes for Medicaid recipients. In… 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 reliant on in-patient and emergency services. What the plan is not adequately provided is resources as you've heard as well to support this transition for community based providers. While the Manage Care

tradition has not yet replaced the existing fee for service structure and currently the Medicaid Manage Care plans are required to pay the same reimbursement rates that the state had been paying for clinic and pro services. This arrangement will be changing in the next two years. Currently it is planned and reflected in statute Medicaid Manage 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 client's health outcomes. This value based approach requires not just an increased array of services but also greater collaboration amongst established healthcare institutions and community based organization. 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 piece wheel… 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 permit reimbursement model. The challenge for behavioral health community based providers to comply with the Medicaid Manage 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 Manage Care arena community based providers must invest in creating a trained skilled work forced equip to address the complex needs of low income individuals with behavioral health challenges and often multiple chronic medical needs. This require 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 up with the cost of service delivery. Beyond the increase personnel cost Medicaid Manage Care building systems as you've heard require a large capital investment to in… create the needed data management and analytic resource information to receive reimbursement. This will be even more important when we move into a risk based system where the data analytic needs and the population health management needs will be significant and something that's brand new to all of us in the field. This includes an extensive retooling of provider's financial and clinical tracking systems required to receive payments based upon proven outcomes of care. Administratively Manage Care requires new capabilities as you've heard 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 Manage 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. Not… not in my testimony but let me add about HCBS as you've heard the start up for HCBS is complicated. The admissions process is complicated. The rate structure is extremely complicated. It requires accounting for every 15 minute units of service. And the rates in fact in some of the HCBS services that are a 13 overall are not adequate. So there is a significant need for a more robust HCBS reimbursement rate. There's also at this point no startup funding from the state for HCBS and again as has been mentioned earlier by several speakers for many of us this is a… these are brand new services or they're services that we provided in the past but in very different ways and with very

different reimbursement systems. 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 Manage 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 requirement of the new Medicaid Manage Care system and city council funding has been a tremendous resource or can be a tremendous resource for otherwise un-reimbursable costs. Thank you and I look forward to answering any questions you may have.

PHIL SAPERIA: Thank you. Good morning Chairman Cohen and members of the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse, and Disability Services. I'm Philip Saperia, CEO of the Coalition of Behavioral Health Agency. We are the umbrella advocacy and learning organization of New York City's community based organizations of substance use and mental health service providers serving anywhere from three to 450,000 clients and consumers in neighborhoods throughout New York

City. Our members are the front line safety net providers where… go where the consumers go we are where they are… we are where we are needed and our people provide the very hard work. They're in every council district and in every neighborhood in the city. Thank you very much for holding this second hearing on Medicaid redesign, process. We are very early in the transition but we want to… we want to present our thoughts more on how the Medicaid redesign implementation has affected our sector to date. I want to thank you Chairman Cohen and Council for initiating the Medicaid redesign transition initiative for this year and I'll… though the funds have been either slow or not materialized at all we believe it will have a positive impact on the ability of the agencies to meet the new billing and data requirements necessary in Medicaid Manage Care and we hope you will continue. Now I am going to talk mostly about state issues as everybody else has today. But I underline the comments that I'm making today is a very important emphasis on seeking your help. You are the people in the community who have colleagues in the assembly and the senate. You have pipelines

to the governor and to the second floor etcetera. It's very important that you weigh in on these issues. You can really help us so we're looking to you as partners. So we are supporting the movement from fee for service to Manage Care despite all of its difficulties and problems, despite the fact that it's moving from a series of… of mental conceptions into on the ground reality and that's where all the barriers and problems are. We support that. But I… it's really important for me to… to mention Doctor Belkin… I mean to refer to his testimony and to say amen, amen, amen. He was very careful I think not to be very critical but to point out in some indirect ways some of the problems that exist with the transition. And Scott Wetzler and Jen March and John Kastan here have also pointed out some of the problems, the potential weaknesses, and some of the needs of the community based provider community. And I just remind you again that Doctor Belkin said that the transition is not easy or quick. It's not without risks and uncertainties. And it's certainly… I want to emphasize, is not without… So… so I'm going to point up a few different issues I think, some more

