ACL
Association for Community Living

Advocacy
Commitment · Leadership

Thank you Senators DeFrancisco and Hannon along with Assembly members Farrell and Gottfried for this opportunity to submit testimony. The Association for Community Living (ACL) represents Mental Health Housing providers across the state that are licensed and/or funded by the Office of Mental Health. Our members operate approximately 30,000 units of housing with rehabilitative services for people with mental illnesses living in the community. Of these 30,000 units approximately 9,000 bill Medicaid for rehabilitative services.

Behavioral Health Managed Care

We urge the legislature to hold separate hearings periodically to monitor the initiative that moved all behavioral health services into Managed Care. There are many concerns of which the following are only a few.

Up until two years ago the State's plan to move Behavioral Health into managed care was to keep behavioral health services out of mainstream managed care by using specialty Behavioral Health Organizations (BHOs) with experience with this population to manage and pay for behavioral health services. However, it was subsequently decided that all behavioral health services will, instead, be added to the mainstream managed care system. This move was and continues to be of concern to those of us who work with people with serious psychiatric illnesses on a regular basis. We do not yet know what the impact will be but we are concerned that the system will contract resulting in an inadequate behavioral health system. New York City just switched over on January 1, 2016. We suggest that the legislature continue to monitor clinical results, access to services as well as ask for reports regarding actual savings, if any, that should be reinvested in the behavioral health community based system.

The creation of Home and Community Based Services (HCBS) under specialty Health and Recovery insurance Plans (HARPS) could potentially provide services that, not only could keep people with mental illness from using other more costly alternatives such as emergency rooms and inpatient hospital stays, but that would add to quality of life and stability. However, we need to ensure that these services remain available for consumers and are funded at a level that allows providers to deliver quality while remaining cost-efficient. Rates for HCBS services need to increase to ensure access for all consumers that have been assessed as needing and qualifying for HCBS mental health services. Many providers have begun to submit analyses showing that many of the services are priced too low. In addition, assessments have been slow to start so that the ramp up of this new service is anticipated to be very slow. For two years the DOH will keep payment for HCBS out of the capitated rate of MCOs until there is enough information to do an actuarial analysis. But if the ramp up is very slow, DOH will not have enough information at the end of two years upon which to base an adequate rate for the MCOs on a go forward basis. We suggest that the HCBS payment remain outside of the MCO capitated rate for at least three years.

Also, the Medicaid Rehabilitative Services that are provided in Mental Health housing programs are currently carved out of managed care, which will continue for at least another year. These services, when attached to a housing program, allow people with very challenging behaviors and symptoms, who would otherwise remain in institutional settings, to transition into communities. The potential for rationing these services by MCOs could put a person's ability to remain in the community at risk. In addition, if a Managed Care Organization makes the decision that residential services are no longer needed, it must ensure that there is a safe and affordable alternative setting. We ask that OMH residential programs remain carved out of managed care for at least 5 years to safe-guard the housing of the most vulnerable people in the system. This would assure stability of housing if the rest of the mental health service system contracts during the transition period and would allow some time for the new housing in the budget to be developed that would increase options for this population.

Workforce and COLA
There has been a Human Services COLA tied to the CPI in statute for the past 7 years. During this time the CPI has ranged from 1.4% up to a high of nearly 5%. However, every year the COLA has been deferred and providers have had to deal with rising costs of operating services while dealing with funding that does not keep pace with these increases. The CPI for 2015 was nearly flat. The 2016-17 executive budget proposal did include the COLA for Human services based on the 2015 CPI, which resulted in a 0.2% COLA – nearly nothing. While we commend the Governor for keeping the promise of a COLA tied to the CPI, this year's amount is so low that it doesn't help anyone. The result of the 0.2% COLA will be a penny increase for every five dollars of a community based agency's budget.
We ask for an additional $91 million increase in funding for community based mental health programs, including those that bill Medicaid. This number represents a one percent across the board increase to partly make up for the past seven years of no COLAs.

Medicaid Redesign Team Housing
The state has invested considerable dollars from State Medicaid savings into housing since the Medicaid Redesign Team first made its recommendations. We applaud this approach to creating more housing, as it has been demonstrated over and over again that stable housing reduces health care costs. We ask that funding continue and be increased each year.