Version 3.0

Industry Challenges, Opportunities, and Demographic Changes Impacting on Strategic Positioning of OMH / OASAS Providers
March 12, 2020 | Updated May 18, 2020

NOTE: This document has been updated as of May 18, 2020, after initially being prepared the day after the World Health Organization announced that the Coronavirus Disease (COVID-19) was a global pandemic.

In this updated version, it reflects an extraordinary and unprecedented Federal and State response to the global pandemic. It has been just nine weeks since the pandemic was announced and the United States was declared a national disaster area. As of the date of this update, the Federal Government has authorized funding through the Treasury Department and the Small Business Administration totaling $10 trillion. Current predictions are that another $15 trillion may be required in the next 12 months if the country is to avoid a major economic depression. As of the date of this update, 33 million Americans have filed for unemployment benefits, and predictions are that the number of unemployment claims will grow to exceed 40 million. In the absence of an effective vaccine being developed by December 2020, there is general agreement that this coming fall and winter will have a resurgence of the Coronavirus pandemic.

The information that follows is an attempt to document a realistic and reasonable assessment of the impact of the pandemic on OMH and OASAS providers. It is clear that the demand for Mental Health and Substance Abuse services will be increasing substantially as a result of the pandemic's uncertainty and the stay at home requirements. However, it should be acknowledged that no one can predict the ultimate impact of the COVID-19 pandemic on each and every health and human service provider.

The Behavioral Health service sector, funded primarily by OMH, OASAS, and certain programs funded by DOH, continues to experience significant reform initiatives, financial pressures, and challenges to service quality. Managed Care initiatives and related reforms, particularly in the past seven years, have resulted in potentially long-term implications for the individual autonomy of New York State Behavioral Health service providers, most notably in the tax-exempt sector.

I. Industry Challenges, Opportunities, and Demographic Changes

1) Historic and Flexible NYS Budget Approved on April 1, 2020
The budget provided Governor Cuomo with tremendous flexibility and authority to evaluate the State's economic and budget situation on a quarterly basis. His first reset date will be no later than June 30, 2020. The following topics are the most significant issues yet to be finally decided as the calendar moves forward towards June 30.

- On May 13th, in Watertown, NY, at his daily briefing, Governor Cuomo announced that the State would need $61 billion of additional Federal aid / stimulus in order to avoid economic catastrophe for New York employers, businesses, municipalities, and its health and human service provider infrastructure.
- The $61 billion was a shock to many in that the Department of Budget projections of the current year deficit in early April were for a budget shortfall of approximately $14 billion. Obviously, the need for additional Federal stimulus has increased substantially as the impact of the pandemic progresses each week. Governor Cuomo has indicated that without additional Federal aid, there may be a need for draconian cuts to State spending of up to 20% in various State-funded programs.
- The budget adopted, subject to Governor Cuomo's reset, provides, in the absence of future Federal funding, significant authority for the Governor to assess and implement additional budget adjustments on a quarterly basis throughout the period of the pandemic for the budget period ending March 31, 2021.
- In February 2020, the Governor appointed the Medicaid Redesign Team – Part 2 and they provided him with recommendations amounting to $2.5 billion in reduced Medicaid spending during the last week of March 2020. Most of the MRT recommendations were included in the adopted budget, subject to Governor Cuomo's quarterly reviews and resets.
- Of the more than 1,000 providers in New York State, a significant number continue to be at risk of not being able to sustain financial viability during and after the pandemic. Less than 50% of OMH/OASAS providers have accumulated financial reserves, investment portfolios, and diversification of revenue sources to enable them to continue normal business operations. This distinction between "Have" and "Have Not" providers will force an exponential number of mergers, affiliations, and program service transfers from the "Have Nots" to the "Haves".
- The reduction in government Medicaid funding will continue to require all successful providers to access new Foundation Grants, increase fundraising revenue, and pursue for-profit business activities to offset reduced government funding.

- For the five years ended March 31, 2020, the Federal and State governments collaborated on an $8 billion, five-year Medicaid Reform Program referred to as DSRIP. New York State submitted an extension application that was rejected by the Federal Government in February 2020. The future of the 25 regional Performing Provider Systems created by DSRIP is totally unpredictable. However, at this time, each of the PPS organizations has funds remaining that will allow most of them to continue funding Medicaid Reform Program Service Initiatives through March 31, 2021. Every health and human service organization needs to aggressively pursue PPS funding from the last year of available funds.
- Further Medicaid cuts and reform initiatives in the midst of a global pandemic would appear to be "political suicide". However, providers must recognize that even though Governor Cuomo has significant authority for this budget year, , additional and more significant Medicaid cuts may be required in 2021 and future years.

