Submitted Testimony

NEW YORK STATE COALITION FOR
CHILDREN'S BEHAVIORAL HEALTH
P.O. BOX 7124, ALBANY, NY 12224 518-436-8715 WWW.CBHNY.ORG INFO@CBHNY.ORG

2017-18 State Budget Requests-Joint Fiscal Hearing 2/6/17

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 - Restore the $7.5 million budgeted, but unspent in the 2016-17 State Fiscal Year for new capacity, and $10 million of readiness funds to address the capacity crisis in children's behavioral health care;

- **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, Chairpersons Young and Farrell and members of the Legislature.

My handout is very clear – there are insufficient funds proposed in the Executive Budget for children's behavioral health capacity, for the capital transformation of community based providers and for the necessary investments and support of the community behavioral health workforce.

Related to the children's **behavioral health capacity**, we are at a crisis point. From the very beginning of the children's Medicaid Redesign it was acknowledged that the children's system of care was under-resourced and had insufficient capacity. Unlike every other aspect of Medicaid Redesign, the commitment was for MORE-ADDIOTIONAL and NEW resources to be invested; not for efficiencies or savings to be achieved through re-design. Now, after years of design efforts, "the submission of the 1115 Waiver Amendment is pending review of the new Federal Administration's priorities and processes and depending on the timeframes for acquiring the necessary approvals, the implementation dates will be modified accordingly." That is a quote from the proposal managed care plan qualification documents released last week.

When translated into budget action, the delay on the kids' implementation means that the Executive is proposing to take savings out of the kids' system rather than let funding PREVIOUSLY BUDGETED flow immediately to address the long-standing capacity problems. (see addendum for anticipated funding explanation).

Each of you is familiar with the paucity of children's behavioral health services. Your offices field calls from families frantically searching for access to services when their children are in crisis. Year after year, the children's advocates come and urge additional investment. Well, this year, the proposal is worse than not proposing any increases. This year, the children's behavioral health recommendation is to take away promised resources. Please, do not let that happen!

We are asking for a portion of the state funding that was set-aside for children's behavioral health reform flow into the community to address the capacity crisis. Specifically, we urge that state-only funds be allocated while we wait for CMS so the service system can respond to the expansion of care coordination, going on under Health Homes for children, so there is enough care to coordinate:

- 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 crisis 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

The children's redesign application was not submitted to CMS prior to the federal election. That puts implementation at risk, but the lack of capacity that existed in 2011 that precipitated the formation of a Children's MRT Subcommittee tasked with addressing the limits on capacity, lack of variety and stagnant access to children's behavioral health services, along with the systemic under-funding of children's health care in general, persist. Address them during this budget cycle.

Characteristics of Current Children's Services:

1) Services triaged by what is available, not what is needed – a limited number of everything, 514 RTF beds, 1845 HCBS Waiver slots (only 36 in Staten Island), 7600 Day Treatment slots, 528 State operated C&A beds some with the readmission rates of 40%
2) Geographic sparsity, lack of capacity and long waiting lists
3) Artificial time limits on service access – continuation of care not based on medical necessity but assumption that a child has been in care "long enough"
4) Lack of funding to provide care to non-Medicaid kids, when working poor and Child Health Plus kids needed access as desperately as Medicaid kids
5) "Soft services" that families want, such as, Family Support and Youth Peer Support are unavailable because not enough training and credentialing funding has been forthcoming
6) Outpatient clinics spend precious operating funds trying to recruit child psychiatrists, psychologists and licensed mental health practitioners, while waiting times for initial and follow-up visits grow to be months, not weeks.

The real beauty of the Kid's Redesign plan is that it was intended to bring 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. And the 6 new services themselves were selected to address the thorniest problems, like workforce shortages, by expanding services that a variety of licensed mental health professions could provide.

So, the service array that 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 that the necessary applications were not submitted prior to the November Presidential election, so instead of new or expanded services, kids are getting budget cuts.