systemic issues then some of my colleagues and some of the same. I'll try not to reiterate things that have been said but to just point out our support. So regarding the transparency in the Medicaid redesign process we have strongly been advocating that the state office of mental health, the office of alcoholism and substance abuse, and the New York City Department of Health and Mental Hygiene, the most knowledgeable agencies regarding behavioral healthcare for vulnerable people should be given meaningful oversight over behavioral health services in the Manage Care environment. The… we initially were supporting the idea. There is a model contract that the state signs with CMS that governs relationships with the Manage Care organizations and governs Manage Care in general. And we were originally pressing very hard that OMH and Oasis be signers along with the DOH of the… of the model contract. It turns out that CMS has rejected that on the grounds that both Oasis and OMH are providers as well as administrators of services so they can't be a signer to the model contract. But we know that they are developing memorandums of understanding among the agencies.

And we would like for the Os and DOHMH to be in those memorandums of understanding for those to be fulfilled. I'm… I'm worried a little bit that especially since I hear sometimes from people in Albany well we're all getting along so well what do we need MOUs for? And maybe it's true that they're all getting along so well and maybe they are pushing the agenda that's important to us but we don't know about future administrations, we don't know about the future at all. And in fact it seems to me that we need to put in writing, we need to inscribe and make official the fact that OMH, Oasis, and also DOHMH are… are part of the oversight and that those MOUs must be engaged. So it's clear. We think that the Os should be overseeing the behavioral health services in the Manage Care. And we think also with respect to transparency that in the… that the legislature should require specific information reports from DOH and whoever else is in there, how the MRT funds are being spent and the rollout of that funding and to whom the funds are being provided, and of course the report must identify where Medicaid funds are being saved, and most importantly where they're

being reinvested in a system that's already incredibly underfunded. Only then can we find out if the Medicaid redesign team goals are adequately being met and if community safety net services are being continued and funded at a… at an important and substantive and meaningful level. In addition, as we move to Manage Care payments we're looking for assistance from the legislature that… you know that would also show that the savings that come out of value based payments are also reinvested in behavioral health and particularly into community based parts of behavioral health. We need your voice. We need the council's voice for needed transparency in the Medicaid redesign and for the reinvestment of savings into our system. The second category of things that I wanted to point out and has been mostly spoken to by Jennifer March of Citizens Committee for Children with whom we work closely and collaboratively is this notion of support for children's behavioral health in a Manage Care environment. We think the state needs to adopt rigorous child and youth focused behavioral health metrics that monitor all the various aspects of plan and network access and

performance to ensure high quality care. We want to be sure that the networks are… I mean that… well you know as well or better than we that the children and family part of our network is incredibly complex. It may be… it's probably more complex than the adult side and needs more care and more attention and more money and more funding because of the already kind of tottering system of… tottery state of our system. So it's really important to increase funding for technology and workforce development to launch the children's health homes and the transition of children to Medicaid Manage Care. We want funding that's comparable to the funding that was given for health homes for adults. We're advocating for a two year children's behavioral health capacity building and start up grant similar to the 30-million-dollar program established for adult providers to provide new services under the state plan amendment for workforce development, training, credentialing fees, expansion of the provider network. We support adding seven and a half million dollars, a minute amount of money actually considering, to create six new children's mental health services in the

Medicaid program. And finally we support reinvesting 16 million dollars in savings from the downsizing of the state psychiatric centers into community based services with a large number of those dollars going to children's services. Any help you can give us in widening the scope of funding and support for children's health services and children and family's health… behavioral health services is really important to us. And finally people who are moving as you know from a fee for service, others have said that, from a fee for service to a Manage Care environment and right now we're being paid a fee for service rate. And we're… we're strongly urging the state to extend those government rates through 2021 when value payment will be in full effect. This will give us a little safety net, a little bit of money to… a little predictable stream of money to work until 2021 to make sure that the system, the… the community based system is strong and is ready for the job and including ready for value based payment. It'll ensure the health and stability of our system and we very much want your support in helping prevail on this. And finally… or I shouldn't say finally