2) Federal Stimulus Funding (please refer to Federal COVID-19 Crisis Aid Programs At A Glance document) The Federal Government has provided and will continue to provide trillions of dollars of stimulus to address the negative economic impact caused by the COVID-19 pandemic.

- The attached document provides a one-page summary of the Federal stimulus activities as of May 11, 2020. Through the second round of the Paycheck Protection Program (PPP) loan program, more than two million loans have been processed, with 83% of the loans being for less than $100,000 and predominantly placed with for-profit small businesses.
- The stimulus initiatives initiated to date will not carry many providers beyond June 30, 2020. Accordingly, there will be additional stimulus legislation enacted. On May 15th, the House passed a $3 trillion additional stimulus package, which, at this time, is Dead On Arrival in both the Senate and the White House. Further negotiations and compromise must be agreed upon, since there is no other choice than to provide additional stimulus to support states, counties, local municipalities, and the entire social service infrastructure of the country.
- While the stimulus activities implemented to date have been necessary, in the absence of a vaccine, there will continue to be trillions of dollars of additional stimulus implemented between now and December 2020.
- There are many issues that have resulted from the unprecedented level of Federal stimulus. The following issues are most significant, but certainly not all inclusive:
    a) The term "Double Dipping" has entered the lexicon. Essentially, if Federal dollars have been provided to New York State-funded providers, does New York State have the right and authority to reduce State funding dollars by an equivalent amount or some percentage of the Federal dollars provided?

b) The CARES Act legislation included a phrase for the eight-week PPP Loan period that indicated that eligible expenditures must be "incurred and paid" during the eight-week period to be used for loan forgiveness. This phrase flies in the face of all aspects of accrual basis accounting and needs to be clarified in order to avoid special payroll periods and a special check run all to be dated on the last day of the eight-week loan period.
c) Mass confusion has existed since Day One regarding the eligibility of nonprofit providers with more than 500 employees and whether or not these providers with more than 500 employees could qualify for a PPP loan using the NAICS Alternative Size Standard.
d) Many, many questions are still open with respect to the loan forgiveness calculation, expense eligibility, and related matters. The Treasury Department does have an ongoing list of Frequently Asked Questions. As of May 17th, 47 questions have been posed and answered on the Treasury website.

3) Medicaid Reform Initiatives and the Potential Impact on Providers
All of the foregoing Medicaid reform and Federal stimulus initiatives are being implemented during the global pandemic, while there are many ongoing program service and management issues that must be addressed by OMH and OASAS providers on a daily, weekly, and monthly basis.

- In February 2020, the unemployment rate in the country was less than 4%. It is now in excess of 15%. In their recruitment processes, OMH and OASAS providers may have a significantly expanded pool of qualified candidates to reduce or eliminate their vacant position issues. The enhanced $600 per week unemployment benefit has many unemployed individuals preferring to stay home vs. seeking new employment.
- As a result of the foregoing, the New York State Workforce Crisis had elevated vacancy rates for many OMH and OASAS employers to between 15 and 35%. However, the ongoing risk of working in direct contact in OMH / OASAS programs in the midst of a global pandemic has resulted in increased overtime costs and incremental Hazard Pay for purposes of adequately staffing each provider's program sites. It is particularly important to note that telehealth and telemedicine capabilities are now a requirement and certainly expected to increase significantly.
- On January 1, 2020, New York City implemented a $15 minimum wage, which has created more pressure on Upstate providers, particularly those with residential programs. Many competing employers (e.g., fast food restaurants, convenience stores, retail, and traditional service businesses, etc.) are offering between $14 and $15 per hour, even though the mandated minimum wage is less than that for counties north of Westchester. As a result of the foregoing, the workforce crisis continues.

- All of the foregoing continues to pressure the ability of providers to render high quality services.
- All of the foregoing will result in significant increases in merger, affiliation, acquisition, and auspice change activities between and amongst all sectors of health and human service providers.

4) Managed Care Implementation
New York State's implementation of Medicaid Managed Care Models in the services provided to New York State's most vulnerable populations continues (currently 7 million eligible Medicaid individuals, or 1 out of every 3 New Yorkers).