CAPITAL TRANSFORMATION

The Legislature took the lead last year in ensuring that community-based healthcare providers were eligible for capital funds being proposed repeatedly for hospital systems. Last year, of the $195 million included in the State Budget for the Statewide Health Care Transformation fund, at least $30 million was set-aside for behavioral health clinics, primary care providers, home care providers and outpatient health clinics. This year, the Executive Budget proposes that $500 million be available, and that at least $30 million be available for the same outpatient providers.

We believe 25% of the proposed $500 million, or $125 million should be set aside for community providers. We urge that the Legislature take an affirmative stance on the need for PPS' and hospital systems to incorporate community based providers into their transformation designs. This can be expressed as advocacy for "buy; not build" approaches to integrated care. In this way, expansion of community based services, at lower capital investment costs and with more geographic reach that hospital centered expansion, can speed up the implementation of reforms and stretch capital resources further. can be and shared investment of the DSRIP workforce transformation funds to both hospital and non-hospital providers in the PPSs.

DSRIP And Workforce

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. Of the $8 billion, $1.08 billion was to have been available for workforce development, Health Home development, Managed Long Term Care development and enhanced behavioral health services. Each PPS was allocated workforce development funds. At last week's Mid-Assessment review, it was clear that only a few PPS' have successfully utilized the workforce development funds. We believe that 25% of any unspent workforce development funds should be diverted into the non-profit community-based provider agencies to support workforce expansion. Again, this strategy would support a "buy, not build" approach to DSRIP reforms, whereby the providers with the most experience in training community outreach, care coordinators, family and peer advocates, would be resourced to accomplish this task. The PPS' regularly testified that "these people just don't exist" and they were unable to recruit and train them. They do exist, they work for us and we need more of them.

Minimum Wage Pressures

The Coalition, in conjunction with the Association for Community Living and other behavioral health care provider organizations, has developed an estimate of the impact to the entire publicly funded mental health system as a result of the incremental increases to the minimum wage that were approved during the last legislative session. Overall, we estimate that an increase to the minimum wage to $15/hour for downstate and $12.50 for upstate counties will require New York State to add an additional $50.5 million per year for the next 6 years to the community-based mental health system. This assessment does not include costs related to growth in existing programs, new programs, or reinvestment. This assessment assumes necessary adjustments as the base of wages for relatively low-paid workers across the workforce.

The Coalition's members take the health and safety of their patients seriously. Both the direct care and professional workforce in the children's behavioral health field require extensive training and employer investment. To ensure workforce competency and to respond to upcoming minimum wage increases and growing competition from other employers, adequate government funding for the nonprofit workforce must be a priority. While helping many individuals, the minimum wage increase is adding recruitment and retention challenges for nonprofit providers, keeping turnover rates to

a manageable level is key to quality care and patient recovery. These are the compelling reasons why the $50.5 million request is so critical.

METHODOLOGY: Information for this analysis was gathered using data from the 2014 Consolidated Fiscal Reports (CFRs) submitted by community mental health providers. The information includes:

1. Position codes (Lines 100s through 700s)
2. Hours worked as reported by each agency for each position code
3. FTEs as reported by each agency for each position code
4. Average annual salary as reported by each agency for each position code

REQUEST: Provide $50.5 million per year for five years to support the impact of the incremental increases to the minimum wage that were approved during the last legislative session.

o we estimate that the full implementation of the minimum wage to $15/hour for downstate and $12.50 for upstate counties will have an approximate $423 million impact on the community mental health system.

