NEW YORK STATE COALITION FOR
CHILDREN'S
BEHAVIORAL HEALTH
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2017-18 State Budget Requests-Joint Fiscal Hearing 2/16/17

The entire premise of Medicaid Redesign for children's behavioral health was based upon the dramatic unmet needs and the need for capacity building.

October 15, 2011 – MRT Recommendations

THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM LACKS CAPACITY TO BEST SERVE THE NEEDS OF THE STATE'S CHILDREN AND YOUTH; COMMUNITY-BASED CARE SHOULD BE TARGETED FOR PLANNED INVESTMENTS AND REINVESTMENTS. THIS NEED FOR INVESTMENT MUST BE TAKEN INTO ACCOUNT"

After 5 years of design discussions about **how to expand capacity**, but without specific investment in children's service capacity[i] the 2017-18 Executive Budget recommends savings on children's behavioral health[ii]

The NYS Coalition for Children's Behavioral Health, representing 45 provider agencies, and on behalf of the children and families we serve, urgently ask that the NYS Legislature:

- INVEST $17.5 million in children's behavioral health services - Reject the proposed savings of $20 million in budgeted, but unspent 2016-17 State Fiscal Year funding, and restore $17.5 million to address the children's behavioral health capacity crisis;

- INCREASE to $125 million the floor for community based providers' eligibility for the proposed $500 million capital fund, the Statewide Healthcare Facility Transformation program;

- SUPPORT the nonprofit Office of Mental Health workforce by adequately funding the minimum wage increases, an estimated $50.5 million cost to the system, and re-direct 25% of any unspent DSRIP workforce development funds to community based providers to support hospitals systems that want to "buy, not build" behavioral health services so they can meet Value Based Payment targets.

CAPACITY, CAPITAL, WORKFORCE

[i] Except for about $8 million in outpatient clinic rates in 2015 and $10 million for Health Information Technology in 2016
[ii] $30 million for delayed State Plan Services and $10 million transformation readiness funds

Thank you, Senator Young and Assemblymember Farrell. I am Andrea Smyth, Executive Director of the NYS Coalition for Children's Behavioral Health. I testify before you this evening for the sole purpose of asking you not to address the Medicaid Global Cap pressures by agreeing the Executive's recommendation to save $20 million by reversing planned investments into children's behavioral health services.

Rather, accept the recommendation to invest $5 million into pilot project that would allow children's residential providers to convert bed capacity into more market-driven, community-responsive services. Then, reject the proposed $20 million savings and restore $17.5 million to address the children's behavioral health capacity crisis immediately beginning April 1, 2017.

For your benefit, I have taken stock of the contemporary array of children's behavioral health services.

- ✓ 104 outpatient clinics serving children & adolescents
  - 49 in the 5 Boroughs;
  - 8 in Erie County;
  - 7 in Westchester County;
  - 3 in Albany, Dutchess, Onondaga & Monroe counties;
  - 2 in Oneida & Ulster counties;
  - 1 in 22 upstate counties; and
  - 0 in 13 counties around New York State)
- ✓ 15 Partial Hospitalization programs (4 in Manhattan; 1 in Queens, Ulster, Dutchess, Onondaga, Erie counties; 2 in Monroe, Suffolk & Westchester counties)
- ✓ 8 Crisis Residences (6 at state-operated child & adolescent hospitals – 2 community based)
- ✓ 5 Crisis/Respite programs
- ✓ 514 RTF beds (proposed for downsizing in pilots)
- ✓ 1845 HCBS Waiver slots
- ✓ 7600 Day Treatment slots (proposed for redesign and/or elimination under MMC)
- ✓ 528 State operated C&A beds (as high as a 40% readmission rate at some)

In addition to geographic sparsity and inequity, the children's behavioral health system is characterized by:

- ✓ long waiting lists;
- ✓ artificial time limits on service access;
- ✓ lack of funding to provide care to non-Medicaid kids (poor commercial rates and non-compliance by Child Health Plus plans to pay APG rates for clinic visits as you authorized in 2015);
- ✓ Insufficient Family Support and Youth Peer Support because not enough training and credentialing funding has been forthcoming; and
- ✓ Insufficient support for clinics to recruit enough licensed professionals to meet demand, as wait times for initial visits grow to be months while they spend operating funds trying to recruit child psychiatrists, psychologists and licensed mental health practitioners.