but Cola, instead of the governor, you know the governor put in his budget a .2 percent, point… .02 percent… two percent cola… .2 percent cola… anyway it's… it's incredibly inadequate and we're looking for something more like a three percent across the board cola for all OMH and Oasis contracted providers, the same percentage by the way that was given to Manage Care companies, help us stabilize, again these are transformative changes and we need to be ready for them. And then the home and community based services. You've already heard about how inadequate the rates are and how difficult it is for the money to flow and how people are not getting paid. And in our case there are many providers that are not stepping up to offer those home and community based services which are so important because they will address the social determinants of health. So we need adequate rates to strengthen and ensure a robust capacity for these services. Please, again, help us, reach out to your colleagues in the state legislature. And finally health information technology and capital investment. We need it. We need as much of it as we can possibly get. Most of the heal… the

federal heal money that went to health information technology and electronic health records went to hospitals and to primary care physician practices. They did not go into the behavioral health community. We need that kind of money. We need that kind of infrastructure. And I would say most particular everywhere… but particularly in the Oasis license facilities where there haven't historically build Medicaid and are not robust enough in the systems to meet the demands. But that's true with everybody in our system. So we look forward to continuing to work with you to help ensure that people with serious behavioral health issues who live in your communities and their safety net providers come through these changes with a stronger and at least a sustainable community behavioral health system that highlights rehab and recovery. Thank you again for the hearing and for joining with us to… up the community based behavioral sector.

WENDY GARRINGER: Good afternoon. My name is Wendy Garringer and I'm the Chief Operating Officer for Medicaid Redesign Research and Evaluation at New Alternatives for Children. And

I'd like to thank Chair Council Member Cohen and the rest of the committee for inviting us here today. I agree with everything that Phillip said. I'm going to speak from the perspective of one of those agencies that is a member of the behavioral coalition who's on the front lines. And I'll just briefly talk about New Alternatives for Children. We are one of the leading child welfare agencies in the city. We've been around for 34 years. We're the only agency that exclusively serves children with complex behavioral and medical disorders as well as their family. Our children have multiple co-occurring conditions. Their medical diagnosis include cancer, sickle cell disease, spina bifida, cerebral palsy, muscular dystrophy, and… and many others that I won't go into. And they also suffer from traumatic brain injury, ADHD, autism spectrum disorders, intellectual disabilities as well as physical disabilities, and developmental delays. And these are children that are living in poverty. These… the children a family face multiple… multiple psycho-social stressors, domestic violence, street violence, homelessness, food insecurity. These… and these are families caring

for a critically… critically ill both behaviorally and physically… physical child. These are truly the most vulnerable children in this city. They are the highest need and highest cost Medicaid beneficiaries. And they are the population that Medicaid redesign is supposed to be serving. And Medicaid redesign from our perspective holds a great deal of promises for our children with respect to its focus on care management, on expanded behavioral health services for children, and on expanded home and community based services for all children who are eligible. That being said Medicaid redesign from our point of view and I think from the point of view of the… the speakers thus far poses significant challenges particularly to our children and to our agency. Firstly, it requires a tremendous amount of preparation and readiness to get ready for these new initiatives. With respect to children's health homes we have been working for the last two years preparing and getting ready for the… for the children's health homes and that the same goes for the other two major initiatives which have been talked about, the behavioral health services and how many community

based services. We are very concerned about the transition from Medicaid fee for service to Medicaid, to Manage Care. We're basically afraid that we're going to be squeezed by the MCOs and that has been our experience thus far. We serve… we have a number of programs for… for child welfare involved children and families; foster care, preventive services, after care services, and a number of… of other services. So we have the experience. Foster care children have not yet been transitioned into Manage Care but our children in preventive services have been. So we have experience with them. We have an on-site Article 31 behavioral health clinic which has a wide variety of services and interdisciplinary staff. And we also have an on-site Article 28 pediatric clinic which is directed by a developmental pediatric… pediatrician who specializes in children with complex medical and behavioral needs. So we have these clinics on site to promote access of our children to utilizing these services which as everybody knows the children and families in this population, access is a very difficult problem. There are many barriers to accessing care. The