For additional questions, contact:

Andrea Smyth, Executive Director

NYS Coalition for Children's Behavioral Health

andrea@asmythadvocacy.com/ (518) 795-5270

2016-17 DOH Budget Medicaid Investments– UPDATE JANUARY 2016
Behavioral Health Transformation Initiatives Including Investments for Managed Care/Health And Recovery Plans (HARPs)

Proposal	Details	2016-17		2017-18	
		Gross	State	Gross	State
HARP Managed Care Start-up/Technical Assistance: Ongoing system readiness activities to develop the HARP and Home and Community Based Services (HCBS) infrastructure and capacity to support the transition of behavioral health services for adults into Medicaid managed care.	Funds for start-up activities and ongoing technical support including: - Managed Care Technical Assistance Center training activities ($6M); - Targeted Health Information Technology (HIT) technical assistance and HCBS grants to non-Medicaid providers in HARPS ($14.5M); and - County Regional Planning Consortiums ($2M).	$12.5M	$ 6.25M	$10M	$ 5M
Children's Managed Care Start-up: Targeted investments for children's readiness activities to develop the infrastructure and capacity to facilitate the transition of behavioral health services for children into managed care.	Funds for Targeted Health Information Technology (HIT) and HCBS grants and start-up resources to expand system capacity for evidence based services for children's providers.	$20M	$10M	--	--
New State Plan Services for Children: The State will expand the Medicaid benefit package to include six new State Plan services for children to produce better outcomes for children and families. The new services focus on earlier intervention for children experiencing behavioral health issues, helping to keep children with their families, thus preventing the need for more costly, high-intensity services and out-of-home placements.	The State Plan will be expanded to include six new Medicaid services for children starting January 1, 2017: - Crisis Intervention; - Community Psychiatric Support and Treatment; - Psychosocial Rehabilitation Services; - Other Licensed Practitioners; - Family Peer Support Services; and - Youth Peer Training and Support Services.	$7.5M	$3.75M	$30M	$15M
Integrated Treatment Care\Collaborative Care: Ongoing funding for the implementation and expansion of the evidenced based integrated treatment model.	Funds to support Collaborative Care programs; State Plan submitted which established this as a Medicaid service effective January 1, 2015.	$15M	$ 7.5M	$15M	$7.5M

OASAS Residential Restructuring: Ongoing funding for reimbursable services provided in a new redesigned residential treatment model.	Funds for residential restructuring for services carved into managed care. Will assist OASAS residential providers as they convert licensure with start-up funding to hire new staff (medical, clinical).	$5M	$2.5M	$5M	$2.5M
Preserve Critical Access: Targeted Vital Access Provider (VAP) program to preserve critical access to behavioral health inpatient, outpatient clinic and other services.	Funds support ongoing efforts already underway to preserve critical access to behavioral health services including: -Rural status expanded to four additional counties and upstate inpatient psychiatric rates were increased by 10 percent effective July 1, 2014 ($6.9M Full Annual). - Psychiatrist fees for facility and office based visits were increased to 80% of the Medicare fees effective July 1, 2014 ($3M Full Annual) -Targeted VAP program for Article 32 OASAS inpatient services ($5M Full Annual). - Targeted VAP proposals for several upstate Article 28 hospitals for restructuring to preserve needed psychiatric inpatient and outpatient capacity ($10.9M in 2016-17 and $5.2M in 2017-18). -Targeted VAP program for Article 31 freestanding clinics ($20.5M in 2016-17 and $6.2M in 2017-18). -Targeted Ambulatory Patient Grouping (APG) Updates for mental health clinics effective October 1, 2014 and January 1, 2014 ($8.7M Full Annual).	$55M	$30M	$35M	$20M
Health Homes Plus: Balancing Incentive Payment (BIP) funds will be used to support ongoing Health Home Plus expenditures through September 30, 2017.	Health Home Plus was implemented effective April 1, 2014 for individuals receiving care management under a court order for Assisted Outpatient Treatment (AOT).	--	--	--	--
SUBTOTAL		**$115M**	**$60M**	**$95M**	**$50M**
BIP SAVINGS		**($20M)**	**($10M)**	--	--
TOTAL		**$95M**	**$50M**	**$95M**	**$50M**

*The 2016-17 Executive Budget also includes a new investment of $30M in 2017-18 for Children's Managed Care Enhanced Services to ensure that Medicaid eligible children will be able to access home and community based waiver services as these programs are integrated into the benefit package.