   - Frail Elderly – MLTCs Formed 2012/13
   - Mental Health / Substance Abuse – HARP Carve-Out 2014/15
   - At Risk Youth – Children's Transformation Program – 2019/20…
   - Intellectually / Developmentally Disabled – SIP-PL/CCOs 2022/23

   Federal oversight of the New York State Medicaid program continues at a high level of scrutiny, with the Centers for Medicare and Medicaid Services (CMS) responsible for the oversight. CMS continues to challenge NYS Oversight Agencies (OMH, OASAS, OCFS, OPWDD, DOH) throughout the process, ensuring that NYS is compliant with Federal regulations governing Medicaid and that it develops a service delivery system that controls targeted spending growth (Medicaid growth percentage is currently 2%). One of the primary components of these Managed Care contracts relies on the implementation of Value Based Payment (VBP) Models, which are attempting to change the focus of provider service delivery revenue (i.e., "from volume to value"). DOH wants 85% of providers to be in some form of a VBP contract, described further below, by the end of 2020. Those providers that are unable or unwilling to adjust their own service delivery system to meet these new requirements of volume to value will experience a severe negative impact.

5) Value Based Payment Contracting with MCOs
The most recent iteration of the VBP Road Map was issued early in 2020. The concept of paying performance incentives to providers for impacting and generating desirable, lower cost, higher service quality, and desirable outcomes as VBP's primary objectives. The implementation of performance-based incentive payment (i.e., VBP) remains a challenge for community-based health and human service provider organizations (CBO). There are a variety of hurdles that must be overcome to determine whether or not VBP in a CBO environment can be successful. First and foremost, if there are no cost savings generated by changes in service delivery, then there are no dollars to distribute as Value Based Payments to providers. In addition, the process and methodologies being used to measure and value provider activities have been both complicated and subject to a wide variety of opinions as to what provider actions should generate VBP.

   There appears to be a trend in favor of modifying the VBP traditional model and replacing it with specific targeted performance metrics, which, if achieved, can generate a performance incentive payment for providers.

One of the most significant drawbacks to VBP contracting is that the Department of Health has mandated that VBP contracts can only be entered into with organizations that have "Primary Care Physician Attribution". This requirement limits contracting to hospitals, health systems, physician groups, and Federally Qualified Health Centers. As a result, Behavioral Health (BH) providers and organizations supporting Social Determinants of Health (SDOH) are precluded from any form of direct contracting and, therefore, must join a network of providers with Primary Care attribution.

Every OMH / OASAS provider should currently be participating in one or more Independent Provider Associations (IPA) and/or Accountable Care Organizations (ACO).

6) DSRIP 1.0 and 2.0 – Federal / Medicaid Reform Initiative
DOH has instructed that the remaining DSRIP 1.0 funding should be disbursed through March 31, 2021. Each and every Medicaid service provider must ensure that funding from the Performing Provider Systems (PPS) operating within the provider's program service geography is pursued aggressively. In other words, there may be a benefit derived by BH and SDOH providers in obtaining final year funding from the final year of DSRIP 1.0, in that PPSs have been told to provide additional financial support to Community Based Organizations (CBO).

DSRIP 1.0 was created in 2015, when New York State entered into a joint agreement for $8 billion of Federal Government funding to implement the Delivery System Reform Incentive Program for New York State's seven million Medicaid eligibles. The rejection of the DSRIP 2.0 application and related loss of funding will have a major detrimental impact on hospitals and health systems and represents a significant lost revenue opportunity for CBOs.

7) Technology Sophistication Requirements and Related Costs
In the second quarter of 2019, New York State passed the SHIELD Act, which requires all New York State corporations to implement various technology and cybersecurity procedures by March 2020. We continue to predict a significant financial investment in improving providers' technology sophistication for both telehealth and telemedicine and meeting the data analytics required to effectively manage provider contracts in a VBP Managed Care environment. The initial technology implementation as well as the ongoing operating costs WILL NOT be affordable for many small to mid-sized OMH / OASAS / DOH providers as they are currently structured. We continue to recommend that all providers complete a comprehensive assessment of their Information Technology systems including hardware, software applications, cybersecurity, network communications, and firewall (e.g., periodic network penetration testing) in order to estimate the expected cost impact over the next 3-5 years and how it will be financed.

8) Behavioral Health Care Collaborative (BHCC) Implementation
Eighteen (18) BHCCs were established in 2017, but most did not become operational until mid to late 2018. The total grant award for these Regional Behavioral Health Delivery Networks was $64 million. The grant was for two years, ending on March 31, 2020, but has been granted a six-month extension, as BH networks continue to form. The primary objective of this grant award was to prepare BH providers for VBP / Risk-Based contracting with Managed Care Organizations. OASAS-funded providers are, as a result of the pandemic, experiencing significant increases in service volume and demand. OASAS and OMH are both supporting the BHCC initiative, with Fidelis as the MCO Fiscal Intermediary.