problem we're having with Manage Care right now is that for our children that are in Manage Care although the behavioral health services under Fee for, under Manage Care are still government rates. They're equivalent to the rates for Manage Care. The MCOs are squeezing us when they are… they are imposing very strict authorization rules on us when we try to get authorization for services for our children. There's a… there's a lot of back and forth. There are utilization thresholds so that children cannot… get the number of services per year that they need. And we're also just speaking down the line we're concerned about eligibility for the health home initiatives as well. So I'm… I'm kind of skipping around here I… I didn't have this very well organized. But I wanted to just say that for example one of the things we're very concerned about in terms of Medicaid redesign and these new programs is how they're defining eligibility for these programs. It's still very vague. For children's health homes they have specific criteria that they've lied out for who is… who is eligible and who is not. But there's a big piece, there's one criterion that automatically makes a child

eligible for a health home and that's called complex trauma. And there's been a tremendous amount of discussion between our agencies and the state and CMS around the definition and who's… who's eligible… who meets the definition, how… how is it going to be measured, etcetera. Our concern is that basically all the children who come to NAC who are in the child welfare system have experienced abuse and neglect. We see in our Article 31 clinic trauma is… is front and center in all of these children's lives as well as all of these other co-occurring conditions. We are concerned and there has not been a clear definition as to how complex trauma is going to be measured and who's going to be identified. And we have a big concern that a lot of our children who have experienced trauma are somehow not going to meet this new definition are going to be excluded from health homes. So there's just a lot of… there's still a lot of vagueness around these eligibility criteria. And we are very concerned about that. The other thing I… I… just to talk about the six behavioral health services and home and community based services. We as providers are certainly we

have all of the inter… disciplinary staff to provide the six behavioral health services in the community. We do not know yet what the rates are going to be. We know about the adult rates for HCBS. We don't know about the children's rates. We are concerned that it's not going to be in our interest to provide these services. That we're not going to… they're not going to be sustainable in terms of reimbursement to our providers for providing these services. And we desperately want to provide these services. We have the expertise to provide them. And we want to provide them to our children as well as to other children that need these services. As far as the home and community based services we currently provide them under the B2H waiver program, 1950C, one of the waiver programs that will be transitioning into the new home and community based benefit in 2007 and be available to all eligible children on Medicaid. We… again we don't know how much we will be paid for providing these services. We have ideas based on… on the… again on the adult rates. But we're concerned about… there's going to be… if you think about it you're expanding H… home and community

based services from the… the waiver programs to all eligible children on Medicaid. There should be a huge demand for these services. And these are… these are services that we've been providing for a long time. And you know we know that they are very beneficial to our children. There needs to be more information and as Philip said more transparency about exactly what the rates are for these programs. We… from an agency point of view we want to… we are determined to provide all the children's Medicaid redesign services; health homes, …behavioral services, and home and community based services. Our children need them. Other children on Medicaid with special healthcare needs need them. We want to be able to provide them. We are concerned about whether we can… there… the reimbursement rates will be high enough for us to be able to do this for an organization that basically we can't fund ourselves right now on Medicaid. We have to rely on outside funding. So that's where we are as an organization. I can answer any questions. I want to again thank Council Member Cohen and the committee in helping NAC as we prepare for the transition to Medicaid redesign.

CHAIRPERSON COHEN: Thank you very much. You know the organizations represented on this panel particularly have been real partners with this committee you know as I… as I've sort of learned my way around what the landscape in… in mental health in New York City. But I am really appreciative of that. The… the… the… Doctor Belkin testified about sort of feedback in terms of working with the… you know all of these commissions and groups sort of overseeing the transition. Do any of your organizations participate in… in these, and how is that going?

