Submitted

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COMMITTEE OF METHADONE PROGRAM ADMINISTRATORS OF NEW YORK STATE, INC.

Testimony of Henry M. Bartlett
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Before The New York State Legislature
On The 2012 - 2013
Budget for Mental Hygiene Agencies
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The Committee of Methadone Program Administrators of New York State Inc. (COMPA) is a non-profit organization representing a large network of community based treatment programs across New York which utilize medications in the treatment of substance use disorder. The provider network which my coalition represents, supplies life-saving treatment to more than 38,000 New Yorkers struggling with the disease of addiction.

I want to thank the New York State Legislature for this opportunity to discuss the Governor's proposed budget. In a year of such tight fiscal constraints COMPA is grateful to the Governor and his staff at OASAS and DOB for a proposing a budget which does not call for deep cuts in local assistance. We wish the same could be said for the Medicaid side of our funding. This year's budget proposal calls for the continuation of a two percent across the board cut in the Medicaid rate for all Opioid Treatment Programs (OTPs). This translates to a reduction of nearly $4 million dollars on an annual basis. In a time when both heroin use and prescription opioid abuse in New York State is growing at an alarming rate, it seems imprudent to cut Medicaid rates for the treatment modality which specializes in the treatment of opioid abuse and dependence.

This rate cut reminds us once again how dependent our treatment modality is on Medicaid for our continued existence. More than any other treatment modality under the OASAS licensing umbrella, OTPs rely on Medicaid as our prime funding source. For that reason we are keenly interested in the future of Medicaid in New York. For several years COMPA has worked very closely with OASAS to implement the "APG" system of Medicaid reimbursement for outpatient services. APGs (Ambulatory Patient Groups) is an innovative way of pricing specific outpatient services under the Medicaid program, such that the rates provide adequate reimbursement for the provision of quality care, while also encouraging cost savings and efficiency.

Developing the APG system involved multi-year contracts with the 3M corporation, and in total this development process cost the State of New York many millions of tax-payer dollars. We at COMPA applaud the state for taking on this necessary effort to rationalize the rate and reimbursement structure for Medicaid outpatient services. We are just now beginning to see how we can utilize the APG system to create more a cost effective service delivery systems in New York State. COMPA is working with OASAS to create additional low cost alternatives to expensive inpatient detoxification. When targeted to appropriate patients, this new level of care will not only save Medicaid dollars, but also produce better outcomes for patients. Similarly we are hoping to use the flexibility provided by the APG rates to provide "induction services" to patients who wish to achieve recovery through the use of medications such as Buprenorphine. All of this innovative and cost effective system redesign is made possible because of the advent of the APG reimbursement system. As we move towards additional redesign of the Medicaid system in New York we urge the state not to abandon the good work which was done in creating the APG system, but rather to build upon it.

COMPA appreciates the transparency with which the state has approached phase one of Medicaid redesign. We also appreciate the fact that the state is taking the time to study service delivery for this population before rushing into "full" managed care.

Exactly how phase two will proceed is unclear and is a matter of significant concern to us. As we understand it, in phase two of Medicaid redesign the Behavioral Health Organizations (BHOs) will become risk-bearing.

When the BHOs become risk bearing we believe they should do so with the following provisions specified in their contracts with the state:

- All treatment programs licensed by OMH and/or OASAS, and in good standing, must automatically be on the BHOs provider panels;
- The rates of payment to be used by the BHO must be no lower than the APG rates as established by the New York State Department of Health. This will prevent a predatory *rush to the bottom* and will protect both treatment quality and diversity; and
- The BHOs must all utilize standardized instruments and protocols for placing patients in treatment and for conducting ongoing utilization review. Such instruments and protocols must be developed and/or designated by the state with ample input from the treatment community and be utilized during a trial period before final implementation.

We believe that this approach will have a number of benefits. First by including all licensed programs in the initial provider panel the state will preserve patient access to care, and will preserve the diversity of treatment which the state spent many decades and hundreds of millions of dollars to create. Second, the state will see a real return on the investment they made in creating the APG prices. These prices may not be perfect but they reflect a reasonable cost to render a high quality unit of service. The APG system also has mechanisms built in for continuous pricing adjustment to reflect cost and to

encourage efficiency. Lastly, by standardizing the patient placement and utilization review protocols we can ensure that all of the Medicaid eligible patients across the state are treated fairly and are given equal access to care without regard to which BHO manages their care.

Even within these contract provisions the managed care entities would have a wide range of options to regulate care quality and cost, but they would do so without irreversibly disrupting a fragile system of care delivery.

If protections are not included in the contracts the BHOs may choose to take on a standard HMO approach to limiting their financial exposure by:

- Establishing provider panels which include some OMH and OASAS licensed providers, while excluding others;
- Negotiating the lowest possible rates of payment with each provider; and
- Regulating access to care, type of treatment placement, and length of treatment based on the BHO's own (often proprietary) standards and algorithms.

We believe that if BHOs follow this path in phase two, the results could be a seriously damaged treatment system in New York State including the loss of significant treatment capacity which has taken more than forty years and hundreds of millions of tax-payer dollars to create.

In the case before us, there is time to get things right before we get them wrong. Our members are ready to work with the requisite state authorities as preparations for phase two get underway.