The restoration would be used to address the following issues immediately:

- Hire, train and credential new ***Family Peer Advocates***
- Hire, train and develop a credential for new ***Peer Youth Advocates***
- Train and credential to Evidence Based Practices (EBPs) for other licensed professionals, ***hire necessary supervisors and pay fees for EBP compliance***
- Add ***20 new crisis residence/respite/intervention teams*** statewide
- Add ***outreach and engagement to homeless families*** to link to Health Homes
- Support ***clinic recruitment and retention*** with grants to add staff/reduce waiting lists

Access to Capital

The Executive Budget proposes that $500 million be available for the Statewide Healthcare Facility Transformation fund, and that a minimum of $30 million be available for the same outpatient providers. This is insufficient and we ask that a minimum of $125 million, or 25% of the proposed amount be available, because:

- ✓ This is only the 2nd time community based health care providers have been eligible to apply for capital transformation funding, but hospitals have had other

opportunities, in fact, hospital sponsored clinics have a capital component in their rates, which community based Article 31 clinics do not;

- ✓ Support "buy; not build" approaches to speed up Medicaid Redesign and meet DSRIP goals at lower capital investment costs and with more geographic reach that hospital centered expansion.
- ✓ We should consider the transformational needs of other licensed OMH programs, like residential treatment facilities (RTFs) serving children such that *"facility" means a hospital as defined in section 1.03 of the mental hygiene law, and shall include the hospital sub-class of residential treatment facilities for children and youth, as defined in such section.*

We believe that any future funding intended to support transformation, re-design and quality goals should always include a minimum of a 25% set- aside for health care providers that are community-based.

Unique Characteristics of the Kids' MRT DESIGN:

I understand that the proposed savings is tied to delays in implementation of Medicaid Redesign and I wholeheartedly agree that the kids' MRT Subcommittee took the most troubling aspects of the child-serving system to heart. While support for the non-Medicaid kids was determined NOT to be within the scope of the MRT, with a little help from Mercer, the Kids' MRT subcommittee determined early on that we did not support a carve out, with the hope that plans would gain experience with the Medicaid benefit and understand that authorizing a richer service array under commercial and CHP could save money over time.

Once kids are enrolled in a Managed Care Plan, the plan will be liable for both the child's health expenditures and their behavioral health costs. This was based upon a few key facts about children:

1. Plans have been held harmless for the cost of specialty children's behavioral health services, including clinic needs beyond 30 visits annually, so they were not tracking the impact or cost of those services
2. Kids don't all stay Medicaid eligible for ever – their insurance status is tied to their parents circumstances – so if plans are pressured to offer continuity of care when eligibility status changes, the commercial and CHP coverage might adjust over time as well;

3. Because the average annual Medicaid spend per child is uniformly about $2,400 (v. per capita avg of all Medicaid recipients was $11,800 in 2008) when the premiums increase to include the behavioral health coverage, it will be relatively easy to determine if the medical loss ratio (the proportion of premium revenues spent on clinical services and quality improvement) is being diverted away from behavioral health and into expanded health services

The real beauty of the Kid's Redesign plan is that it brings forward a variety of previously non-Medicaidable services that are directly aimed at social determinants of health issues. The plan for moving some Waiver services over into the standard Medicaid benefit was a recognition that lower cost interventions (like Family Support Services) were having the most positive benefit on engaging and retaining child and family involvement in treatment. This also addressed the "cap" on slots – now all Medicaid eligible children would be eligible for the 6 proposed State Plan services.

The Kids' MRT designed was intended to expand the basic Medicaid benefit to bring in more professionals, more flexible services, more services and make all of that available to more kids. BRILLIANT!!! The glitch is in the timing and the unknown direction that CMS will take on proposed benefit expansion.

Implementation may be delayed, but progress does not have to be.