JOHN KASTAN: We've been… well we've been… we're happy not to… we're not on the RPC but we've been very involved in lots of meetings with the Manage Care companies we're… we're active Jewish board in seven or eight of the PPSs that you've heard about. So we're spending literally 10s and hundreds of hours in meetings to be part of the DSRIP initiative. And then there's been lots of trainings and… and webinars and convening of various groups so… but we've been quite active in… in all of that. And it's… it's actually very time consuming. Sometimes it's very confusing because

there's so much information that's being shared and some of accurate, some it not so accurate that to kind of keep up with it and to adjust one strategies and plans based on what we hear from this state… different state agencies, different city agencies, different organizations actually can become almost information overload but I think we all feel that it… we have to be at the table. We need to represent these positions. And I think it reflects though the complexity. And certainly Doctor Belkin illustrated it very well the complexity of all of these initiatives occurring all at once from health home to the Manage Care rollouts, to DSRIP and… and as providers we are trying to figure out you know where we should be. Sometimes we're literally talking about services for the same client but coming through all of these different mechanism and… and it's the…we haven't even talked today about housing but of course that's another important service and many of us provide housing services to these folks as well. So we're dealing with lots of change on that end as well. So it's… it's… it's actually can sometimes get a little cacophonous all of the convening and

all of the meetings on the other hand. it's where we need to be in order to try to know what's going on and stay ahead of the curve. But it's a very frantic… I've been in this system almost 40 years. And I've never seen it quite so frantic and… and… and… and busy and… and… if that's helpful.

PHIL SAPERIA: So I'll pick up on that. It's amazing how many webinars and seminars and meetings and everything that you can have in a given week. You can't… no one person can possibly be everywhere and do it all… all the time. Fortunately, we have a staff whom we share and we do… and we try to you know find time to share information. But this is… a cacophonous is a beautifully apt term. It is… is a cacophonous time and there's just so much happening all at once and I go back to my own metaphor of this being… If you think by the way the… the… sort of the bucket of acronyms that we're dealing with, the HARP, and the BIP and the VAP and the DSRIP and the this and the that. And if you… and you're trying to do it all… get it and do it all at once with all of the various kinds of things. It's almost impossible. And there's not enough time I don't think or money

to make… to make that happen. We're going to have to just you know bear down and hope to make it happen. I do want to say this though about the RPC. I'm on… I was asked to be on the advisory committee and I've been going to meetings of what we call the behavioral health roundtable that the state… that actually we kind of initiated the coalition initiated and originally it was just state and city providers and plans. And… and its grown into more advocates besides the coalition and… and more providers than were in the initial group. And so with… now it's officially part of the RPC. I want to say that that group, I really loved that group in some ways because we talk… we talk real. We… we tell the truth. And there are people from companies that represent billing companies so they can give us right on the spot what the statistics are, how many denials, how many payments, how many nonpayments, how much money is still owed to our providers, etcetera. And there seems to be a growing sense of collegiality on the part of the providers and the plans and the government people. And you know nothing is perfect and there's still lots of problems with payments and denials and… and

disputes and all those other things that come along with this. But I do think that that one… this one group has promise for providing a forum where we can share and learn from one another and hopefully solve problems.

WENDY GARRINGER: I'm… I'll just add that we are participants in CCF, collaborative for children and families which is a health home that's made up basically of all the child welfare agencies in the city, most of them and as well as a lot of… lot of child serving agencies as well. We go to a meet… myself and our executive director go to a meeting every two weeks for two hours. It's very time consuming. It's very helpful. And actually what's really fabulous is… is the first time the child welfare agencies that have always kind of been competing in a way are working together which is really great sharing a lot of information, sharing a lot of misinformation was just one of the problems. We're also… I'm… I'm also on a committee of ACS and OCFS to look at how to integrate health homes into foster care system which is also very very helpful. And that allows for you know communication across different agencies. So we're

doing the best we can but I agree there… the webinars, the among of information coming in and you know having to fill… you have to absorb it which of course I feel I have to know everything. You know is… is a bit… it's… it's… it's a lot. It's a lot.