9) Certified Community Behavioral Health Centers (CCBHC)
Fourteen (14) CCBHCs were launched on July 1, 2017 under a two-year pilot. Statewide, the CCBHCs have made more than $45 million in surplus. Originally, providers were told that there would be no "claw back" of surplus amounts in the first two years. In August 2019, the State announced its intention to claw back all Medicaid surpluses generated in the two-year pilot period. Negotiations regarding claw backs have occurred during the first four months of 2020, with some negotiated settlement being reached for the actual claw back amount. CMS and DOH have implemented extraordinary focus on the objective of integrating CBO BH services with FQHC Primary Care services while, at the same time, attempting to collaborate instead of compete with hospitals and health systems in the BH service sector. This increased focus is designed to break down the silos of fragmented delivery of behavioral and primary healthcare services.

10) Multiple Care Management / Coordination Initiatives – Adult and Children's Health Homes, HARP, CCOs, CCBHCs, BHCC IPAs, and Managed Care Organizations / Insurance Companies
The State continues to be schizophrenic in developing numerous attempts to implement cost-effective Care Coordination / Management initiatives. Many of the structures referred to above have created duplication of effort, increased costs, and patient confusion. Individuals receiving services continue to receive three or more phone contacts from different Care Coordination / Management entities that have obviously not been well-coordinated.

11) The Opioid Crisis and Recreational Marijuana
The opioid epidemic in both New York State and the rest of the country is equivalent to, and in some cases greater than, the HIV / AIDS epidemic of the 1980s. As a result, OASAS is receiving a significant increase in funding to address and hopefully reverse the frequency of opioid deaths. The Cuomo Administration is on the fast track to legalization of recreational marijuana – legality is inevitable to close State budget gaps.

12) NYS Demographics

In the past decade, and particularly since the enactment of the Tax Cuts and Jobs Act, New York State has been declining in population. New York is now the fourth most populous state in the country, being surpassed by Florida. Population growth continues in New York City Metro Area but has slowed as immigration restrictions were enacted by the Trump Administration. Upstate communities are generally losing population, primarily as a result of retiring individuals relocating to lower taxation states. Demographics have had a profound impact on workforce recruitment and retention as well as the significant decline in State and Local tax revenues due to retiree relocations.

II. Strategic Positioning, Corporate Restructuring, and Accelerated Affiliation Processes

It is a stated goal of Governor Cuomo, the Department of Health, OMH, OASAS, OCFS, and the Federal Government that there are too many providers, too much duplication of effort and costs, and that through affiliation and collaboration, the entire Behavioral Health system must be made more efficient. The providers that do not have significant investment reserves and are faced with transforming almost all of their program service delivery models to an integrated non-certified community-based delivery structure may be challenged to develop the appropriate strategic position for their organizations in response to the issues and challenges identified above.

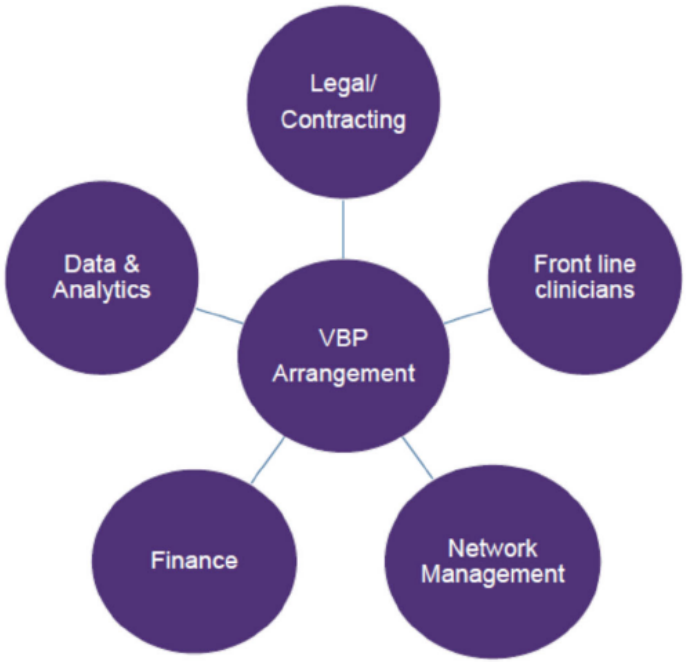
Specific strategies for consideration should be as follows:

- Need to start forming affiliations / collaborations with primary care
- Need to start positioning themselves on why BH providers have a higher quality of outcomes to population they serve than hospital based systems (flexibility)
- Alignment with CBO to address social determinants of health (the new term is social influences of health)
- Establish patient intake procedures and implementation of EMR / EHR systems to create efficient delivery of services throughout the “patient care journey”
- Increased focus on liquidity, sufficient credit lines, and projected cash flows
- Private and public foundation grants to replace government funding and identify other sources of revenue diversification (e.g., for-profit affiliates)
- Increased fundraising and development opportunities, primarily planned giving, legacies, and bequests (i.e., every I/DD Board should have a trust and estate attorney / banker
- The Warren Buffett 50% Initiative has created significant grant opportunities
- Mother Cabrini Foundation, formed as a result of the Fidelis sale, has $3.5 billion in assets, and provides $250 million each year in grants
- Bezos Family Foundation (Amazon) has more than $20 billion in assets
- Therefore, a highly qualified, experienced grant writer is critical to future success for replacing declines in government funding

III. Organizational Transformation / Care Integration and Partnerships

The following pages include slides prepared by NYS DOH for a provider seminar. These three slides visually provide an excellent summary of the structural concepts that will be required for success in Managed Care VBP contracting for vulnerable populations.

Organizational Transformation



Key takeaway:

Assess your organizational structure and maximize integration to support your VBP arrangement.

Bonadio note: The Compliance Program must be included in this integration as well.

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Source: NYS Department of Health, Office of Health Insurance Programs – *Welcome to Value Based Payment Bootcamp – October 10, 2018*

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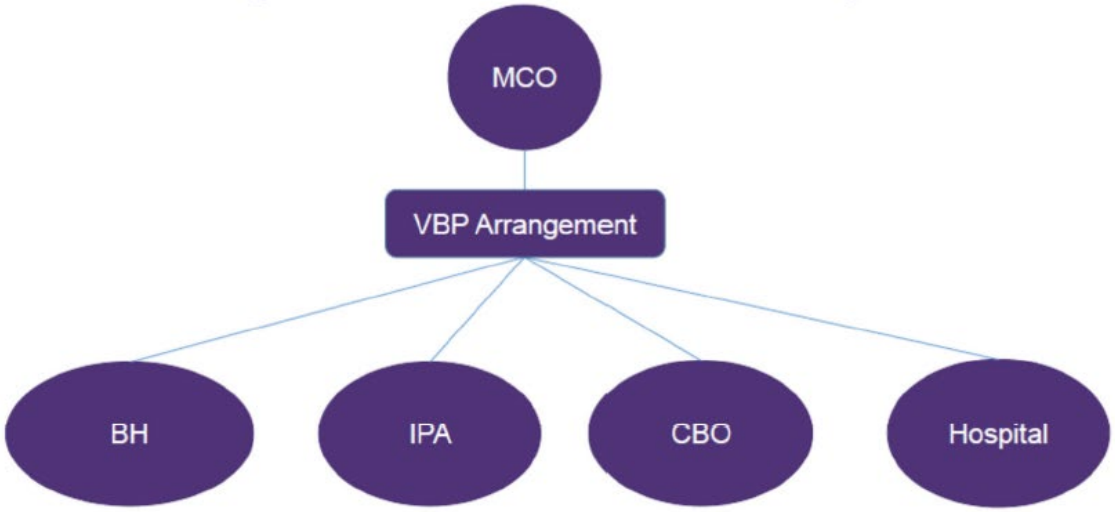
Care Integration & Partnerships



Key takeaway:
Strong partnerships between different provider types will support population health interventions. The ability to address the full spectrum of care for an individual is critical in TCGP arrangements.

NEW YORK STATE OF OPPORTUNITY. Department of Health

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Source: NYS Department of Health, Office of Health Insurance Programs –
Welcome to Value Based Payment Bootcamp – October 10, 2018

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Tier 1, Tier 2, and Tier 3 CBO Definitions

01

Tier 1 CBO

- Non-profit, non-Medicaid billing, community based social and human service organizations
  - e.g. housing, social services, religious organizations, food banks
- *All or nothing*: All business units of a CBO must be non-Medicaid billing; an organization cannot have one component that bills Medicaid and one component that does not and still meet the Tier 1 definition

02

Tier 2 CBO

- Non-profit, Medicaid billing, non-clinical service providers
  - e.g. transportation provider, care coordination provider

03

Tier 3 CBO

- Non-profit, Medicaid billing, clinical and clinical support service providers
- Licensed by the NYS Department of Health, NYS Office of Mental Health, NYS Office for Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services.

Use the **CBO list** on DOH's VBP website to find CBOs in your area

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Source: NYS Department of Health, Office of Health Insurance Programs – *Welcome to Value Based Payment Bootcamp – October 10, 2018*

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