The authority for the Health Homes serving children to continue is intact. In fact, if you fund expansion of clinic staff, and complex trauma screenings can be done at clinics in a timely fashion, you can assist us in generating HH Payments for children who qualify under that category that are at 90% Federal Financial Participation for much of 2017. To be clear, the job of care coordinators is to identify and refer child to appropriate services. If the services aren't available to meet the needs of the estimated 200,000 children and adolescents who are expected to be eligible for Health Homes, it may not feel like the success it should be.

We also advocate that clinics be funded to add Trauma Systems Therapy – an evidence based complex trauma treatment that must be available if children are being screened to be in need of trauma-informed treatment. And expansion of other evidence-based practices for juvenile justice involved youth and their families will be need if youth focused criminal justice reforms are enacted.

The Coalition is advocating that the proposed savings be rejected and that the Legislature restore funding that is released immediately to ensure access to services in your communities.

DSRIP, VBP and Children

The Delivery System Reform Incentive Program was part of authorization in 2014 for New York to "reinvest" $8 billion that the feds saved because of New York Medicaid savings to overhaul the entire health care system. With the recent announcement of an extension of the state's MRT 1115 Waiver, the federal government has assured federal financial participation for DSRIP through March 31, 2020, but will still not allow the amount to exceed $8 billion.

The initial goals were announced to include: (1) safety net system transformation at both the system and state level; (2) accountability for reducing avoidable hospital use and improvements in other health and public health measures at both the system and state level; and (3) efforts to ensure sustainability of delivery system transformation through leveraging managed care payment reform. That third one was later fleshed out to mean Value Based Payments – but at the start, the focus was deemed to be on a 5- year goal of reducing avoidable hospitalizations by 25%. The creation of 25 Performing Provider Systems was intended to create local planning efforts that reviewed the community needs of smaller geographic areas and get input from the entire community about how to reform the system. The mid-points assessments and Independent Assessor reviews were vetted recently. recently released, and the biggest concern is the lack of "Funds Flow" to community based organizations and some lack of activity on some of the selected projects. As loud as the complaints have been around funds flow and involvement of CBOs, it is clear that this funding was intended to put hospitals at the epicenter of change. But will that serve our children?

The DSRIP focus is on the highest cost patients and those that use the hospital inappropriately. While every hospitalization of a child with an emotional disturbance could be considered "avoidable", the fact of the matter is that expenditures on children behavioral health care is not significant enough to make it a focus of the majority of the project work of the PPSs. Child and family health care is not a "hotspot" of expenditure. During the first quarter of 2013, only 11% of New York State's Medicaid expenditures went to children, despite being 21.6% of the state's population. In 2008, pediatric

discharges constituted only 6% of the state's total. These are not compelling numbers for a program with a principal goal of reducing hospitalizations.

However, the Coalition will not allow policy makers to ignore that fact that current spending and service delivery patterns for child and adolescent populations DO HAVE A GREAT DEAL TO DO WITH POPULATION HEALTH!!! The Kaiser Permanente Adverse Childhood Experiences study (1995-97) cements the connection between childhood experiences and adult health status, and quantified the financial consequence of the health care outcomes over time. The cycle of return on investment in children can be very long, but the benefits are widespread and can be measured through lifetime health and economic productivity.

As a result, The Coalition's advocacy around DSRIP is very focused on advocacy for "buy not build" approaches to integrated care. We hope our advocacy will gain favor when the Children's Clinical Advisory Group's releases its recommendations around VBP. To-date, my organization is "ALL In" on the preliminary focus of that group to measures the outcomes of child development when services delivery focuses on pre-natal through age 9 or 10. That is the sweet spot that Robert Anda and the World Health Organization have already identified as the period by which we can alter the health and wellness status of lives and where a Value Based Payment model is far better at measuring success than an insurance-oriented model would be.

Now, as I move on to VBP, I would like to emphasize that there has been a verbal commitment that the child-serving system's goals in all of this will include better outcomes, but DOES NOT HAVE TO INCLUDE LOWER COST or produce savings. At every level, whether the Kids' MRT or the Children's Clinical Advisory Group, it has been noted that the children's Medicaid spend is low to the point of being insufficient and that capacity is so insufficient as to warrant investments, not savings. The admitted truth is that the children's behavioral health system has been chronically underfunded, yet this budget proposes to use funding recommended for children's services to balance the Global Medicaid Cap pressures.

Thanks, and for additional information contact:

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