CHAIRPERSON COHEN: I mean it seems that the city administration and the service providers are sort of all on the same page and that… the city seems to understand that having this healthy network is vital to getting the services delivered. So that seems to be that we're all on the same page and I… I will say I… I think that from when we did this the first time… I mean there does seem to be an appreciation on the city level in securing some money from the state for infrastructure grants and understanding that that's part of this and it sounds like there's some other money too. I asked Doctor Belkin but maybe you guys are better equipped to answer this. Do you foresee contracting issues with DOHMH in the context of redesign, the… the new model of the way you provide services and the way that you've received the city contracted

services? Do you see issues in particular on that front?

PHIL SAPERIA: So I'm going to say this. I think the contracting system is practically broken now, pre-Manage Care. It really needs to be said. I mean you guys, the council, excuse me for the informality but the council allocates money for initiatives in various kinds of things and you often don't see the money until almost the end of the year and you have two months suspended. So contracting please that's a whole other hearing and a whole other bunch of things that we need to talk about. I'm confused frankly about the future with respect to DOHMH contracts because they're using local assistance funds. For the most part this is money… aside from the Thrive NYC and the… and the new money that has come into the mental health… through the mental health road map. The money is state money. And it comes from local assistance money. And I know there's probably some… some state city funding in there also. But I'm worried how… about the length of time that the state will allow those local assistance funds to continue. I think they see the future and for them the rosy future

because it's cost savings in the Medicaid side of things. And I'm perfectly… and I'm frankly worried that even though we're funding the non-Medicaid folks right now that the future is not very rosy.

JOHN KASTAN: And yeah just to answer that. I mean I… I've been in the system long enough to remember when local assistance was actually a very significant portion of the… the dollars for mental health and substance abuse. And then with the COPS program as you may remember in 1990 or so state… state aid was medicated. And… and that took away some of the flexibility the providers had in terms of being able to provide services for example to people who were not on Medicaid and who maybe were undocumented or had needs that extended beyond what Medicaid would pay for. And I think as Phil is eluding to I think down the road we could look at an even further contraction of the… of flexible state aid dollars. Because that may all disappear in… in the effort for the state to first of all make everything under Medicaid which pulls in the 50 percent fed. And then as the state down… down… down streams its own risk by giving it to the Manage Care plans the state in a sense then is out

of this completely as they basically privatize Medicaid to… in New York City about ten plans and then around the state is another five or six. So yes I think that's something to be concerned about and… and advocate for workers. As New York City certainly will continue to need in order to meet the community needs that have been referred to more than just Medicaid in order to carry out its… its functions in terms of all the… all the reasons that you know we know about in terms of people who don't qualify for Medicaid or on and off Medicaid or have other kinds of needs that may not fit into the… sort of the Medicaid benefit package.

CHAIRPERSON COHEN: Phil… Phil you testified about hoping to see a continuation of fee for services for the next couple of years. Is there a… a point to that or just putting off the… the tough action that needs to be taken further down the road? I mean is there something in and of itself that would… we would benefit from that or is it just…

PHIL SAPERIA: Well…

CHAIRPERSON COHEN: …you don't think we can… we can handle it now? But is there any reason

to think we would be able to handle it better in the future?

PHIL SAPERIA: Well no I can't guarantee that we could handle it better in the future. I think it would give us some stability, some predictability, some time to get use to this enormous bucket of changes, etcetera. So that's precisely why it is. Because at least on a fee for… you don't… right now you know a typical provider, no matter what their size is, small, medium, large, they have to negotiate with maybe 10 plans or anywhere from let's say five to ten plans. Each of those plans has their own rule books, has their own payment systems, has their own electronic health record, it has their own contract etcetera etcetera. So… so yeah so I guess it's time to get ready to understand all that sort of stuff for… in the case of the advocacy universe for us folks to be pushing for more universality and more templates and contracting and more ways for agencies to be able to handle this thing, to give us time to get the system… the technology systems up and running, etcetera. Yeah it just buys us time for readiness but essential time.

CHAIRPERSON COHEN: Again I just want to really express my gratitude to the… the quality of the testimony and the collaborative effort from the… the entire community to try to make sure that the council is doing everything we can to help. So thank you very much. This concludes our…

CHAIRPERSON COHEN: Thank you very much.

[gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date Date of Transcription